PATIENT VIEWS AND LIVED EXPERIENCES: UNDERSTANDING AND IMPROVING THE EVIDENCE BASE FOR SECURE INPATIENT SERVICES

by

Amy Louise Jackson

A thesis submitted to the University of Birmingham for the degree of

Doctorate in Forensic Psychology Practice (ForenPsyD)

Centre for Applied Psychology

School of Psychology

College of Life and Environmental Sciences

University of Birmingham

September 2022

Covid-19 Impact Statement

The initial research project for this thesis did not go ahead. It had planned to qualitatively explore patient experiences of the admission process to secure inpatient services; the foundations on which this thesis has been built. However, due to the Covid-19 pandemic, numerous difficulties and delays were encountered. This impacted on the ability to recruit participants and collection of research data (both in person and remotely). Despite best efforts to navigate and overcome these challenges over the course of eighteen months, a reluctant decision was made to close the research project due the timeframe of completing this thesis.

As an alternative, a decision was made to utilise the existing meta-synthesis (comprising Chapter Two) as a research project. An additional literature review (comprising Chapter Three) was conducted to complete this change. This was discussed with both academic supervisors, the Centre of Applied Psychology (CAP) research lead (Dr Chris Jones), and the lead lecturer for meta-synthesis (Dr Andrew Fox). It was approved on the grounds that a meta-synthesis involves analysing and synthesising data - presenting new findings to the field and adding to the evidence-base. As such, meeting the requirements for the research component of this thesis under Covid-19 regulations outlined by the University of Birmingham.

Abstract

The evidence-base for secure inpatient services has historically assigned little prominence to the patient voice. Broadly speaking, this thesis seeks to establish whether the field has progressed in more recent years. Its specific aims are to take an in-depth look at the literature relating to the views and experiences of patients; and to establish the state of the literature within the framework of trauma-informed care (TiC). Insights and knowledge gained will be used to consider areas of the empirical base that may be lacking or would benefit from being enhanced. Chapter One sets the scene with an overview of secure inpatient services. It then highlights the limitations and failures of traditional medically focused research hierarchies, alongside the emergence of TiC. Chapter Two presents a meta-synthesis of the lived experiences of secure inpatient services. Scoping searches reveal increased research attention is being paid to the secure inpatient voice. Yet, limited research into the aspects of care that may be of most significance to patients themselves. Addressing this gap, findings revealed that patients mostly discussed their experiences in the context of: relationships with staff on the ward; re-enactment of adverse early life experiences and subsequent survival strategies; and personal recovery. Findings are interpreted with reference to the wider literature, which generated patient-led recommendations for practice and future research. Chapter Three presents a systematic literature review to establish and improve understanding of what the literature base tells us about TiC within secure inpatient services. Initial scoping searches of the wider TiC literature across various domains demonstrate that it is a rapidly growing yet formative and highly complex field of academic study. With this in mind, the review addresses five specific aims: (i) to determine how TiC has been defined within the literature base; (ii) to identify the specific components of TiC that have been operationalised and/or implemented in practice; (iii) to identify any evaluations of TiC, including both the potential and/or actual impact of implementation; (iv) to identify future recommendations regarding TiC for both practice and research; and (v) to identify any additional and relevant key findings or discussion points that provide deeper insights into the discourse surrounding use of the term TiC. Results indicate the literature is growing, but is very much in its infancy. The complex picture presented is one that is both compatible and, to a larger degree, incompatible with a trauma-informed approach. This suggests TiC is an under-developed area and has perhaps been misrepresented by some in the academic field. After exploring the various systemic and interpersonal factors that pose a barrier to such a significant paradigm shift, recommendations are made to move the field forwards. Chapter

Four examines the psychometric properties of The Working Alliance Inventory – Short Revised (WAI-SR) (Hatcher & Gillasby, 2006) as a tool to measure patient-staff relationships within secure inpatient services. Findings suggest that the WAI-SR, in its current form and as a stand-alone measure, is not appropriate for use within these settings. Alternative recommendations are made for services to measure, or at least pay closer attention to, the quality of relationships on the ward. Chapter Five draws together the findings of each of the three main chapters, summarising the areas of the empirical base that are lacking and would benefit from enhancement. Its strengths and limitations are acknowledged, before drawing overall conclusions.

Acknowledgements

To my academic supervisors - Dr Zoe Stephenson and Dr Victoria Wilkes. Thank you for your ongoing support, patience, and guidance in navigating the numerous life and research-related obstacles I have encountered throughout this process. You have both gone above and beyond throughout my time on this Doctorate and for that I will be forever grateful.

To Dr Caroline Oliver, for lending a listening and understanding ear to my monthly ramblings. Thank you for reminding me that I would make it in the end.

To my clinical supervisor, Dr Rebecca Dunn, and my CAMHS colleagues. Thank you for (tentatively) asking how my thesis was going, normalising this process, and reassuring me of what life looks like on the other side.

To my wonderful, wonderful best friends. My biggest cheerleaders: Emma, Libby, Ava, and Emily. Thank you for always checking in, picking me up, pushing me forwards, and staying firmly by my side. I absolutely could not have done this without you.

Of course, to Max. I’m not sure what to say other than thank you, for everything. I’m looking forward to celebrating the way we do best: on the sofa with de-caffeinated tea and hours of reality TV.

And, to my Mum - Jayne. I don’t know of many parents who would offer (be persuaded?) to jump out of a plane with their daughter to mark the occasion of submitting a thesis.

Table of Contents

List of Tables

Chapter One: Introduction to the Thesis

Chapter Two: The Lived Experiences of Secure Inpatient Services: A Systematic Literature Review and Meta-Synthesis of Qualitative Studies

Chapter Three: What Does the Literature Base Tell Us About Trauma-Informed Care Within Secure Inpatient Services?: A Systematic Review

Chapter Four: The Working Alliance Inventory – Short Revised (WAIS-R): A Psychometric Critique

List of Figures

Chapter One: Introduction to the Thesis

Chapter Two: The Lived Experiences of Secure Inpatient Services: A Systematic Literature Review and Meta-Synthesis of Qualitative Studies

Chapter Three: What Does the Literature Base Tell Us About Trauma-Informed Care Within Secure Inpatient Services?: A Systematic Review

Chapter Four: The Working Alliance Inventory – Short Revised (WAIS-R): A Psychometric Critique

List of Appendices

Chapter Two: The Lived Experiences of Secure Inpatient Services: A Systematic Literature Review and Meta-Synthesis of Qualitative Studies

Chapter Three: What Does the Literature Base Tell Us About Trauma-Informed Care Within Secure Inpatient Services?: A Systematic Review

Chapter Four: The Working Alliance Inventory – Short Revised (WAIS-R): A Psychometric Critique

Definitions of Terminology Used Throughout the Thesis

The focus of this thesis is on the setting of secure inpatient services for adults within the UK. A more detailed and comprehensive description is provided within the introductory section of this thesis (beginning p. 15), referencing definitions taken from the Ministry of Justice (MoJ) and the National Health Service (NHS). Nonetheless, it is recognised that these services sit within a complex field that shares both differences and similarities with other domains, both within and outside of the UK. As such, clarification of the key terminology used throughout this thesis is offered to the reader.

Secure Inpatient

This is a specific term that refers to a subsection of services that fall under the umbrella of forensic mental health, in the literature base as well as practice. Secure inpatient services in the UK are provided according to three levels of therapeutic security, defined specifically as “high”, “medium”, or ‘low” secure. As mentioned within the introductory section of this thesis, the provision of secure inpatient services and the legal frameworks that govern them vary considerably across countries outside of the UK (Edworthy et al., 2016). For example, in Germany and the US, secure inpatient services are not always differentiated according to three levels of therapeutic security. Instead, they are “encapsulated in one ‘single service’ and labelled as ‘forensic psychiatric’ inpatient services” (Edworthy et al., 2016, p. 5) or secure care. The majority of patients within secure inpatient services in the UK are formally admitted under Forensic sections of the Mental Health Act (MHA) (1983, amended 2007). It is recognised that some patients within secure inpatient services will be detained under Civil sections of the MHA (1983, amended 2007). Although, these form the minority rather than the majority (Völlm et al., 2017).

General Inpatient

This is an umbrella term used to describe a collection of services that provide mental health assessment, care and treatment to patients detained informally or formally under the MHA (1983, amended 2007). In contrast to the above, the majority of patients in these services will be detained under Civil sections; only a minority will be detained under Forensic sections of the MHA (1983, amended 2007). Examples of general inpatient mental health services include Psychiatric Intensive Care Units (PICUs), General Acute Units (GAU), and locked rehabilitation settings. It is recognised that many of these services also provide a level of enhanced physical security (i.e., “locked” wards) in the interest of protecting patient safety (often due to risk of harm to themselves) and potential detention under the MHA (1983, amended 2007). However, they are not differentiated according to the type and level of security and therefore fall under the framework of general as opposed to forensic mental health, in the literature base as well as practice.

Forensic or Forensic Mental Health

This is a generic term used to describe a collection of services that provide mental health assessment, care, and treatment to individuals detained formally under the MHA (1983, amended 2007) and/or are subject to monitoring or restrictions by the Criminal Justice System (CJS). Examples of these type of services include specialist community placements, probation, prison, and secure inpatient. On occasion throughout this thesis, the term forensic or forensic mental health is used, as this is the domain under which secure inpatient services reside in the literature base as well as practice.

Patient

The choice of word - client, consumer, service-user, patient, expert by experience - identifies a power dimension between those who receive services and those who provide them. Dickens (2001) appears to be the first and only study to have explored preference for terminology amongst individuals within secure inpatient services (n = 100). As patient was preferred by the largest group (44%) of respondents, it is utilised throughout this thesis for consistency.

Chapter One

Introduction to the Thesis

Secure Inpatient Services in the UK

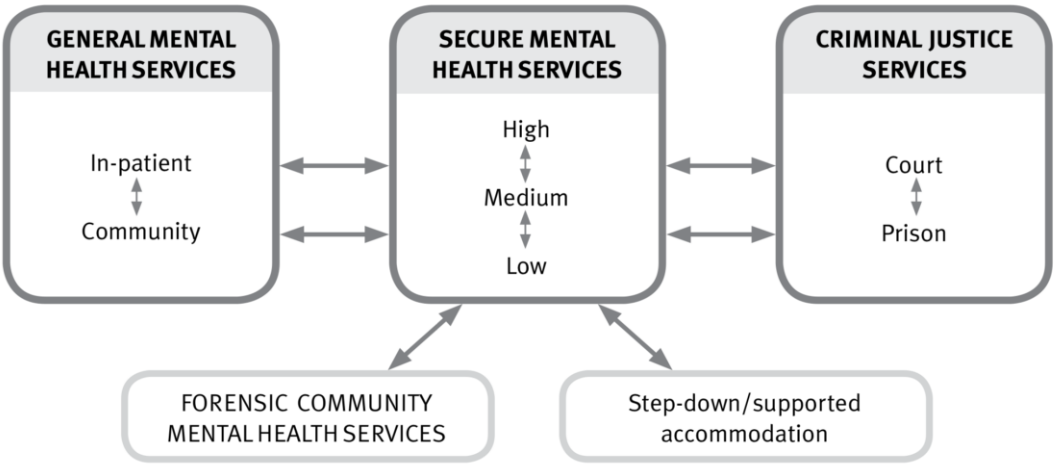
Secure inpatient care is a complex field that sits at the intersection of mental health, social and criminal justice services (Hörberg, 2018). The provision of these services and the legal frameworks that govern them vary considerably across countries (Edworthy et al., 2016). The provision of secure inpatient services for adults in the UK began over 150 years ago with the establishment of Broadmoor in 1863 (Edworthy et al., 2016), which served the whole of the country for a subsequent 50 years (Hamilton, 1980). Since then, and particularly over the past two decades, these services have expanded exponentially (Fazel et al., 2016). They now provide care for almost 8,000 individuals at any given time according to three levels of therapeutic security: high, medium, and low (MoJ, 2020). High secure services are delivered across three NHS hospitals - Broadmoor, Ashworth, and Rampton - with around 795 beds available. Medium and low secure services are delivered by both the NHS and independent sector with around 3,500 available, respectively (Hare Duke et al., 2018; Rutherford & Duggan, 2007).

Admission to secure inpatient services is not a matter of personal choice – it is a compulsory, legal requirement for which two main criteria must be met. The first is that an individual is legally defined as "suffering from a mental disorder of a nature and degree which makes it appropriate for [them] to be detained in a hospital for medical treatment and appropriate medical treatment is available for [them]" (MHA, 1983, amended 2007, s37[2], as cited in Edworthy et al., 2016, p. 20). For the second, it must be determined that the individual poses a "risk of harm to others" and "the risk of escape from hospital cannot be managed safely within other mental health settings" (NHS, 2021, p. 2). Thus, these services are designed to balance both therapeutic care alongside the management and reduction of risk (Kurtz & Jeffcote, 2011).

As illustrated in Figure 1, there are a number of possible admission pathways into a secure inpatient hospital. More often than not, individuals are formally admitted under forensic (Part III) sections of the MHA (1983, amended 2007) (Keown et al., 2018). The most prevalent of these being Section 47 (transfer from prison due to clinical need any time after sentencing) and Section 37 (initiated by the court due to clinical need at the time of sentencing); often with restrictions added (i.e., Section 47/49 and Section 37/41) (Keown et al., 2018).

Figure 1

Possible Admission Pathways into Secure Inpatient Units in the UK (Centre for Mental Health, 2011, p. 36)



However, unlike most other European countries, individuals in the UK can also be admitted without having a formal offending history. In such cases, individuals may have presented with high levels of distress and risk that are not able to be managed safely within general inpatient settings. They can be transferred to secure inpatient settings under civil (Part II) sections of the MHA (1983, amended 2007). Although admittedly, these form the minority rather than the majority (Völlm et al., 2017).

The number of individuals being compulsorily admitted to secure inpatient services has quadrupled over the past forty years (Keown et al., 2018). A significant proportion will require long-term care, potentially for the rest of their life (Vorstenbosch et al., 2014); often far beyond the time they would have spent in prison (if they had been charged, convicted, and sentenced for offending behaviour). The total number of individuals receiving longer-term care been increasing year-on-year for more than a decade and is now higher than ever before (Edworthy et al., 2016). Altogether, secure inpatient services are low-volume and high-cost (Ryland et al., 2021); accounting for approximately one per-cent of the entire NHS budget (Völlm et al., 2016) and approximately 19 per-cent of the overall mental health budget (Fazel et al., 2016). The annual cost per patient is in the range of £165,000 to £300,000 (Centre for Mental Health, 2021).

Given the distinct complexities of secure inpatient care that lend themselves to patient wellbeing, public safety, and economic interests (Collins & Crowe, 2016), it is imperative that the "best available, current, valid and relevant evidence" (Dawes et al., 2005, p.1) is used to understand and establish "what works" (Lindqvist & Skipworth, 2000); to guide both clinical practise and future research (Cartwright et al., 2022). The following sections will explore this concept – also known as "evidence-based practice" - in more detail.

Traditional Research Hierarchies

Since the early 1990's all mental health services – including secure inpatient - have been operating within the context of evidence-based practice (Glasby & Beresford, 2006). This is to ensure that services provide the most effective care possible - the highest quality and, therefore, the best value for money (Department of Health [DOH], 1997; National Institute for Clinical Excellence [NICE], 2018).

A number of official public bodies were established throughout the 1990's to explore, disseminate, and regulate "what works". For instance, the NICE (Glasby & Beresford, 2006). Borrowed from the medical sciences (i.e., physical illness and disease) (Engel, 1977), these entities typically advocate for traditional research hierarchies in that the "best" available evidence should be taken from systematic reviews comprising of randomised controlled trails (RCTs) focusing on professionally driven, quantitative outcome measures (see Table 1). Such evidence is afforded the highest value and thereby receives the most "status, authority and funding" (Faulkner, 2017, p. 5). It is assumed to be "unbiased, objective, and neutral" (Tew et al., 2006, p. 16); often interpreted as clinical fact (Sweeney & Beresford, 2020; Tew et al., 2006). The "expert opinion" - also known as expert by experience or service-user research (Rose et al., 2018) – of those on the receiving end of services have been placed at the bottom of the research hierarchy (Carlin et al., 2005). It is assumed to be "inherently biased and methodologically weak" (Sweeney & Beresford, 2020, p. 1192); not real or good enough evidence because it focuses on patients' subjective views or experiences (Tew et al., 2006).

Table 1

A Traditional Hierarchy of Evidence (Glasby & Beresford, 2006, p. 5)

Hierarchy	Type of evidence
Type I	At least one good systematic review, including at least one randomised controlled trial.
Type II	At least one good randomised controlled trial.
Type III	At least one well-designed intervention study without randomisation.
Type IV	At least one well-designed observational study.
Type V	Expert opinion (i.e., the views and/or experiences of patients or clinicians).

The Problem with Traditional Research Hierarchies

Traditional research hierarchies do, ostensibly, make sense; particularly within the context of the medical sciences, for which they were designed (Gomory, 2013). The assumptions and values base underpinning this paradigm are, however, inherently flawed and inappropriate for use within the domain of mental health (Tew et al., 2006). This has become a contentious topic of debate over recent years alongside increasing awareness into the limitations and failures of the medical model (i.e., a focus on what is *wrong* with someone) (Johnstone, 2022); the dominant framework by which all mental health – especially secure inpatient – services have been built upon (Clarke et al., 2016; Johnstone, 2022).

By way of example, even the most "controlled" of research studies cannot possibly remain objective and neutral. Publication bias is a pervasive and often overlooked problem for RCTs within the field of mental health. Researchers or journal editors can simply choose not to publish research findings that are unfavourable or challenge dominant ideologies (Bialystok et al., 2015). A particular problem within the secure inpatient evidence base is the purposeful inclusion or exclusion of participants diagnosed with certain psychiatric diagnoses (Cartwright et al., 2022). These tweaks can hugely inflate the efficacy of therapeutic interventions (i.e., what *does* work) and hides potential for harm (i.e., what *doesn't* work) (Driessen et al., 2015; Turner, 2013). On this basis, the argument that the patient voice is of significantly lesser value because it is "biased" or "subjective" simply does not hold.

Traditional research hierarchies place patients as passive recipients and lean towards reductionism, by doing *to* and positioning the problem *within* someone (Kidd & Carel, 2019). Again, this is a better fit for the medical sciences, a field that employs medical professionals to study the things that have gone wrong with the brain and body (Johnstone, 2022). By contrast, the subject of study within the domain of mental health is the human experience. The experiences under study – whether they be suicidal thoughts, hearing voices, self-harm, aggressive, violent, or offending behaviour – are not, by definition, scientific entities or problems that can be medically located within someone (Johnstone, 2022; Jones & Willmot, 2022). They are descriptions of responses, reactions and adaptations that make sense within the personal, social, cultural, economic, and political context of people's lives (Read & Harper, 2020). Simply put, "what has *happened?*", and "what is *happening?*" to someone (Butler et al., 2011). It therefore goes without saying that the "experts" here can be both mental health professionals and those on the receiving end of services, albiet in different capacities. Patients themselves hold additional, unique, and invaluable insights, perspectives, knowledge, and lived experiences that researchers and clinicians – "no matter how well trained or qualified" (Tait & Lester, 2005, p. 171) – cannot bring to their work alone (Happell et al., 2018).

As Tew et al. (2006) states, questions of methodological rigour can "miss the point" (p. 28). They detract from more important questions about the relevance and usefulness of research. The main problem with traditional research hierarchies is that what is known and what is important to know (i.e., what counts as "valid" evidence) is determined by people in positions of privilege and power (i.e., academic researchers, clinicians, journal editors, policy makers and commissioners). This can present a misleading, superficial, false, and potentially dangerous view of "what works" (Groot et al., 2022; Tew et al., 2006). As many have noted, this is more than an academic argument (Kidd & Carel, 2019). It is a "fundamental issue of human and civil rights" (Sweeney & Beresford, 2006, p. 12); one that becomes even heavier when considering the complexities of secure inpatient care that lend themselves to patient wellbeing, public safety, and economic interests (Collins & Crowe, 2016).

Dismantling Traditional Research Hierarchies

A more progressive approach is to see the "best available, current, valid and relevant evidence" as coming from a variety of sources; each offering their own unique and valued contributions and limitations (Dawes et al., 2005, p. 1). This is not a radical or liberal approach. It is simply one that encourages better engagement with and critical evaluation of the literature; one that actively seeks out, genuinely listens to, and meaningfully engages with the patient voice as a relevant contributor that can be complimentary and/or contradictory toward existing professionally led expertise (Millar et al., 2016). Ultimately, this could enhance the existing evidence base by making it more clinically meaningful (MacInnes et al., 2011); and provide a better understanding of what works (and perhaps, what doesn't). Although this approach is yet to be "named", its underpinning assumptions and values strongly mirror those of trauma-informed care (TiC), a model of human service delivery that has been gaining momentum across all health, social, educational, and criminal justice settings over recent years (Covington, 2022). Whilst a full description of TiC is beyond the scope of this introductory chapter[1], its four key assumptions - as outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA) (2014) - are worth mentioning here to illustrate this point further. The first of which is to *Realise* the widespread prevalence and impact of trauma amongst those accessing services and receiving care. The definition of trauma being "an event, series of events, or set of circumstances that is *experienced by an individual* [emphasis added] as physically or emotionally *harmful or life threatening* [emphasis added] and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being (SAMHSA, 2014, p. 7). The second assumption is to *Recognise* the signs of trauma such as the various responses, reactions, and adaptations that people develop – whether consciously or not – to cope, protect themselves, and survive. This corresponds to the abovementioned shift in thinking from "what is wrong with this person?" to "what has happened?", and "what is happening?" to someone (Butler et al., 2011). Thus, situating people in the context of their own lives. The third assumption is to Resist re-traumatisation. It asks organisations and services to identify, reflect on, and – where possible - reduce practises that may cause further harm; however subtle or inadvertent these may be. One example being to overlook, ignore, or

---

[1] See Chapter Three - titled What Does The Literature Base Tell Us About Trauma-Informed Care Within Secure Inpatient Services?: A Systematic Review - for a more detailed and comprehensive overview of TiC and clarity regarding definitions of trauma (p. 86).

intentionally devalue the patient voice. The fourth assumption is to actively *Respond* to all of the above. It places emphasis on TiC being a whole-systems approach; integrating and adopting these changes across *all* areas of an organisation or service. Hence, being applicable to both research and practise.

Returning to traditional research hierarchies: it is interesting that some public bodies have started to openly declare that the over-reliance on "outdated legal and regulatory frameworks" hinders progress in the field of mental health (WHO, 2021, p. 17), indicating that the "power is shifting" (NICE, 2018, p. 5). Yet, whilst these publication declarations are new, the approach itself, is not. Calls to listen to the patient voice have been ongoing for several decades (Campbell, 2005; Department and Health and Social Care, 2018). The "origin" of service user involvement - Mental Patients Union - for example, was formed over fifty years ago (Crossley & Crossley, 2001). The antecedents for the emergence of such declarative shifts are multifaceted and difficult to pinpoint. They are undoubtably the cumulative and ongoing effort of numerous individuals and groups of people within the fields of: psychiatry (Engel, 1977; Szasz, 1960); feminist literature (Harding, 2004; Hartsock, 1987; Rose, 1994); social model of disability (Oliver, 2008; Shakespeare, 2006); personal recovery (Frese et al., 2001; Slade et al., 2008); mad and survivor studies (Beresford et al., 2010; Faulkner, 2017; Menzies et al., 2013); and, as mentioned above, TiC (Becker-Blease, 2017; Butler et al., 2011).

The impact of this work has been gaining traction since the start of the 21st century, which saw the emergence of a plethora of policy reforms, legislative and organisational guidance, as well as national networks and independent charities; all of which have, in one way or another, recognised that patients have expertise, and should be listened to when planning, designing, and delivering mental health services (Mottershead et al., 2020; Tait & Lester, 2005; Völlm et al., 2017). The Research Governance Framework for Health and Social Care (DoH, 2001, amended 2005), for example, was the first document to recommend involving patients at every stage of research. Some years later, The World Health Organisation's (WHO) mental health strategy for Europe declared patient involvement to be essential in the development and evaluation of services (Callard & Rose, 2012). Other, more recent examples include Implementing Recovery - a new framework for organisational change (Sainsbury Centre for Mental Health, 2014), the UK Policy Framework for Health and Social Care Research (NHS Health Research Authority, 2017), and The Women's Mental

Health Taskforce Final Report[2] (Department of Health and Social Care, 2018). The latter documents the work of the Women's Mental Health Taskforce, set up in 2017, to define, address and improve the "mental health of women, and their experiences of mental health services" (p. 15). Part of this work involved hearing from the voices of women themselves, including those with lived experience of secure inpatient services. Findings of the report present a drastic call for change in-line with TiC relevant to the design and delivery of services as well as "at every stage of the research and data process" (p. 51). Some of the key recommendations here include embedding and promoting women's lived experience, and identifying knowledge gaps that may hinder current understanding of the evidence-base. The report concludes by acknowledging these proposals are by no means novel; "there are those who have been calling for these changes for many years" (p. 2). Instead, it urges all those involved – from researchers and practitioners to providers and commissioners – to engage in conversations that revive the debate and set higher expectations for women's mental health services.

Taken together, the picture presented is certainly one that supports the dismantling of traditional research hierarchies within the field of mental health. Yet, whilst relevant to secure inpatient services, none of the above is *specific* to secure inpatient services. In fact, there currently exists no comprehensive policy or guidance relating to the importance of incorporating secure inpatient views or experience into the evidence-base (Völlm et al., 2017).

The Evidence-Base for Secure Inpatient Services

In keeping with traditional research hierarchies, the evidence base for secure inpatient services has "predominantly been conducted from a clinical perspective, where evaluation methods and markers of what constitutes success are determined by care providers" (Tapp et al., 2013, p.1). Evaluation markers afforded the highest relevance include those relating to risk of violence, re-admission rates, need for therapeutic security, and clinically driven quantitative outcome measures (i.e., reduction in "symptoms") in response to specific interventions or treatments (Kennedy et al., 2019; McIntosh et al., 2021; NHS, 2021; Ryland et al., 2021). Whilst this evidence is undeniably critical, it paints only one part of the picture.

---

[2] The Women's Mental Health Taskforce: Final Report (Department of Health and Social Care, 2018) will be referenced and explored further at various points throughout this thesis.

Some even argue it has paradoxically proved to have limited or suboptimal efficacy when it comes to achieving what it set out to do: reduce risk (Markham 2021a; Markham, 2021b; Willmot & Jones, 2022).

What is noticeably missing here are the insights, knowledge, and lived experiences of the people at the very centre of secure inpatient services – the patients themselves (Cartwright et al., 2022; Shinkfield & Ogloff, 2015). This is, of course, not to say that such research simply does not exist, nor that its importance has been entirely overlooked. Indeed, there exists a handful of articles dedicated solely to advancing the involvement of patients within secure inpatient services across all areas of research; their input into both what is known, and what is important to know (Banongo et al., 2006; MacInnes et al., 2011; Ryland et al., 2021; Spiers et al., 2005; Völlm et al., 2017). The question is then, do patients within secure inpatient services have a voice?

Aims and Overview of this Thesis

The aims of this thesis are twofold. Firstly, to take in-depth look at the literature relating to the views and experiences of patients; and secondly, to establish the state of the literature relating to TiC within secure inpatient services. The insights and knowledge gained will be used to consider areas of the empirical base which may be lacking or would benefit from being enhanced. To achieve this, three distinct pieces of work were carried out, as summarised below.

Chapter Two presents a systematic literature review of the lived experiences of secure inpatient services within the UK. A meta-synthesis of qualitative studies that adopted a patient-centred approach was undertaken to establish the aspects care that may be of most significance to patients themselves. Findings are interpreted with reference to the wider literature in order to generate patient-led recommendations for practice and future research. In response to these findings, Chapter Three[3] presents a systematic literature review of TiC within secure inpatient services. More specifically, it explores definitions of TiC, how its components have been operationalised for practise, the impact of TiC, and recommendations

---

[3] As mentioned, the planned research project for this thesis (to explore patient experiences of the admission process to secure inpatient services) did not go ahead. Refer to Covid-19 Impact Statement for further details (p. 2).

for both research and practice made by the authors of the included studies regarding TiC within secure inpatient services. The complex picture presented is interpreted alongside an exploration of the various systemic and interpersonal factors that pose a barrier to such a significant paradigm shift within the field of forensic mental health, followed by recommendations to move the field forwards. Combining the findings of both these reviews, Chapter Four examines the psychometric properties of one of the most popular, widely researched, and up-to-date alliance tools: the Working Alliance Inventory – Short Revised (WAI-SR) (Hatcher & Gillasby, 2006). It is critiqued with a view to assess its appropriateness for use within secure inpatient services as a tool to measure the quality of patient-staff relationships. A variety of recommendations are proposed for services to measure, or at least pay closer attention to, relational components of care.

Finally, Chapter Five draws together the findings of each of the three main chapters, summarising the areas of the empirical base that are lacking or would benefit from enhancement. These are used to develop further implications for both practice and research. The strengths and limitations of this thesis are acknowledged, before drawing overall conclusions.

Chapter Two

The Lived Experiences of Secure Inpatient Services: A Systematic Literature Review and Meta-Synthesis of Qualitative Studies

Abstract

This review provides a meta-synthesis of qualitative studies that adopted a patient centred and holistic approach to explore the lived experiences of secure inpatient services in the UK. Initial scoping exercises revealed increased research attention is being paid to capturing the secure inpatient voice. Yet, they also revealed limited research into the aspects of care that may be of most significance to patients themselves. This review sought to address this gap. Its aims were to provide context-rich narratives that encompass any/all aspects of care and, in doing so, identify the most salient aspects of these experiences.

To achieve this, a systematic search strategy was employed. This involved five electronic databases (PsycINFO, CINAHL Plus, Social Services Abstracts, Sociological Abstracts, and Web of Science), grey literature sources, hand searching of reference lists, and contact with experts. Seven studies met the inclusion criteria and remained following quality assessment. Findings were extracted and synthesised using a detailed, systematic, and context-rich process of meta-aggregation whereby the existence and prevalence of key themes were identified.

Central to the narratives of all participant interviewees were ten key, interconnected themes: (1) Relationships on the Ward; (2) Re-Enactment of Adverse Early Life Experiences and Survival Strategies; (3) Personal Recovery; (4) Physical and Psychological Safety; (5) Disempowerment and Dehumanisation; (6) A Future in the Community; (7) Entering and Leaving the Ward; (8) Psychological Interventions; (9) Occupational Activities; and (10) Medical Treatment and Diagnoses. The first three themes were particularly prevalent, making up almost half of all findings.

These findings demonstrate that when participants discussed their experiences of care within secure inpatient services, they mostly did so in the context of: their relationships on the ward; the ways in which these services can re-enact adverse early life experiences and subsequent survival strategies; and their own personal recovery. These themes are then interpreted with reference to the wider literature, which indicated that the existing literature may be slightly biased towards professional interests. The strengths and limitations of this review are discussed and, in addition, recommendations for clinical practise and future research are made.

Introduction

As discussed in Chapter One, the evidence base for secure inpatient services has "predominantly been conducted from a clinical perspective, where evaluation methods and markers of what constitutes success are determined by care providers" (Tapp et al., 2013, p.1). Evaluation markers afforded the highest relevance include those relating to risk of violence, re-admission rates, need for therapeutic security, and clinically driven quantitative outcome measures in response to specific interventions or treatments (Kennedy et al., 2019; NHS, 2021a; McIntosh et al., 2021; Ryland et al., 2021). The field has, historically, assigned little prominence to the views and lived experiences of the people at the very centre of secure inpatient services: the patients themselves (Ryland et al., 2021; Shinkfield & Ogloff, 2015). This approach, however, can present a misleading, superficial, false, and potentially dangerous view of "what works" (Groot et al., 2022; Tew et al., 2006).

Views and Experiences of Secure Inpatient Services: Existing Research

Initial scoping searches were conducted to gain a better understanding of the existing literature base relating to the views and experiences of patients within secure inpatient services. It appears the very first literature review was conducted by Coffey (2006), tilted "Researching service user views in forensic mental health: a literature review" (p. 73) and thereby encompassing secure inpatient, prison, and community services. Across a period of 14 years (1990 to 2004), only 21 research papers were retrieved: 16 from the UK, two from the US, and three from Canada[1]. Coffey (2006) surmised there to be a healthy eclecticism of quantitative, qualitative, and mixed methodological approaches. A closer look however, revealed significant flaws relating to the application and reporting of research processes. Interview excerpts from patients, for example, were often either non-existent or presented out of context. The limited data retrieved was briefly summarised as indicating both negative and positive experiences of forensic mental health services, with specific concerns for restrictions on liberty. Reference was also made to the "immense importance" of therapeutic relationships; with professionals providing "supportive yet challenging therapeutic

---

[1] Byrt & Reece (1999); Dell & Grounds (1995); Ford et al. (1999); Goodwin (1994); Russel & Kettles (1996); Hinsby & Baker (2004); Huckle (1997); Morrison et al. (1996); Robinson & Collins (1995); Rees & Waters (2003); Riordan et al. (2002); Ryan et al. (2002); Sainsbury et al. (2004); Skelly (1994a); Skelly (1994b); Sequeira & Halstead (2002); Vaughan & Stevenson (2002); Arrigo (2001); Brodey et al. (2000); Gerber et al. (2003); Quinsey et al. (1996); Schafer & Peternelj-Taylor (2003).

assistance" being considered the most helpful (p. 79). Coffey (2006) concluded there to be a significant gap in literature base regarding the patient voice. It was recommended that research expands in both quantity and quality to produce more credible research findings that can be used to inform and develop forensic mental health practice.

It is now over 15 years since Coffey's (2006) review. Since that time, the literature seems to have expanded quite significantly (Holley & Weaver, 2019). It appears to have begun with a focus on quantitative studies. These have typically utilised surveys and questionnaires that measure patient views of, for example: service satisfaction (Bressington et al., 2011; Macinnes et al., 2010); quality of life (Bouman et al., 2008; Vorstenbosch et al., 2014); recovery (Green et al., 2011); social climate (Howells et al., 2009; Schalast et al., 2008); and relationships with staff (Bressington et al., 2011; Donnelly et al., 2011). Eventually, more qualitative studies began to emerge. These have typically employed semi-structured interviews to explore lived experiences of, for example: restrictive practice (Askew et al., 2019; Tomlin et al., 2019; Tomlin et al., 2020); specific psychological and/or occupational health interventions (Lord et al., 2016; Morris et al., 2016); risk assessment and management (Dixon, 2012; O'Dowd et al., 2022); and personal recovery (Glorney et al., 2019; Gran, 2014). Other more unique topics include: parenting within secure inpatient services (Parrott et al., 2015; Wells et al., 2022); preparing for discharge into the community (Madders & George, 2014); growing older within secure inpatient services (Visser et al., 2019); and comparison with general psychiatric inpatient settings (Mottershead et al., 2020). More recent studies have combined both professional and patient views to establish priorities for research and outcome measurement (Aboaja et al., 2021; Ryland et al., 2021)[2]. A recently completed - yet currently unavailable - Doctorate thesis titled "Experiences of secure patients within forensic settings" was also found (Humpries, 2022).

There has also been an increase in literature reviews attempting to capture this emerging research base. Since Coffey (2006), at least ten more reviews have been published (see Table 2). Topics explored mainly include personal recovery (Clarke et al., 2016; Lovell, 2019; McKenzie-Smith, 2019; Shepherd et al., 2016; Senneseth et al., 2022). But also: social climate (Doyle et al., 2017; Robinson et al., 2018); environmental factors (Greenacre & Palmer, 2018); restrictiveness (Tomlin et al., 2018); and female experiences (Ratcliffe et al.,

---

[2] Explored further in the Discussion section (p. 70).

2021). Collectively, these reviews include over 100 individual research studies. These originate from several different countries, and have utilised a variety of qualitative, quantitative, and mixed methodologies. Although, a large proportion were set within the UK and adopted a qualitative research design.

Table 2

Existing Literature Reviews Exploring Patient Views and Experiences of Secure Inpatient Services (in Order of Publication)

		Articles retrieved			
Title, author, and year	**Phenomenon of interest**	**Total**	**Design (n)**	**Settings**	
				Services (n)	**Locations (n)**
Coffey (2006)	Patient views of forensic mental health provision	23	Qualitative (13) Quantitative (8) Mixed (2)	Secure inpatient (17) Community (2) Prison (3)	UK (16) US (2) Canada (3)
Clarke et al. (2016)	Patient perceptions of recovery	11	Qualitative (11)	High secure service (1) Regional secure service (1) Community and secure (1) Not specified (1)	UK (7) New Zealand (2) Canada (1) Australia (1)
Shepherd et al. (2016)	Patient experiences of personal recovery	5	Qualitative (5)	Secure inpatient (5)	UK (4) New Zealand (1)
Doyle et al. (2017)	Patient views of social climate	20	Qualitative (20)	Secure inpatient (20)	UK (9) Sweden (5) Canada (2) Australia (1) New Zealand (1) Belgium (1) South Africa (1)
Greenacre and Palmer (2018)	Staff and patient views of social climate	9	Qualitative (4) Quantitative (4) Mixed (1)	Variety of therapeutic and rehabilitative environments (5) Prison (4)	UK (4) Australia (2) Germany (1) US (1) Europe (1)

Robinson et al. (2018)	Staff and patient perceptions of social climate and associations with aggression	7	Quantitative (7)	Secure inpatient (6) Prison (1)	UK (3) US (1) Netherlands (1) Holland (1) Germany (1)
Tomlin et al. (2018)	Staff, patient, and academic commentators' experiences of restrictiveness in forensic care	50	Qualitative (not reported) Quantitative (not reported)	Secure inpatient (50)	UK (31) Canada (5) Sweden (6) US (2) Australia (2) New Zealand (2) Five other European Nations (5)
Lovell (2019)	Patient experiences of recovery	22	Qualitative (22)	Secure inpatient (not reported) Community (not reported)	UK (14) New Zealand (2) Australia (2) Sweden (2) Canada (2) Belgium (1)
McKenzie-Smith (2019)	Patient experiences of recovery	15	Qualitative (15)	Secure inpatient (13) Prison (1) Not specified (1)	UK (13) Canada (1) Sweden (1)
Ratcliffe et al. (2021)	Female service users' experiences of secure care in the UK	15	Qualitative (14) Mixed methods (1)	Secure inpatient (15) Community (2)	UK (15)
Senneseth et al. (2022)	Personal recovery and its challenges	21	Qualitative (21)	Secure inpatient (21)	UK (7) Canada (3) Sweden (3) Australia (1) New Zealand (1) China (1) Denmark (1) Finland (1) Belgium (1)

Rationale for the Current Review

Clearly, increased attention is being paid to the secure inpatient voice within the academic field. It is promising that we seem to know much more about the "perspectives of people who use forensic mental health services" than we did fifteen years ago, particularly within the UK (Coffey, 2006, p. 73).

That said, the provision of care within secure inpatient services is typically complex, dynamic, and multi-disciplinary in nature; involving a host of independent and inter-dependent therapeutic and risk-focused ingredients. The existent reviews highlighted above have not consistently included studies that have allowed patients to fully explore the intricacies inherent in these services; often being limited or restricted by researcher interest. There is, in fact, limited research into what makes secure inpatient services operate effectively, or ineffectively, as a whole (Ryland et al., 2021).

The rationale for this review was to address this gap. To achieve this, it will provide a meta-synthesis of qualitative research studies that adopted a patient centred and holistic focus to explore the lived experiences of being cared for in secure inpatient services. It endeavours to only include studies that provided participants with the flexibility to narrate the complexity of their experiences more freely; emphasising the importance of particular domains - independently or interdependently (Tapp et al., 2013) - without being as tightly limited or restricted by researcher interests (i.e., pre-determined specific aspects of care). Such an approach may be "better able to capture the nuance and subjectivity of individuals' experience, circumstances and views and can therefore be said to be better able to represent what [it purports] to, that is… greater validity" (Picker Institute Europe, 2011, p. 24).

Aims of the Current Review

This review provides a meta-synthesis of qualitative studies that adopted a patient centred and holistic approach to explore the lived experiences of secure inpatient services. The specific aims are two-fold:

1. To provide context-rich narratives encompassing any/all aspects of receiving care in secure inpatient services.
2. To identify the most salient aspects of these experiences.

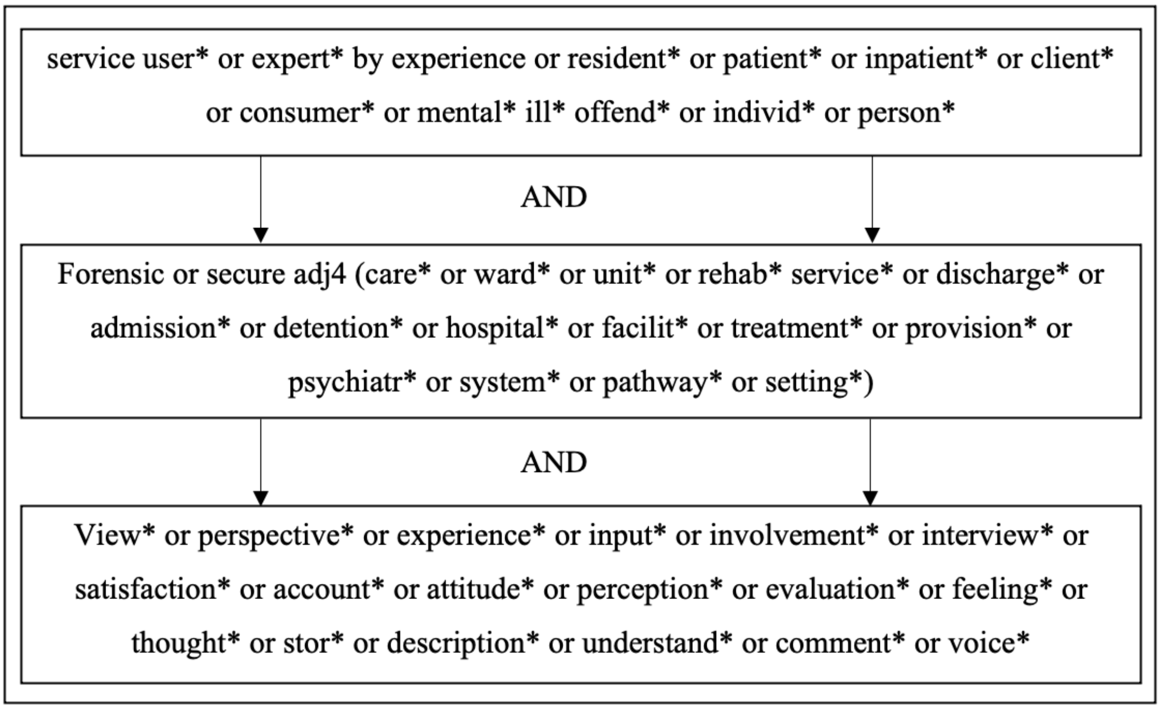
Methodology

Search Terms

The researcher utilised a process similar to citation pearl growing techniques in an attempt to identify as many relevant search terms as possible (Papaioannou et al., 2010). The first stage of this process was completed during the scoping exercise (i.e., key search terms identified). The second stage was to identify the “pearl”: “a known, highly relevant article” (Sutton et al., 2016, p. 115). Coffey’s (2006) review was chosen as this is the first to have explored secure inpatient views and experiences and is therefore regularly cited by others. Relevant keywords and phrases from within this article were identified. The researcher then located the article within PsycINFO. All subheadings were included to view more general or specific terms within the thesaurus. This process revealed minimal additional and relevant search terms from the Key Concepts/Words, Subjects Headings, and Index Terms. Given this, the researcher chose to manually identify further search terms from within the reviews and articles identified during initial scoping exercises. Additional synonyms were generated by the researcher and advice was sought from the University of Birmingham specialist librarian for psychology. Adjacency/proximity and wildcard operators were applied to maximise the number of relevant results. The final search terms can be found in Figure 2. Modifications were made to accommodate the specific requirements for different databases and platforms.

Figure 2

Search Terms Used for Electronic Database Searches



Search Strategy

Databases and sources were chosen by the researcher according to the subject coverage. Advise was also taken from a specialist librarian in Psychology at the University of Birmingham:

1. Five electronic databases were searched: PsycINFO (1967 to 2022); Cumulated Index to Nursing and Allied Health Literature (CINAHL) Plus (1937 to 2022); Social Services Abstracts (1979 to 2022); Sociological Abstracts (1973 to 2022) and Web of Science (1991 to 2022).
2. Grey literature sources were also searched to minimise publication bias: the Department of Health (DoH); National Institute for Health and Care Excellence (NICE) Evidence; National Health Service (NHS) Institute for Innovation and Improvement; and ProQuest Dissertations and Theses (Global).

The original search strategy was employed in January 2020. A repeat of electronic, grey literature, and manual searches was conducted in July 2022 (specific to the years 2020 to 2022). The exact syntax, limits/filters and results for each database search can be found in Appendix A (excluding organisational websites).

3. The reference lists of all the articles that met the predefined inclusion/exclusion criteria and of the eleven reviews identified from initial scoping searches (Table 2) were hand searched by the researcher. Citation searches of all the articles that met the predefined inclusion/exclusion criteria were conducted using the cited by function in Google Scholar and the Times Cited function in Web of Science.
4. Where email addresses were obtainable, contact was made with experts who had either published a number of research studies directly relevant to the review question, or had co-authored at least one of the articles that met the predefined inclusion/exclusion criteria (excluding Doctoral theses): Gillian Mezey; Jacqueline Parkes; James Tapp; Lisa Maltman; and Mick Mckeown. The researcher made contact to request for any published or un-published references relating to the current review; a summary of inclusion/exclusion criteria was included in the email. Two experts responded.

Screening and Selection Tool

The search strategy tool Sample, Phenomenon of Interest, Design, Evaluation, Research type (SPIDER) (Cooke et al., 2012) was chosen to develop the inclusion/exclusion criteria for the current review (see Table 3). This was deemed to be a more appropriate framework than Population, Intervention, Comparison, Outcome (PICO), which is not recommended for synthesising qualitative research (Cooke et al., 2012).

Of note, a focus on studies within the UK was chosen for two reasons. Firstly, it is the context throughout which this thesis has been set and thereby increases specificity. Secondly, initial scoping searches identified a large majority of existing research has been published with the UK. The author also chose to include unpublished research papers as the peer-review and publication process can be subject to bias (Bialystok et al., 2015).

Table 3

Inclusion and Exclusion Criteria Using the SPIDER Tool (Cooke et al., 2012)

	Inclusion	**Exclusion**
Sample	<u>Setting</u> - Low, medium, or high secure/forensic inpatient services within the UK <u>Population</u> - Currently a secure/forensic inpatient or experience of being a secure/forensic inpatient - Male and/or female - Adults (over 18 years of age)	<u>Setting</u> - Services outside of the UK - Prison or community services <u>Population</u> - Not currently a secure/forensic inpatient or no previous experience of being a secure/forensic inpatient - Mixed samples (i.e., general psychiatric patients/clinical staff) - Children or adolescents (under 18 years of age)
Phenomenon of interest	- A multidimensional and/or holistic focus on being the recipient of care within secure inpatient services Thus, having allowed participants to speak during interviews more freely about their experiences of care, without being directed, limited, or restricted by researchers' interests.	- Focused on specific aspect/s of care within secure inpatient services (i.e., psychological, occupational, or medical interventions/treatment, relationships with staff, psychiatric diagnoses, risk assessments, restraint, etc.). Thus, participants' responses during interviews were more directed, limited, or restricted by researchers' interests.
Design	- Loosely structured interviews (i.e., un/semi-structured interviews and/or interviews utilising open-ended questions only)	- Survey - Questionnaire - Focus group - Other
Evaluation	- Patient input	- No patient input - Staff input
Research type	- Qualitative	- Quantitative - Mixed methods[3] - Systematic review - Commentary
Publication type	- Published peer-reviewed article - Unpublished research paper - Doctoral thesis	- Conference abstracts - Below Doctorate level dissertations or theses - Organisational or government reports

---

[3] Further clarification as to why mixed methods studies were excluded is provided on page 42.

Screening and Selection of References

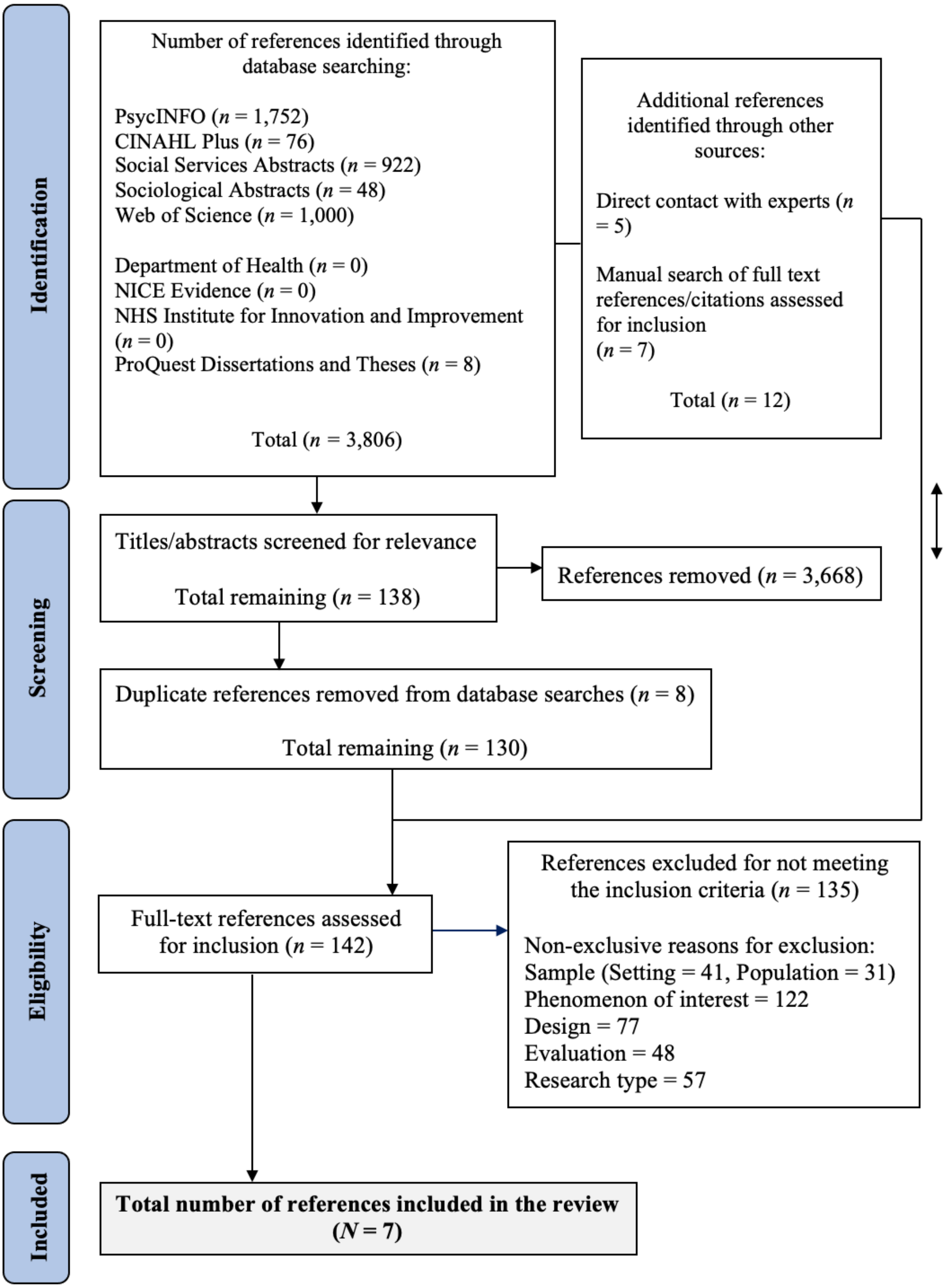
Once all of the electronic searches had been conducted in 2020, a total of 3,806 hits were returned. All references were removed where it was evident that the titles and/or abstracts were unrelated to the current review (*n* = 3,668). Following removal of duplicates, a total of 130 articles remained. Seven additional references were identified through citation/hand searches and five were identified through direct contact with experts. The full texts of all these articles were obtained (*n* = 142), and the inclusion/exclusion criteria were applied by the researcher using the selection and screening tool (see Appendix B). Following screening, 135 articles were excluded. The results of updated searches conducted in July 2022 revealed an additional 467 hits; 27 of which progressed to the screening stage but none of which met the inclusion criteria. Appendix C documents all 162 references and reason/s for exclusion.

In total, seven studies proceeded to the quality assessment stage (two of which were identified through citation/hand searches). A diagrammatical representation of the selection and screening process that took place in 2020 can be found in Figure 3.

It is of note that one study identified through citation/hand searches (Riordan & Humphreys, 2007) met all of the inclusion criteria except for method of data collection. Although it seems that the authors utilised interviews with open-ended questions, there was no direct evidence for this. In line with best practice (Dundar & Fleeman, 2014), the researcher attempted to make contact with the authors to seek clarification on the matter. No contact was able to me made and a decision was made to exclude the study.

Figure 3

Flow Diagram of the Selection and Screening Process Completed in January 2020



Quality Assessment

Quality assessments were conducted on all seven studies included for review using the Critical Appraisal Skills Programme (CASP) Qualitative Checklist (2020). An example of the scoring sheet can be found in Appendix D. For the purpose of transparency, the researcher modified the tool by adding a numerical scoring system: *Yes* = 2, *Can't tell* = 1, No = 0. *Can't tell* was only used where there was limited or an absence of information that prevented the researcher from coming to a firm conclusion; not when the researcher had difficulty making a decision. The maximum score for each study was 20.

The researcher assessed the quality of all seven studies (see Appendix E). The quality of the studies ranged from 70% to 100%, with an average of 89%. The main methodological strengths were: clear statement of aims (i.e., the relevance of the research); justified and appropriate methodology (i.e., qualitative design); clear statement of findings; and research value (i.e., reference to wider literature, clinical/research implications and study limitations). The two highest scoring studies (Baker, 2017; Tapp et al., 2013) provided in-depth descriptions of methods of data collection and analysis. They also included detailed reflective statements pertaining to the relationship between researcher/s and participants.

The main methodological weaknesses were limited information relating to: the recruitment strategy of participants (i.e., the use of participant information sheets, specific inclusion/exclusion criteria, why some participants chose not to take part); data collection (i.e., full content of the interview schedule); consideration of the relationship between researcher and participants (i.e., critical examination of the researchers role, potential bias and influence); ethical issues (i.e., written informed consent, data confidentiality and/or debriefing); and data analysis (i.e., in-depth description of the analysis process). The lowest scoring study (Barsky & West, 2007) specifically suffered from a lack of information relating to data collection and analysis. They also did not include evidence of approval from an ethics committee.

It was the researcher's decision not to exclude any articles from this review at the quality assessment stage for multiple reasons. The number of studies included (*n* = 7) meets the minimal recommended requirement for qualitative systematic reviews to allow for sufficient data analysis: no fewer than six and no more than 12 (Sutton et al., 2016). All studies obtained a quality assessment score of $\geq$70%. Although a numerical scoring system is not always advised for qualitative reviews (CASP, 2020), the researcher deemed these scores to be, at the very least, satisfactory. The researcher is also aware that word limits for published research may place strain on researchers looking to describe complex qualitative methodology and/or results (Malterud, 2001). It is possible that all research methodology was of sufficient rigour, but the reporting of such was limited by word count. Finally, the method chosen to synthesise the data allows for further quality assessment (explored below).

Results

Method

The synthesis of qualitative data is a continuously evolving, complex, and arguably contentious methodological domain (Hannes & Pearson, 2011). Indeed, there were at least fifteen approaches available to the researcher (Lockwood et al., 2015). A qualitative expert from the University of Birmingham and a decision-making framework on choosing appropriate qualitative evidence synthesis methods (Sutton et al., 2016) were used to decide upon meta-aggregation for this review. The rationale for which is provided below.

Meta-aggregation is a specific type of meta-synthesis that was initially developed by the Joanna Briggs Institute over twenty years ago (Hannes & Lockwood, 2011). It was designed intentionally to offer a methodology for synthesising qualitative research that reflects the standardised and rigorous processes applied to quantitative data, whilst also being “sensitive to the contextual nature of qualitative research and its traditions” (Hannes & Lockwood, 2011, p. 1633). Thus, demonstrating the value of qualitative data in contributing to evidence-based care (Hannes & Pearson, 2011). It has therefore been deemed appropriate for reviews within health and social care that aim to summarise “a range of views regarding interventions or health issues” (Munn et al., 2014, p. 2).

Meta-aggregation is defined as a detailed, systematic, and context-rich process of extracting and synthesising qualitative research (Paterson, 2001; Bergdahl, 2019). It is rooted in pragmatism in that it does not seek to re-interpret findings or generate new/add to existing theory (as per interpretative analytic methods) (Hannes & Pearson, 2011). Instead, it seeks to aggregate findings so that the synthesised results are transparently linked to the authors findings and original participant data. Findings represent “a verbatim extract of the author’s interpretation” (Lockwood et al., 2015, p. 183). Original participant data represents “the actual words of the participant” (Hannes & Pearson, 2011, p. 2).

Meta-aggregation is said to perform at its best with studies that present sufficient context and qualitative detail; when the researchers’ position, data collection and method of data analysis is clarified and the findings are “largely secure and well specified” (Joanna Briggs Institute, 2007, as cited in Hannes & Lockwood, 2011, p. 1636). The reason being that meta-aggregation offers an additional and unique layer of quality assessment at the individual findings level. Each extracted finding (based on the authors’ interpretation) is assigned a level of plausibility[4] according to how representative it is of the original data (based on the participants’ words). This assesses for transparency and credibility (Lockwood et al., 2015) and, in combination with the contextual details of the included studies, provides an overall evaluation of “the trustworthiness of findings” (Hannes et al., 2018, p. 6).

Staying as close as possible to the participant voice was deemed to be particularly important in meeting the specific aims of this review ([i] to provide context-rich narratives encompassing any/all aspects of receiving care in secure inpatient services; and [ii] to identify the most salient aspects of these experiences); in addition to meeting one of the main aims of this thesis which is to take an in-depth look at the literature relating to the views and experiences of patients within secure inpatient services.

The steps involved in conducting meta-aggregation were taken, combined, and adapted to meet the aims of this review from Hannes and Pearson (2011) and Lockwood et al. (2015):

1. Extraction of general study details: study characteristics, participant characteristics, and results
2. Extraction of findings
3. Categorisation
4. Synthesis

---

[4] For more detail regarding levels of plausibility allocation, see Extraction of Findings (p. 55).

Rationale for Exclusion of Mixed Methods Studies

The inclusion of qualitative data from mixed methods studies into qualitative meta-synthesis reviews is a long-standing and contentious topic of debate. Whilst they can undoubtably offer important, additional contributions they can also create challenges at multiple stages of the review process (Atkins et al., 2008; 2012). The relative weight of which is dependent upon the aims and purpose of a review as well as the specific type of methodology employed.

Prior to conducting the search strategy, it was the researcher's decision to exclude mixed-methods research for two reasons. Firstly, the exclusion was determined in consideration of the specific aims of this review, which are: (i) to provide context-rich narratives encompassing any/all aspects of receiving care in secure inpatient services; and (ii) to identify the most salient aspects of these experiences. In order to meet these aims, the "phenomenon of interest" detailed within the inclusion/exclusion criteria (p. 36) was intentionally designed to capture studies that provided participants with the flexibility to talk about their experiences of secure inpatient services more freely, without being as tightly limited or restricted by researcher interests (i.e., pre-determined specific aspects of care). Naturally, the quantitative element of mixed-methods studies can pose a barrier here, in that more structured methods of data collection (i.e., surveys, questionnaires) would focus data collection on a particular element, or elements, of care within secure inpatient services.

Secondly, as mentioned above, meta-aggregation performs best with studies that present sufficient context (i.e., researchers' position, data collection, method of data analysis) and qualitative detail (i.e., data and findings) (Joanna Briggs Institute, 2007, as cited in Hannes & Lockwood, 2011, p. 1636). Although it is recognised that the quality of all published studies – regardless of methodology – will inevitably vary, it was the researcher's decision to exclude mixed-methods research on the basis that they typically offer less methodological context and qualitative detail due to the space they share with quantitative elements (Atkins et al., 2012). Ultimately, the decision was taken to exclude mixed-methods studies with a view to conduct a review that stays as close as possible to the voices of patients themselves.

To verify the decision made to exclude mixed-methods studies from this review, a number of additional steps were taken:

1. Firstly, discussion pieces and methodological guidance on conducting meta-aggregation were sourced and reviewed (Bergdahl, 2019; Hannes & Lockwood, 2011; Lockwood et al., 2015). No specific reference to the inclusion/exclusion of mixed methods was found. However, throughout the papers it was emphasised that meta-aggregation is most suited to studies that offer sufficient "direct quotes from research participants" (Hannes & Lockwood, 2011, p. 1636), emphasising sufficient qualitative detail.
2. Secondly, worked examples of meta-aggregation were sourced and reviewed (Hannes & Pearson, 2011; Hannes et al., 2018). Both worked examples excluded mixed-methods studies. Hannes and Pearson (2011) did not provide further rationale, whereas Hannes et al. (2018) explain their rationale as being because they were "mainly interested in experiences and perceptions of young people…" (p. 3). Thus, they sought to include qualitative studies with sufficient context and detail of qualitative findings.
3. The third step involved sourcing and reviewing existing literature reviews that had utilised meta-aggregation from various domains. From this scoping search, it appears that the balance of studies that included or excluded mixed methods is relatively even; being very much dependent upon researcher discretion, seemingly guided by the aims/purpose of the reviews. For instance, three studies excluded (Behera & Dash, 2021; Lolkus et al., 2022; Wieland et al., 2021) and three studies included mixed methods (Lim et al., 2022; Rouhi et al., 2019; Simpson et al., 2022). However, no further detail or rationale was provided as to why the authors of these studies adopted either of these approaches.
4. The search was then broadened to other worked examples of qualitative meta-syntheses that had used alternative methodological approaches to meta-aggregation (Atkins et al., 2008; Lachal et al., 2017). The first worked example by Atkins et al. (2008) utilised meta-ethnography and included mixed methods, explaining that this decision required "considerable discussion" (p. 3). Their decision to include such studies was to "avoid omitting research of potential value" (p. 3). However, in practice, they encountered numerous obstacles. More specifically, they noted that "the distinction between quantitative and qualitative findings was not always apparent" and that the qualitative data that was available was often "the authors' interpretation", as opposed to the voice of participants themselves (p. 6). This made it difficult to apply the methodological steps required in conducting meta-synthesis. The second worked example by Lachal et al.

(2017) utilised meta-synthesis and excluded mixed methods, explaining their decision more succinctly as: “because it remains unclear how to deal with mixed method (combining qualitative and quantitative datasets) (Atkins et al., 2008)” (p. 4).

5. The final piece of literature sourced and reviewed was Atkins et al. (2012); a combination of two literature reviews that sought to compare the quality of mixed methods and qualitative studies (Atkins et al., 2012). Atkins et al. (2012) recognised that qualitative data from mixed methods research can make “important contributions” but requires careful consideration as, generally speaking, these studies provide less detail of the research method and data analysis, and are less “likely to be judged credible or provide rich data and thick description compared with standalone qualitative studies” (p.1).
6. Furter input and advise was then sought from a Clinical Psychologist and qualitative expert in meta-synthesis at the University of Birmingham. They reviewed and supported the rationale for exclusion of mixed methods based on the evidence from the literature presented above. They also drew attention to the distinction between “Big Q” and “small q” qualitative research (Kidder & Fine, 1987, as cited in Braun & Clarke, 2022). In short, small q employs only qualitative techniques (i.e., data collection and analysis), whereas Big Q employs qualitative techniques and adopts the “underlying research values” of a qualitative paradigm (Braun & Clarke, 2022, p. 1). This means that Big Q research typically offers more detail with regards to research context (i.e., reflexivity) and participant data (i.e., rich, thick descriptions). As Braun and Clarke (2013) note, mixed methods studies “rarely” qualify as “Big Q qualitative research” (p. 5). This compliments the findings of Atkins et al. (2012) above.

In sum, evidence for the inclusion/exclusion of incorporating mixed-methods research into meta-aggregation reviews is mixed but does, overall, fall in favour of exclusion; particularly when taking worked examples of meta-aggregation into account (Hannes & Pearson, 2011; Hannes et al., 2018). This therefore provides verification for the decision made to exclude mixed-methods studies from this review. Nonetheless, it is recognised that this approach is a matter of researcher discretion and is therefore not without its limitations (explored further within Strengths and Limitations of this Review) (p. 79).

1. Extraction of General Study Details

A data extraction form was developed by the researcher for the specific purpose of this review (Table 4). No re-interpretations were made by the researcher.

Study Characteristics

Six published peer-reviewed articles and one doctoral thesis (Baker, 2017) made up the seven studies in this review. All studies sought to obtain the perceptions, views, and experiences of patients in relation to the care that they had received within secure inpatient settings. Whilst all participants were reportedly free to discuss any/all aspects of care, each study was shaped by specific, albeit similar, phenomena of interest. The majority were interested in recovery (Baker, 2017; Barksy & West, 2007; Laithwaite & Gumley, 2007; Mezey et al., 2010). Although, “the word ‘recovery’ was omitted” from Baker’s (2017) interview schedule due to “any preconceptions” participants “might have had about this term” (p. 69). Others included: aspects of care that influence motivation to engage (Sainbury et al., 2004); factors that “helped or hindered” in progressing to discharge stage (Tapp et al., 2013, p. 1); and factors associated with or responsible for change (Willmot & McMurran, 2013).

Methods of data collection primarily included semi-structured interview formats (Baker, 2017; Barsky & West, 2007; Mezey et al., 2010; Sainsbury et al., 2004; Willmot & McMurran, 2013). Two studies utilised unstructured formats (Laithwaite & Gumley, 2007; Tapp et al., 2013). The development of interview schedules was completed in collaboration with other professionals for four studies (Baker, 2017; Barsky & West, 2007; Laithwaite & Gumley, 2007; Mezey et al., 2010); the latter study was the only one to collaborate with patients. One study utilised the puzzlement approach (Lofland, 1971) to develop an interview schedule (Tapp et al., 2013). Two studies did not specify how interview schedules were developed (Sainsbury et al., 2004; Willmot & McMurran, 2013). Transparency in relation to the full content of interview schedules varied across all seven studies. Two studies included the full interview schedule within the appendices (Baker, 2017; Tapp et al., 2013).

The interviewers for four studies were reported to have no direct clinical contact and/or responsibility for participants (Baker, 2017; Barsky & West, 2007; Mezey et al., 2010; Willmot & McMurran, 2013). Two studies stated that interviews were known or familiar to participants via working in the service (Laithwaite & Gumley; Tapp et al., 2013). One study did not specify who conducted the interviews (Sainsbury et al., 2004).

Participant Characteristics

A total of 65 participants were included across the seven studies. A large majority of participants were male (95%). The lowest reported age was 22 years, and the highest reported was 60 years (Laithwaite & Gumley, 2010). The mean age across the studies was 40 years (from the available data of $n = 53$). Only three studies reported the ethnicity of participants. Baker (2017) reported that participants were predominantly of white ethnicity. For Mezey et al. (2010) and Tapp et al. (2013) combined ($n = 22$), 55% were of white ethnicity and 45% were of black ethnicity.

Three studies recruited participants from medium secure (Baker, 2017; Barsky & West, 2007; Mezey et al., 2010), and four from high secure services (Laithewaite & Gumley, 2007; Tapp et al., 2013; Sainsbury et al., 2004; Willmot & McMurran, 2013). All services were located within the UK. Length of stay ranged from two months (Laithwaite & Gumley, 2007) to 20 years (Sainsbury et al., 2004), with an average of around 10 years.

Study Results

Three studies analysed the data using Grounded Theory (Laithwaite & Gumley, 2007; Mezey et al., 2010; Sainsbury et al., 2004); three used Thematic Content Analysis (Barsky & West, 2007; Tapp et al., 2013, Willmot & McMurran, 2013); and one used Interpretative Phenomenological Analysis (IPA) (Baker, 2017). Varying degrees of inter-rater agreement to reduce bias when interpreting the results was reported by all seven studies. Only two studies involved participants in this process (Mezey et al., 2010; Sainsbury et al., 2004). The total number of themes extracted from each study ranged from six (Barky & West, 2007) to 15 (Sainsbury et al., 2004), with an average of ten.

Table 4

Summary of Studies Included in this Review (N= 7)

Reference 1	Summary of aim/s	Sample and participant characteristics	Design	Analysis	Summary of findings
Baker (2017) **Doctoral thesis** **Quality score: 100%**	Experiences of care guided by recovery principles	(*n* = 6) **Setting** Medium secure services (dual diagnosis and generic rehabilitation ward) **Gender** Male = 6 Female = 0 **Age (years)** Average = 33.7 Range = 23 to 44 **Ethnicity** Predominantly White British; African Caribbean ethnicity also represented. **Length of stay (years)** Average in forensic mental health services = 5 **Legal status** Not reported **Additional information**	**Interview style** Semi-structured interviews. **Interview schedule development** Developed with professionals in forensic mental health services. **Content of interview** Enabled participants to speak about "aspects of their experience most important to them. The word 'recovery' was omitted from the interview schedule due to any preconceptions FSUs might have had about this term" (p. 69). Interview schedule provided in appendices. **Conduction of interview** Conducted by the researcher "trainee clinical psychologist, who had previously worked in a forensic PD service" (p. 74). **Length of interview** Between 30 and 109 minutes (average 66).	**Method** IPA (Larkin et al., 2006) **Reflexivity** Bracketing interview conducted first, to "identify assumptions brought to the research" (p. 74). Research journal used for data collection, analysis, and interpretation. **Inter-rater agreement** Findings discussed with supervisors and sections of two transcripts "analysed by another researcher using IPA and emergent themes compared" (p. 74).	**Themes** (1) Disempowered, dehumanised • The dynamics of power • Contained and deprived • Echoes of the past (2) Coming back to life • A safe and humane environment • Becoming a person again (3) The Struggle • A "normal" self? • "Snakes and ladders" (p. 75)

		Psychiatric diagnoses			
Reference 2	**Summary of aim/s**	**Sample and participant characteristics**	**Design**	**Analysis**	**Summary of findings**
Barsky and West (2007) **Peer-reviewed article** **Quality score: 70%**	Patient experiences of long-stay medium secure and comparison with previous high secure	(*n* = 6) **Setting** Two long-stay medium secure wards **Gender** Male = 6 Female = 0 **Age (years)** Not reported **Ethnicity** Not reported **Length of stay (years)** Average on the ward = 1.5 Average in high secure previously = 12 **Legal section** All sectioned under the MHA (1983, amended 2007). **Additional information** Psychiatric diagnoses and offending behaviour	**Interview style** Semi-structured interviews. **Interview schedule development** Draft interview schedule was "ratified by senior members of staff", "from a range of disciplines (psychiatry, psychology, nursing, occupational therapy)" (p. 6). **Content of interview** Questions "focused on the participants' perceptions of recovery and the scope for it at both sites" (p. 5). **Conduction of interview** "Trained mental health workers who were not familiar with any of the participants" (p. 6). **Length of interview** Between 30 and 90 minutes (average 50)	**Method** Thematic content analysis **Reflexivity** Not reported **Inter-rater agreement** "Independent and experienced clinician ratified the themes, with a 75% concordance rate" (p. 6).	**Themes** (1) Activities (2) Freedom on the ward (3) Access off the wards and the security wall (4) Atmosphere on the wards (5) Staff (6) Positives of high-secure care: access to therapies

Reference 3	Summary of aim/s	Sample and participant characteristics	Design	Analysis	Summary of findings
Laithwaite and Gumley (2007) **Peer-reviewed article** **Quality score: 95%**	Experiences of "people with psychosis residing in maximum security" (p. 313)	(*n* = 13) **Setting** High security hospital **Gender** Male = 12 Female = 1 **Age (years)** 45, 22, 45, 24, 34, 44, 42, 24, 43, 40, 43, 60, 43 **Ethnicity** Not reported **Length of stay** In hospital = 8, 2, 8, 2, 8 months, 2 years, 6 months, 1 year, 8 years, 3 years, 7 months, 10 years, 10 years **Legal section** Not reported **Additional information** Psychiatric diagnoses and offending behaviour	**Interview style** "In-depth, unstructured, and open-ended" interviews (p. 304). **Interview schedule development** Discussed in supervision with co-author. **Content of interview** Opening question: "What is it like for you being in the hospital?" (p. 304). Prompts included "Can you give me a specific example of what you mean?" and "Can you remember a specific memory to describe what you are saying?" (p. 304). **Conduction of interview** Researcher, a clinical psychologist at the research site (known to participants). **Length of interview** Between 60 to 90 minutes	**Method** Grounded theory (Strauss & Corbin, 1990) **Reflexivity** Social constructionist, reflective statement provided to explore role in conducting interviews and analysing data **Inter-rater agreement** Discussed in supervision with the co-author. Two colleagues (clinical and forensic psychologist) "cross-checked a sample of four transcripts" (p. 306). Interviewer arranged "another meeting with the participant to discuss the emerging codes" (p. 305).	**Themes** (1) Relationships and a changing sense of self • Past experiences of adversity - Parental break-up and loss - Feeling rejected and worthless - Relationships with significant others - Perspectives on past selves • Recovery in the context of being in hospital - Frightening versus safety - Feeling entrapped - The importance of relationships - Development of trust - Coping - Valued outcomes

Reference 4	Summary of aim/s	Sample and participant characteristics	Design	Analysis	Summary of findings

Mezey et al. (2010)
Peer-reviewed article
Quality score: 85%
	Experiences of recovery, with comparison to “non-offender patients, that could inform service planning and interventions”[5] (p. 684).	(*n* = 10)
		Setting
		Medium secure unit.
		Gender
		Male = 8
		Female = 2
		Age (years)
		Average = 37.1
		Range = 24 to 56
		Ethnicity
		White = 4
		Black and Minority = 6
		Length of stay (years)
		Within secure inpatient services = 4 (ranging from 1 to 11)
		Legal section
		Section 31/41 = 7
		Section 3 = 2
		Section 37 = 1
			Interview style
			Open-ended and semi-structured
			Interview schedule development
			“Discussion and piloting with team members and three service users in a series of iterations and revisions” (p. 685).
			Content of interview
			Two sections:
			(1) Narrative section – open-ended questions to “elicit the meaning, goals and stage of recovery for each individual and any personal or service-based factors that were seen as helping or hindering recovery” (p. 685).
			(2) Semi-structured questions – to explore themes within existing recovery literature: “social inclusion; autonomy; self-esteem; hope; understanding one’s illness; overcoming stigma; human rights; being valued as a person; the treatment setting; staff attitudes; practical issues relating to money
				Method
				Grounded theory (Strauss & Corbin, 2009) and directed content analysis (Hsieh & Shannon, 2005)
				Reflexivity
				“A former mental health service user” included as an interviewer to reduce the risk of bias (p. 694).
				Inter-rater agreement
				Five members of the research team “conducted analyses on a sub-sample of transcripts” (p. 686). Four others “(clinicians and service user researchers) rated samples of each interview question” (p. 686). Consistency rates reported.
					Themes
					(1) Definitions and understandings of recovery
					(2) What helps to bring about recovery
					• Diagnosis, psychoeducation, and medication
					• Secure detention as a route to recovery
					  o Security vs. sanctuary
					  o Time
					  o Positive relationships and attachments
					(3) Impediments to recovery
					• Physical environment/atmosphere
					• Negative relationships and interactions

---

[5] Mezey et al. (2010) was “an extended subsection of a larger study comparing narratives of recovery amongst users of three specialist mental health services – eating disorder, dual diagnosis, and forensic psychiatry (Turton et al., 2009)” (p. 684).

		Additional information Psychiatric diagnoses and offending behaviour	and housing; and physical health" (p. 685). Also asked for feedback on the questions and "attitudes and response to being interviewed by a doctor and by a service user researcher" (p. 685). **Conduction of interview** "Two researchers, a service user researcher and a psychiatric trainee, who had no direct clinical contact with, or responsibility for the participants" (p. 685). **Length of interview** Average just over 1 hour		
Reference 5	**Summary of aim/s**	**Sample and participant characteristics**	**Design**	**Analysis**	**Summary of findings**
Sainsbury et al. (2004) **Peer-reviewed article** **Quality score: 85%**	Aspects of care that may "influence patients' motivation to engage in treatment" (p. 29).	(*n* = 6) **Setting** Personality Disorder Directorate within Rampton High Secure Hospital (block wards = high security, villas = lower security) **Gender** Male = 6 Female = 0	**Interview style** Semi-structured interviews **Interview schedule development** Questions left deliberately open **Content of interview** Times participants had "felt motivated in treatment and what had helped" and "did not feel motivated and what had contributed" (p. 31). **Conduction of interview** Not reported	**Method** Grounded theory (Strauss & Corbin, 2009) **Reflexivity** Interview schedule deliberately open to avoid bias from researchers. Acknowledgement that two declined to participate due to having a therapeutic relationship with the interview	**Themes** (1) Support (2) Treatment • Waiting for treatment • Relevance of the assessment process • Coaxing it out safely (the therapist's approach) • Preparation for and support during treatment • Treatment content • Exposing vulnerabilities (3) Safety

		Age Under 30 = 1 Under 40 = 2 Over 40 = 2 Over 50 = 1 **Ethnicity** Not reported **Length of stay (years)** In the Directorate = 1, 3, 4, 5, 8, 8 In the hospital = 1, 3, 4,10, 20, 20 **Legal section** Temporary transfer from prison = 2 Directed by the courts to the hospital = 4 **Additional information** None reported	**Length of interview** Between 40 minutes and 1 hour (average 50 minutes).	**Inter-rater agreement** Two coded transcripts examined independently by psychologist and psychiatrist from the hospital. Level of agreement and disagreement documented. Categories fed back to two participants for comments	• Practical methods • Psychological methods (4) External belief (5) Belonging (6) Internal motivation (7) Therapeutic relationship
Reference 6	**Summary of aim/s**	**Sample and participant characteristics**	**Design**	**Analysis**	**Summary of findings**
Tapp et al. (2013) **Peer-reviewed article**	Experiences of high secure that had “helped or hindered” in progressing to discharge stage (p. 1).	(*n* = 12) **Setting** High secure hospital **Gender** Male = 12	**Interview style** Open-ended, neutral, and singular (i.e., not double-barreled) question **Interview schedule development** Created with puzzlement approach (Lofland, 1971) - “writing down points	**Method** Thematic analysis (Braun & Clarke, 2006) **Reflexivity**	**Themes** (1) Temporary removal of responsibility (2) Collaborative care (3) Learning from others (4) Talking therapies (5) Supportive alliances

Quality score: 100%		Female = 0 **Age (years)** Average = 44.6 SD[6] = 9.7 **Ethnicity** White = 8 (66.6%) Black of Black British = 4 (33.3%) Asian or Asian British = 0 Unspecified = 0 **Length of stay (years)** On current ward = 9.5 SD = 6.6 **Legal section** Not reported **Additional information** Psychiatric diagnoses and offending behaviour	of interest related to the research question”, organised into “potential topics” and “broad questions” (p. 3). Three pilot interviews conducted **Content of interview** Topic guide included, for example: “what were your early impressions of arriving at this hospital?”, “what do you think high security has provided you with?”, “what would you say have been the key experiences you have had?” (p. 22). Interview schedule provided in appendices. **Conduction of interview** Conducted by individual part of the service **Length of interview** Not reported	Critical realist perspective. Reflective statement is provided. **Inter-rater agreement** Coding conducted independently by a “blind reviewer on an interview transcript” and “divergent interpretations were discussed” (p. 6).	(6) Living in a non-toxic milieu (7) Medical treatments (8) Opportunities for work

Reference 7	**Summary of aim/s**	**Sample and participant characteristics**	**Design**	**Analysis**	**Summary of findings**
Willmot and	Views of the process of change: “how do	(*n* = 12) **Setting**	**Interview style** Semi-structured interviews.	**Method** Thematic analysis (Braun & Clarke, 2006)	**Themes** (1) What changed? • The self

---

[6] SD: standard deviation.

McMurran (2013) **Peer-reviewed article** **Quality score: 85%**	participants believe they have changed while in this service and what was responsible for these changes?” (p. 596).	High secure men’s personality disorder service within a high secure hospital **Gender** Male = 12 Female = 0 **Age (years)** Average = 44.1 SD = 15.4 **Ethnicity** Not reported **Length of stay (years)** Average of current detention = 14.9 (SD = 10.2) Average in service = 7.8 (SD = 9.6) **Legal section** Not reported **Additional information** Psychiatric diagnoses and offending behaviour	**Interview schedule development** Not reported. Pilot interview conducted. **Content of interview** Two broad questions: (1) How they had changed in relation to “key areas of dysfunction in personality disorder”: “relationships with other people, dealing with emotions, dealing with urges and impulses, and beliefs about the self and others” (2) Causes of this change and any “critical incidents and experiences” (p. 598). **Conduction of interviews** 9 conducted by first author (clinical psychologist at the service), 3 conducted by a Master’s level research assistant (where author was participant’s therapist), 1 conducted jointly **Length of interview** Between 30 and 60 minutes	**Reflexivity** Not reported **Inter-rater agreement** Authors coded independently and met to discuss and resolve differences	- Other people - The future (2) What are the change processes? - The self - Other people - The future

2. Extraction of Findings

A finding is defined as “a verbatim extract of the author’s interpretation” of their qualitative data (i.e., the results) (Lockwood et al., 2015, p. 183). All findings were extracted by the researcher from the Results section of each of the seven studies. To assess for transparency and credibility, a level of plausibility was allocated to each, as defined by Lockwood et al. (2015) (p. 183):

1. Unequivocal - findings accompanied by an illustration (i.e., a direct quotation from a participant) that is representative of the finding beyond reasonable doubt and therefore not open to challenge.
2. Equivocal - findings accompanied by an illustration (i.e., a direct quotation from a participant) lacking clear association with the finding and therefore open to challenge.
3. Unsupported - findings not supported by any data (i.e., the absence of a direct quotation from a participant).

Findings allocated as Unequivocal and/or Equivocal share parallel value within meta-aggregation. It is a matter of contention as to whether Unsupported findings are incorporated into a final synthesis. It was the researcher’s decision to include all findings regardless of plausibility rank for two reasons. Firstly, published research is often subject to word restrictions. Secondly, there should be a good balance between researcher narratives and participant spoken words (Corden, 2007); “an overemphasis on the researcher’s interpretations at the cost of participant quotes will leave the reader in doubt as to just where the interpretations came from [however] an excess of quotes will cause the reader to become lost in the morass of stories” (Morrow, 2005, p. 256).

A total of 327 findings were extracted from all studies (Table 5): 148 (45%) were rated as Unequivocal; 53 (16%) were rated as Equivocal; and 126 (39%) were rated as Unsupported. It was positive to find that the highest percentage of findings were rated as Unequivocal (45%) and thereby accompanied by direct quotes from participants. This is in keeping with the purpose of meta-aggregation, which is to stay as close as possible to the participant voice. Unsupported findings should be interpreted with caution. Although there was some evidence of support (i.e., paraphrases or summaries of what participants had said), they were still marked as Unsupported in the absence of illustrations. Overall, there appeared to be a good balance between researcher narratives and participant spoken words, which increases the transparency and credibility of the findings (Corden, 2007).

It is of note that the quality score (%) of each study is not reflective of the total number of individual findings extracted or the percentage of Unsupported findings. For example, the highest percentage of Unsupported findings were extracted from Laithwaite and Gumley (2007), which obtained a quality score of 95%.

Table 5

Number of Individual Findings Extracted from Each Reference and Level of Plausibility Allocations

	Number of individual findings			
	Level of plausibility			Total
	Unequivocal	Equivocal	Unsupported	
Reference 1 Baker (2017) Quality score: 100%	62 (51%)	18 (15%)	42 (34%)	122**
Reference 2 Barsky and West (2007) Quality score: 70%	30 (62.5%)	6 (12.5%)	12 (25%)	48
Reference 3 Laithwaite and Gumley (2007) Quality score: 95%	12 (21%)	6 (11%)	39 (68%)**	57
Reference 4 Mezey et al. (2010) Quality score: 85%	10 (42%)	7 (29%)	7 (29%)	24
Reference 5 Sainsbury et al. (2004) Quality score: 85%	4 (14%)*	7 (24%)	18 (62%)	29
Reference 6 Tapp et al. (2013) Quality score: 100%	12 (50%)	9 (37.5%)**	3 (12.5%)*	24
Reference 7 Willmot and McMurran (2013) Quality score: 85%	18 (78%)**	0 (0%)*	5 (22%)	23*
Total	**148** **(45%)**	**53** **(16%)**	**126** **(39%)**	**(*N* = 327)**

Note*:* Lowest percentage/number of findings per column marked with a single asterisk (*); highest percentage/number of findings per column marked with double asterisks (**).

3. Categorisation

This stage involved repeated, detailed examination of the assembled findings. The researcher then identified groups of findings (at least two per category) based on similarities in wording and/or meaning. A total of 52 categories were generated (see Appendix F).

4. Synthesis

To create synthesised findings, the researcher first identified groups of categories based on similarities in wording and/or meaning. Each group of categories were allocated to a key theme (at least two categories per key theme). A total of ten key themes were generated. The results are displayed below (Figure 4). Appendix G documents all individual findings according to level of plausibility, categorisation, and key theme allocation.

Figure 4

A Diagrammatical Representation Depicting the Distribution of Individual Findings Across the Ten Key Themes

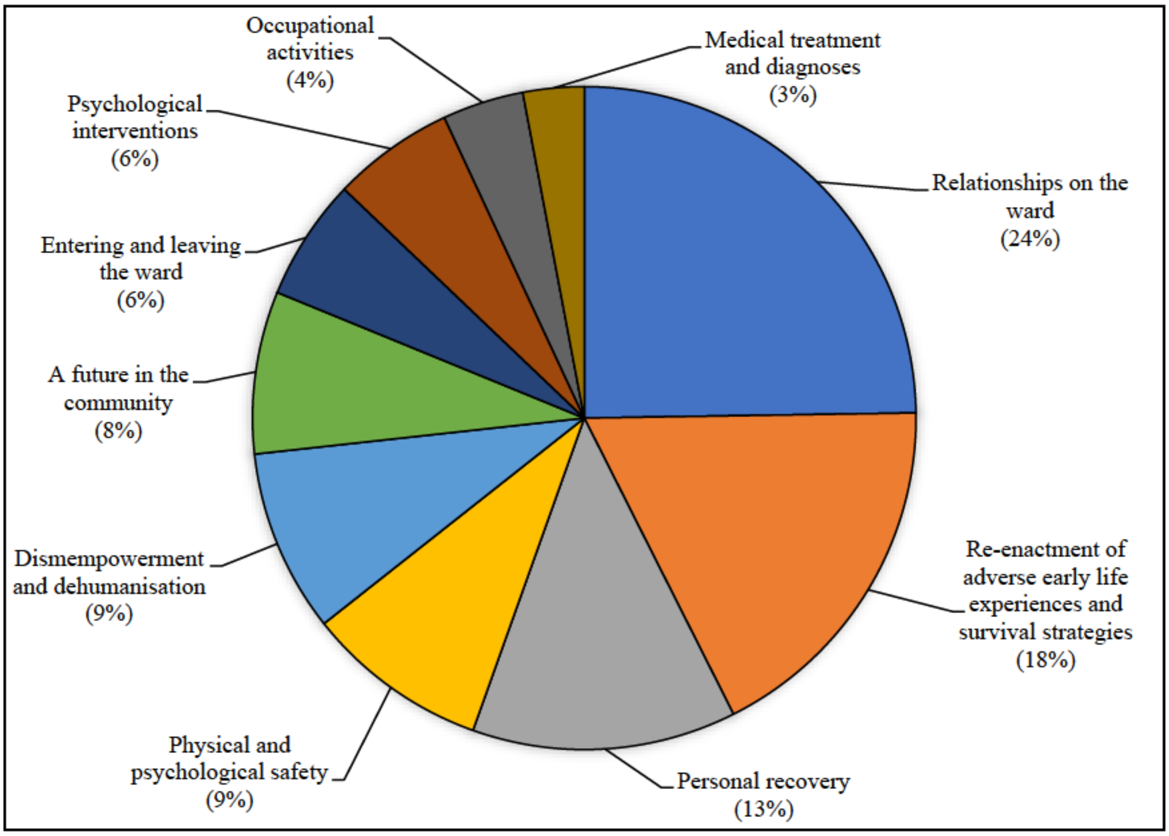


Table 6 demonstrates the percentile distribution of individual findings across the key themes. The number of studies represented within each key theme ranged from three to seven, with an average of five. As expected, the percentage of individual findings from each study becomes less evenly distributed as the number of findings within each key theme decreases.

Table 6

Distribution of Findings Across Key Themes and References

	Reference, number of individual findings and percentile distribution						
Key theme (number of individual findings)	**(1)**	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**
Relationships on the ward (82)	26%	20%	12%	2%	18%	6%	15%
Re-enactment of adverse early life experiences and survival strategies (60)	47%	6%	40%	2%	2%	3%	0%
Personal recovery (43)	47%	5%	21%	9%	7%	0%	11%
Physical and psychological safety (29)	31%	10%	7%	21%	17%	14%	0%
Disempowerment and dehumanization (28)	57%	7%	14%	0%	11%	11%	0%
A future in the community (26)	38%	15%	12%	23%	0%	0%	12%
Entering and leaving the ward (18)	22%	61%	17%	0%	0%	0%	0%
Psychological interventions (16)	25%	12.5%	12.5%	6%	19%	12.5%	12.5%
Occupational activities (14)	36%	36%	0%	0%	0%	21%	7%
Medical treatment and diagnoses (11)	27%	0%	0%	27%	0%	46%	0%
References (1) Baker (2017); (2) Barsky and West (2007); (3) Laithwaite and Gumley (2007); (4) Mezey et al. (2010); (5) Sainsbury et al. (2004); (6) Tapp et al. (2013); (7) Willmot and McMurran (2013)							

Table 7

Key for Table 6

Percentage of individual findings	■
	61-75%
	46-60%
	31-45%
	16-30%
	1-15%
	0%

The final stage of meta-aggregation involves creating synthesised findings which provide overarching narrative descriptions of the key themes. The researcher attempted to summarise the data using synonymous words and/or phases and sought to avoid any re-interpretation. Specific illustrations found to be most representative of the key themes are included in italicised text. The results are displayed below.

Relationships on the Ward (25 Percent)

Many participants expressed that they had learnt to form new relationships and develop interpersonal skills through every-day interactions with staff and other patients on the ward. These included: a better understanding and regard for other people's perspectives (i.e., improved empathy and compassion); the ability to be more assertive and appropriately self-disclose; being better able to resolve conflicts and help others to problem solve; and gaining mutual trust and respect. These experiences fostered a new or improved desire to connect with others.

> *"Talking to people and people listening to me. That's how I trust them more, because they listen to what I've got to say"* (Willmot & McMurran, 2013, p. 602).

More often than not, participants spoke specifically of the messages and actions – both explicit and implicit - from ward-based staff. Many participants cited nursing staff as the most consistent and available sources of support, crediting them for being caring and helpful. Participants felt that staff on the ward took treatment more seriously in comparison to prison (where many participants had previously been detained). Staff were considered committed to working with participants and were persistent in their efforts to do so, despite this being understood to be challenging at times. Staff presented to participants as confident in their ability to manage aggression and/or violence; not seeming frightened that participants may harm them and, as a result, avoiding physical intervention (i.e., restraint) where possible. Staff were seen as believing in participants' abilities to successfully engage in treatment, which was important for developing motivation. Participants also spoke of staff being friendly; stating that they were willing to engage in day-to-day conversation and that they were able to share jokes with them. Staff who actively listened and provided accurate feedback without being judgemental were described as having a significant impact on recovery. These genuine conversations helped participants to understand themselves more and acknowledge their own positive attributes. All of the above helped to create a therapeutic atmosphere and supportive treatment culture.

> *"[named nurse] can seem to see through my crimes and he can see through the person that I was to the person that he's always suspected I am, which is I'm not too bad a bloke, that will make a go of it, that tries. He can see the changes*" (Willmot & McMurran, 2013, p. 602).

Although many positive attributes of relationships with staff were raised, participants also reported feeling morally judged. This often related to their offending behaviour and was described as creating an *us and them* atmosphere. For instance, staff were reported to have made unkind, insensitive, and intolerant remarks. Some staff were perceived as being passive or inconsistent in their approach, which participants felt signalled limited understanding about mental health difficulties.

> "*…sometimes I feel they look at us as objects, like it's their job, that they come in and they have to do it…they're just here, they're just doing their job and they want out of here and that doesn't help*" (Mezey et al., 2010, p. 692).

In a similar manner, participants questioned the motives of staff, believing that they were only there for the money. Some indicated that there was corruption from staff teams, explaining that staff protected each other and were suspected to have brought illicit drugs on to the ward. Some participants reported that staff members were antagonistic and engaged in punitive treatment, treating participants like prisoners. For instance, staff were seen to discourage social relationships between patients, displayed aggression and utilised physical restraint unnecessarily as a form of punishment. Negative experiences of staff were experienced as very challenging. They contributed to a feeling of tension on the ward and had a significant negative impact on participants' motivation to engage in treatment.

> "*It's just antagonising you and pushing you that little bit further until you snap and snap back at them and they turn around and say 'see I told you', that sort of thing*" (Barsky & West, 2007, p. 9).

Participants also spoke of being able to share their experiences with, relate to, and learn from their peers. Repeatedly discussing problems with peers could generate feelings of hopelessness. However, more often than not, talking about life experiences with peers helped participants to gain a deepener understanding of their own difficulties and reduced feelings of loneliness; promoting the idea that they were similar to others.

> "*I used to think that I'm the only one that these things have happened to, and when I was listening to other people's stories and they were the same as mine, I thought well I'm not on my own*" (Willmot & McMurran, 2013, p. 603).

Whilst the majority of change processes occurred within relationships outside of formal therapy, some participants spoke specifically of the importance of their relationship with their therapist; someone they worked closely with on an individual basis. Positive attributes of the therapist's approach included the ability to successfully work with participants through denial and defensive mechanisms. Participants were able to develop an understanding of their difficulties through their therapist's containment. Where therapy was mentioned, participants generally alluded to the therapeutic relationship as inciting change, as opposed to specific therapeutic techniques.

> "*I was in denial, but I wasn't. I was waiting for someone, a reassuring person, to guide it out of me, to coax it all out of me… he wasn't aggressive he wasn't anything – he just sat there, which is basically what I needed – someone to guide me […]*" (Sainsbury et al., 2004, p. 34).

The presence of supportive messages and actions from friends and family in the community were felt to have an important impact on participants' motivation to engage in treatment. At the same time, participants encountered anxieties as a result of being separated from their loved ones in the community. Participants expressed their worries about the impact that their offending behaviour may have had upon these people, and a desire to repair some of these relationships.

> *"A bit more contact with my family would have helped a bit I suppose…on the phone like knowing they are well like it's just, makes a break from you know…every time I call it's like, phew"* (Tapp et al., 2013).

Re-Enactment of Adverse Early Life Experiences and Survival Strategies (18 Percent)

Participants described the variety of strategies they had learnt to employ in order to gain a sense of control and to protect themselves; ultimately, as a necessary means to survive. They had developed these strategies in response to adverse life experiences[7], particularly during early life. Adverse early life experiences cited by participants consisted of abuse, neglect and/or maltreatment from those in positions of trust (i.e., primary caregivers), as well as the loss of/rejection from family members and being bullied in school. Participants described the long-term effects of these experiences in relation to how they felt about themselves and other people. Many participants described feeling worthless. They described holding on to the expectation that other people will always either let them down or attempt to control them in some way; ultimately, that others cannot be trusted. Survival strategies largely involved participants having developed a strong sense of autonomy and avoidance. For some, this included being able to detach from emotions and feeling ambivalent towards and/or deliberately avoiding relationships; retreating into a shell. This was despite their simultaneous desire for close relationships with others. Participants also spoke of using their physical strength, aggression, and violence as a self-defence strategy to avoid appearing weak. Some described using alcohol and illicit drugs or engaging in self-harmful behaviour.

> "*I've seen really emotional people and they don't get nowhere*" (Baker, 2017, p. 85).

---

[7] Participants themselves did not refer to their experiences as "adverse". This term was utilised by the authors of the studies included in this review.

The challenges of being within a secure hospital environment sometimes resonated with aspects of participants adverse life experiences which, in turn, reinforced believes about the necessity of these survival strategies. Participants defined some of these challenges as feeling dominated, helpless, and experiencing a lack of control. This was particularly in relation to staff and, subsequently, their treatment as a whole. They also cited being unable to escape the sense of threat from other patients; being exposed to verbal, physical and/or emotional harm. This was attributed to: overcrowding; lapses in physical and/or relational security; being bullied by other patients; being exposed to illicit drugs; and being a victim of or witnessing violence. Other challenges involved experiencing a loss of liberties and feeling vulnerable. For instance, participants spoke of a sense of loss concerning aspects of their lives in the community, such as not being able to purchase items from the shops or accessing the internet. Having to expose perceived weaknesses and vulnerabilities resonated with how participants felt early on in their lives.

"*You know a lot of people don't realise what it does to you to have all those things taken away from you*" (Baker, 2017 p. 81).

Personal Recovery (Thirteen Percent)

Participants described the Participants described the factors that they felt defined, helped, and hindered their journey towards recovery. A reduction in clinical symptoms was viewed as necessary, but not the sole indicator of recovery. Many participants spoke of the progress they had made by reflecting on being very unwell prior to admission. For instance, being able to reduce and/or stop self-harmful behaviour and being able to stop taking prescribed medication that they had previously needed in order to function.

Progress was also defined by being able to explore and make sense of past experiences, as well as developing effective coping strategies for difficult thoughts, emotions, and behaviours. This enabled participants to engage in goal-directed behaviour, namely making decisions and settings targets. Achieving this progress was helped by having an open mind; not holding on to preconceived ideas about treatment enabled participants to adapt. Similarly, seeing people as less hostile enabled participants to start trusting others again. Some participants spoke of the little privileges and responsibilities that they gradually received, such as being able to make tea and coffee. This created a sense of freedom, belonging and made them feel trusted by staff.

> *"I think that one important thing for me is to gain knowledge of my past, instead of growing up being a nobody and rejected and believing that it was my fault for what happened to me many years ago, when it's not my fault, it was other people's fault"* (Willmot & McMurran, 2013, p. 599).

Several participants referred to their own internal motivators of acceptance and inner strength. The former included accepting that change was necessary; accepting that setbacks would occur; and accepting that the journey to recovery would be challenging. The latter included the motivation and resilience to keep going particularly during difficult times. Internal motivators seemed to be perpetuated by noticing or reflecting on progress made.

> *"You don't get to the top of a mountain just by looking at it"* (Baker, 2017, p. 96).

Obstacles to recovery were explored in relation to experiencing setbacks and identities as forensic mental health patients. Setbacks were experienced in the form of self-harm, suicidal ideation, aggression and/or violence. Such incidents had a significant negative emotional impact on participants, leading to feelings of exhaustion. One participant described this process as like "*snakes and ladders*"; often taking "*one step forward and one step back*" (Baker, 2017, p. 94). Participants described how being hospitalised impacted on their self-esteem and created feelings of worthlessness. Participants also spoke of a desire for a new identity not associated with violence and criminal activity. One participant reported that he had started this process by legally changing his name. There were a range of factors deterring the formation of a new identity, both internal and external. For instance, one participant suggested that violence is an important part of how he sees himself and may struggle to depart from this.

Physical and Psychological Safety (9 Percent)

Participants described the variety of ways in which they felt safe, respected, valued, and treated like a person. This enabled them to feel alive again.

"*People are being treated like people*" (Baker, 2017, p. 87).

The temporary removal of responsibility through being detained in an environment with enhanced levels of care was seen as necessary for participant safety. It provided respite from the challenges and responsibilities of the outside word and, at times, a destructive lifestyle. The ward was seen as a sanctuary that provided time out and offered an opportunity to reflect on previous actions, as well as providing free meals and a bed to sleep in. This managed participants' risk of harm to themselves, which enabled them to build upon their confidence and self-esteem. In a similar manner, participants spoke of the ward being a physically safe environment. The locked doors, video cameras, security alarms and staff being able to effectively manage violent incidents all helped them to feel safe from the outside world and from other patients.

"If you are not in a safe environment, you don't feel motivated for treatment because you'd be more worried about your safety, and you are less free minded to continue with your treatment" (Sainsbury et al., 2004, p. 35).

Along the same lines, participants experienced a sense of belonging, acceptance, and inclusion; a sense of community that they had not previously encountered in their lives. This was largely attributed to treatment being collaborative. Staff were credited for working with participants to create a shared understanding of personal difficulties and treatment options, promoting autonomy in care decisions, communicating with patients and being proactive in care planning. Participants also described everyone on the ward joining together for celebrations and events. Experiences of collaborative care fostered treatment engagement and motivation.

Disempowerment and Dehumanisation (Nine Percent)

Participants described feeling held, warehoused, and contained without attempts to help them work towards a better future. This was reminiscent of difficult early life experiences. There were occasions participants felt they were not considered to be human beings, due to aspects of the environment that made them feel powerless and punished. Similarly, participants described a feeling of institutionalisation; becoming conditioned to comply with treatment and adopting a degree of learned helplessness. Being on the ward too long was seen as detrimental to wellbeing and indicative of increased levels of aggression and/or violence.

"Keep ticking the boxes and keep following the rules" (Baker, 2017, p. 78).

Consistent with a feeling of being held, participants described feeling "*got rid of*" (Baker, 2017, p. 84) as they were moved between wards and hospitals at times. For some, this was again reminiscent of adverse early life experiences, such as foster care and residential settings. A lack of stability was also evident within the ward, which had a negative impact on participants' motivation and feelings of ability to cope. Participants spoke of unexpected disruptions such as psychological treatment stopping suddenly and repeated changes in their psychologist or named nurse. They spoke of a sensation of uncertainty and uneasiness in relation to not having a fixed sentence, which made them feel stuck and trapped.

"…sometimes it is a struggle. It is hard to keep yourself motivated and keep the momentum going. […] There's no date to look to. You are just stuck here without knowing what is going to happen. It's hard. It's hard thinking about the future and all that. (Laithwaite & Gumley, p. 310).

Similarly, participants described experiencing a lack of control over their care; feeling *done to* by the clinical team and feeling that their voice had no impact. For instance, medical treatment was imposed without consent, which had physically harmful consequences. When participants felt powerless over their own lives, they felt that they presented a heightened risk of becoming unwell and harming others.

A Future in the Community (Eight Percent)

The prospect of a future in the community was viewed with both hope and fear. Before being admitted to the ward, some participants did not care for their future and would live day-to-day. During the early stages of admission participants believed that they would never see the outside world again. Participants gradually became hopeful about the long-term future; having a normal or ordinary life in the future; having a job, a place to live, friends and family.

> *"If you feel you are capable of living your life…doing things that the average person does, you know, just even getting to an average standard of competence in certain areas of life…being just worthy as a person"* (Mezey et al., 2010, p. 687).

Participants did however express their concerns relating to the challenges they may face when returning to the community. Some spoke of feeling anxious about their ability to cope with these challenges, citing previous experiences of using alcohol and illicit drugs. For some, these concerns related to possible restrictions dictating where they would be permitted to live (i.e., multi-agency public protection arrangements [MAPPA]) and feeling frightened that their accommodation would not provide them with enough support. Some participants spoke specifically of the discharge process; seeing this as an important indicator for recovery yet also worrying that it would be a potential destabiliser if not carefully planned and sensitively handled. These concerns extended to the stigma in society, being categorised as both mad and bad. They regarded this as a barrier to the following: gaining acceptance and forgiveness; achieving relatively modest goals; developing relationships; and seeking employment. Some participants had learnt to cope with these anxieties by focusing on the here and now..

> *"Forensic mental health patients that's probably as big a stigma as you can get I think…it heaps a lot of pressure on my mind the fact that…you've got to be guarded against talking about your past in some way"* (Mezey et al., 2010, p. 691).

Entering and Leaving the Ward (Six Percent)

Participants spoke about the process of being admitted to the ward. Some reported that it had been a positive experience and had created an immediate sense of safety. Some reported that it was frightening as it had exacerbated the extreme psychological distress that they were already experiencing. Participants also spoke of temporarily leaving the ward. The quality of leave within the hospital grounds was not viewed favourably; all participants could do was "*walk in a circle*" on their own (Barksy & West, 2007, p. 8). The prospect of community leave on the other hand, was highly valued. It provided participants with a sense of hope, independence, confidence, motivation, and social inclusion. This was the case whether staff escorted participants or not.

> *"There's light in the tunnel"* (Barsky & West, 2007, p. 7).

Psychological Interventions (Five Percent)

Participants spoke of both individual and group talking therapies, as well as the psychological assessment process. Psychological interventions enabled participants to explore difficulties in a safe space whereby they were listened to, felt encouraged to talk, and taken seriously. This helped participants to develop ways to better understand, monitor, and manage mental health difficulties.

> *"All these things I have learnt in here, it's given me building blocks really to reflect more about my past and what I have done and try to find the solution to my problem…that's how I have managed to recover because I have understood exactly what my illness is about and I have tried to find ways for me to prevent it from happening again"* (Mezey et al., 2010, p. 689).

Conversely, some participants did not see psychological interventions as necessary or helpful. Specific therapeutic techniques were not frequently mentioned as inciting change. Specific reference was made to the assessment process, which participants found tedious and struggled to understand the relevance of.

> *"I didn't benefit nothing from it, it was a waste of time"* (Baker, 2017, p.7 8).

Occupational Activities (Four Percent)

Participants discussed the occupational activities available, which included vocational achievements, work, and education. Some participants described there being a good access to and variety of activities. Participants spoke of the benefits of being occupied, having temporary respite from the ward environment, acquiring new skills and socialising with others. This translated into positive benefits for their well-being and quality of life. For instance, some participants cited improved self-esteem, confidence, and a reduction in clinical symptoms.

They took me down the gardens and that stopped me self-harming for quite a while, because you couldn't see Broadmoor from the garden ... if you turned round you actually couldn't see any of Broadmoor (Tapp et al., 2013, p. 173).

Some participants specifically mentioned feeling empowered by education. For example, acquiring an understanding of socio-cultural issues incited a desire to effect change within society. However, some participants described there being long waiting lists and a lack of variety in or access to meaningful activities. For instance, there was a concern that activities did not lead to qualifications, which in turn would not translate into employment opportunities in the community. A lack of meaningful activities contributed to feelings of boredom, lack of motivation and possible increase in risk to others on the ward.

"What are you getting up for? [. . .] You're up and sitting and staring at four walls or asking for an argument or being provoked." (Baker, 2017, p. 81).

Medical Treatment and Diagnoses (Three Percent)

The medical treatment spoken of by participants included medication and electroconvulsive therapy (ECT). Some participants valued these interventions for reducing clinical symptoms, such as those related to psychosis. There were also reported improvements in cognitive and social functioning, which enabled participants to engage in activities on the ward. Similarly, some participants found that being given a diagnosis helped them to understand their difficulties.

"All I remember, I used to hear voices and see things, and I was paranoid and then after that [ECT], everything, all that had gone away ... it's a real godsend." (Tapp et al., 2013, p. 172).

Conversely, some participants found medication to be unnecessary and irrelevant; it was seen to suppress their mental health difficulties as opposed to helping them understand the root cause. They also spoke of the difficult process in establishing whether the side effects of medication and ECT outweighed the risks. Particular reference was made to adverse impacts upon cognitive and social functioning; making it difficult for participants to engage in other activities on the ward. Some participants did not agree with their diagnosis and felt confused by this.

> “*There’s loads of different ones. I don’t know if they make them up as they go along. Or I don’t really revise or look up on them things, but people who go uni, college, training or whatever they know that sort of thing*” (Baker, 2017, p. 76).

Discussion

Summary of this Review

This review provided a meta-synthesis of qualitative studies that explored the lived experiences of secure inpatient services in the UK. A total of seven studies were included, which comprised of 65 participant interviews. Whilst each participant’s experience will be unique, central to the narratives of all interviews were ten, albeit interconnecting, key themes. The first three were particularly prevalent, making up almost half of all findings. This suggests that when participants discussed their experiences of care, they mostly did so in the context of: *Relationships on the Ward* (25%); *Re-enactment of Adverse Early Life Experiences and Survival Strategies* (18%); and *Personal Recovery* (13%). The other seven themes included: *Physical and Psychological Safety* (9%); *Disempowerment and Dehumanisation* (9%); *A future in the Community* (8%); *Entering and Leaving the Ward* (6%); *Psychological Interventions* (6%); *Occupational Activities* (4%); and *Medical Treatment and Diagnoses* (3%).

Interpretation of Findings

Overall, the findings of this review offer rich insights into the many different ingredients that make up secure inpatient services. Some of these findings unearthed valuable experiences of care, suggestive of inciting positive change and progress. Others were more negative, arguably harmful, indicating impediments to progress and the potential for increased risk of distress and violence on the ward.

It is interesting to compare the ten key themes with more recent literature that has established priorities for outcome measurement within secure inpatient services. Ryland et al. (2021) combined interviews of 15 patients with focus groups of 48 key stakeholders. The latter included staff, members of the Quality Network for Forensic Mental Health Services (QNFMHS), and Adult Secure Clinical Reference Group at NHS England. Areas of priority were developed into a new patient-focused FORensic oUtcome Measure (FORUM), which includes “six overarching domains containing 42 individual outcome areas” (p. 6). These included: “About me” (i.e., I have a sense of belonging), “My quality of life” (i.e., I have the relationships and friendships I want and need), “My health” (i.e., I have helpful relationships with staff), “My safety and risk” (i.e., I feel safe), “My life skills” (i.e., I am able to make realistic plans), and “My progress” (i.e., I am making progress towards greater independence) (p. 8). Many of the FORUM domains - relationships with staff, peers, friends and family in the community, the need for safety, personal identity, quality of life, and future pathways – were represented within this review. The findings of which not only corroborate the tools potential utility, but also provide an additional level of qualitative detail as to *why* these aspects of care may be significant to patients. However, some of these domains were not represented within the results of initial scoping searches for this review. This gap suggests the existing literature base relating to the views and experiences of patients themselves may be slightly biased towards topics of professional interest; offering only one part of the picture when it comes to developing an understanding of “what works”. This will now be explored further with reference to the three most prevalent themes found within this review.

Interpretation of Key Themes

Relationships on the Ward. This was the most frequently explored topic, making up a quarter of all findings and thereby forming the backbone of participants’ experiences. Participants discussed the existence, quality, and impact of their relationships with staff on the ward, as well as with other patients and family and friends in the community. Many participants spoke specifically of the messages and actions – both explicit and implicit – from day-to-day interactions with staff on the ward. These appeared to be a powerful force in positively or negatively shaping how participants felt about themselves, their recovery, and their motivation to engage in treatment.

It is unsurprising that relationships on the ward formed the backbone of participant experiences considering patients are, first and foremost, human beings; many of which had been detained in secure inpatient services for extended lengths of time. By contrast, only ten per-cent of findings related to formal or structured interventions (i.e., *Psychological Interventions*, *Occupational Activities,* and *Medical Treatment and Diagnoses*). This is intriguing, as the latter is often seen as the backbone of patient care from a policy and commissioning perspective (Kennedy et al., 2019). Indeed, the only direct reference to staff-patient interactions within service specifications for secure inpatient services can be found within subsections of the Appendices designed for patients diagnosed with personality disorder and neurodevelopmental disorders (i.e., learning disability, autism). Here, it is recommended that "Sufficient attention must be paid to the environment around the patient *as well as the interactions between people* [emphasis added], to offer structure support, validation, and opportunities to practice new ways of relating" (NHS, 2021a, p. 25), with a focus on providing "social scaffolding and modelling of relationships" (p. 24). There is no mention of this within the main document. This brings to question the relative value that patients, policy makers, and commissioners place on different aspects of care.

The Women's Mental Health Taskforce Final Report (Department of Health and Social Care, 2018) is worth mentioning here. As noted within the Introduction section of this thesis (p. 23), the taskforce was set up in 2017 to define, address and improve the "mental health of women, and their experiences of mental health services" (p. 15). Part of this work involved hearing the voices of women themselves, including those with lived experience of secure inpatient services. This was achieved via a series of focus groups, involving 31 women. The Taskforce then "used the testimonies heard […] to develop a series of statements to powerfully capture *what was important to women* [emphasis added] when experiencing mental health problems and accessing support" (p. 30). The first core theme to come out of their findings was "women's experiences of mental health services" (p. 19). Complementing the findings of this review, women identified relationships with staff as being one of the most important aspects. More specifically, "the ability to develop trusting relationships", as this helped women to feel "safe and supported", which in turn enabled them to "open up about their lives and past experiences of abuse or trauma" (p. 19). As one of the women who took part in the focus groups expressed: "I am treated with respect and given the time to express how I feel, and not made to feel a burden when seeking help" (p. 31). Again, similar to the participants' narratives in this review, the women also described difficulties in being able to establish trusting relationships, often due to "care continuity issues" and "high turnover of staff" (p. 19). The Taskforce urges all those involved – from researchers and practitioners to providers and commissioners – to take note of the women's testimonies; and to consider these when planning, designing, and delivering all mental health, justice, and social care services. This offers a valuable exemplar of how service specifications, policy and/or guidance documents can actively seek out, genuinely listen to, and meaningful engage with the patient voice. Thus, whilst the work of the Women's Mental Health Taskforce detailed here does serve to complement and thereby strengthen the findings of this review, it also serves to further highlight the concerns raised in the paragraph above: that service specifications, policy and/or guidance documents specific to secure inpatient services may not include or be representative of what is important to patients themselves.

Although, an alternative viewpoint would be that the nature and quality of all relationships on the ward are indirectly captured within the domain of relational security. Secure inpatient services have been organised around the trinitarian model of therapeutic security for over a decade (Department of Health, 2010). That is: (1) physical (i.e., locked doors, walls, personal alarms, CCTV); (2) procedural (i.e., systems level policies in place); and (3) relational. The latter generally refers to "the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care" (DoH, 2010, p. 5). However, it is much more complex than this. In fact, the challenges of defining and measuring relational security have become the focus of increased research attention in recent years (Chester et al., 2017; De Pau et al., 2021; Ryland et al., 2022; Markham, 2022). Some have called for better clarity on "exactly *how* [emphasis added] relational issues affect security" (Chester et al., 2017, p. 358). The findings of this review contribute here, by offering a more detailed look at *how* interactions were experienced by patients and *why* they may contribute to an increase or decrease in risk. They are also relatively unique as – disappointingly - only one other study has focused on patient experiences of relationships with staff using qualitative methodology. Bennett and Hanna (2021) interviewed 30 male patients from high, medium, and low secure services. Their results compliment this review by emphasising the importance of day-to-day interactions with staff. A handful of other studies have attempted to measure staff-patient relationships using various quantitative alliance measures (Bressington et al., 2011; Donnelly et al., 2011; Long et al., 2011; MacInnes et al., 2014; Otte et al., 2019). Whilst they offer less context and detail into the how and why, their value lies in demonstrating the crucial links between the perceived quality of these relationships and a variety of key outcomes (i.e., increased treatment motivation, decreased number of aggressive and violent incidents). Again, adding weight to the findings of this review. Although, it is unclear if any of the alliance measures used have been specifically designed or validated for use within secure inpatient services[8].

---

[8] Explored further in Chapter Four (p. 155).

It must also be acknowledged that an emphasis on staff-patient relationships appears to be a running thread within the findings of wider patient experience literature. Evidence for this can be taken from the results of initial scoping searches (see Table 2, page 30). Five reviews combined qualitative data in relation to social climate (Doyle et al., 2017), personal recovery (Senneseth et al., 2022; Shepherd et al., 2016), restrictiveness (Tomlin et al., 2018), and female services (Ratcliffe et al., 2021). Collectively, the findings of these reviews indicate that participants narratives maintained a focus on staff-patient relationships regardless of the topic they were invited to discuss during interviews. Doyle et al. (2017), for example, found that "the therapeutic relationship between staff and patients […] was the most commonly identified theme" (p. 131). This provides further evidence that they are the backbone of the patient experience.

In terms of other relationships on the ward, there appears to be only one research study to have specifically explored peer relationships (Gran, 2014). Mirroring the findings of this review, Gran (2014) found that peers have a strong influence on patients' sense of self and their personal recovery journey. No individual research studies were found to have specifically explored patient experiences of contact with friends and family in the community. However, the need for better support and involvement for families/carers has been acknowledged and recommended (McKeown et al., 2016; NHS, 2018).

Re-Enactment of Adverse Early Life Experiences and Survival Strategies. This was the second most frequently explored theme, making up eighteen per-cent of all findings. Here, participants referred to early life experiences of mistreatment, neglect, and abuse. They described the long-term impact of these experiences and the various ways they had learnt to cope and protect themselves; ultimately, to survive (i.e., avoidance, aggression, violence, self-harm). Participants also illustrated the various ways in which the secure inpatient environment can re-create situations, trigger reminders, and generate feelings associated with these past experiences (i.e., feeling dominated, helpless, vulnerable, and experiencing a lack of control). These challenges were said to reinforce beliefs about the necessity of survival strategies and therefore potentially increase the risk of distress and violence to others on the ward. A thread of similar narratives can also be found within the theme *Disempowerment and Dehumanisation.*

These findings strongly resonate with some of the key elements of trauma-informed care (TiC) [9]; an increasingly important area of consideration for secure inpatient services given the significantly high rates of trauma within the population (McKenna et al., 2019; Willmot & Jones, 2022). TiC is grounded in four key principles: (1) *Realise* the widespread prevalence of trauma; (2) *Recognise* the signs of trauma (i.e., the various ways people adapt, cope, and protect themselves for survival); (3) *Resist* causing further harm by reducing practices that can, however subtly or inadvertently, be re-traumatising; and (4) *Respond* by integrating all of the above into practice (Substance Abuse and Mental Health Services Administration [SAMHSA], 2014). All principles – especially *Resist* – are pertinent to participants' narratives in this review.

The work of the Women's Mental Health Taskforce (Department of Health and Social Care, 2018) is particularly pertinent here. Findings of the report present a drastic call for change in-line with TiC relevant to the design and delivery of all mental health, criminal justice, and social care services (including secure inpatient services). In setting the context and outlining their argument for these changes, the report details "alarming cases of women who had experienced trauma" (p. 13). The women's testimonies, obtained via focus groups, expose experiences of both general and secure inpatient services that were "disempowering and, in some circumstances, *re*-traumatising [emphasis added]" (p. 19). More specifically, a "worrying number" (p. 20) spoke of disturbing practices - such as physical restraint, one-to-one observations, and assault – that were "profoundly distressing, triggering and humiliating" (p. 24). They described feeling unsafe directly from staff and other patients and indirectly from the "problematic" physical, social, and cultural environment (p. 24). They also described a "profound lack of voice or control" over their own care, which intensified "feelings of powerless" (p. 20). Thus, these experiences recreated situations, triggered reminders, and generated feelings associated with "previous experiences of abuse and coercive control" (p. 20). Taken together, it is evident that the work of the Women's Mental Health Taskforce included here resembles, and therefore intensifies, participants' narratives

---

[9] Chapter Three - titled What Does The Literature Base Tell Us About Trauma-informed Care Within Secure Inpatient Services?: A Systematic Review – provides a more detailed and comprehensive overview of TiC (p. 86).

from this review. It also provides powerful evidence from patients themselves that TiC is not just important for secure inpatient services, but essential.

On a similar note, it is interesting that the participants in this review often referred to their own coping and survival strategies in the absence of reference to psychiatric diagnoses. The choice of words and sensemaking used here are very much in harmony with the Power Threat Meaning Framework (PTMF) (Johnstone et al., 2018); a specific trauma-informed model that seeks to identify how various forms of power (i.e., adverse childhood experiences, the secure inpatient environment) link to patterns of distress, unusual experiences, troubling or risky behaviour (i.e., violence). This is achieved by asking, amongst other questions: “what happened to you?” and “what did you have to do to survive?”. This is in opposition to locating the problem *within* someone, as a *symptom* of illness or disorder (Markham, 2021b). The importance and potential value of secure inpatient services adopting a trauma-informed approach guided by the PTMF has been documented previously from a clinician perspective (Ramsden, 2019). The findings of this review offer a unique and complimentary patient perspective. The examples provided suggest one of the key benefits of this approach - in addition to being valuable to patients in helping them make sense of their experiences - would be for services to gain a better awareness and understanding of the many ways in which the secure inpatient environment itself can perpetuate further harm and contribute to increased levels of distress and risk.

What is perhaps most interesting about these findings is that wider research focusing on TiC within secure inpatient services appears, at first glance, to be sparse (Maguire & Taylor, 2019). The medical model is said to be highly dominant within both research and practice (Cartwright et al., 2022; Jackson-Blot et al., 2019). The findings of this review therefore seem unusually progressive in comparison. This, again, highlights a gap in the literature base and perhaps brings to question the relative value that patients and service providers place on different aspects or models of care.

Personal Recovery. This was the third and final most prevalent theme, making up thirteen percent of findings. The medical model emphasises that a reduction in or absence of clinical symptoms is indicative of recovery (Mann et al., 2014). However, for the participants in this review, a reduction in clinical symptoms was viewed as necessary, but not the sole indicator of recovery. Participants spoke instead of their desire for a new identity, being able to explore and make sense of past experiences, learning to trust others and feeling trusted by staff, and developing internal motivators such as self-acceptance, inner strength, motivation, and resilience. For some, it was re-gaining little privileges and responsibilities.

The idea of personal recovery was further touched upon in the theme *A Future in the Community*, whereby participants described being hopeful about the idea of having a normal or ordinary life in the future. They also expressed their concerns relating to the challenges they may face in the community, such as: alcohol and drugs; possible MAPPA restrictions; lack of supportive accommodation; the discharge process; and the sigma in society of being seen as both "mad and bad". Interestingly, the Women's Mental Health Taskforce (Department of Health and Social Care, 2018) present very similar findings. As mentioned throughout this discussion, the Taskforce conducted focus groups with 31 women, some of which had experience of secure inpatient services. The first core theme to arise from their findings was "women's experiences of mental health services" (p. 19), which captures "*what was important to women* [emphasis added] when experiencing mental health problems and accessing support" (p. 30). Whilst the majority of their findings are relevant to all mental health, criminal justice, and social care services, a handful are specific to secure inpatient services. These closely mirror the findings of this review as they detail the challenges women have faced upon discharge into the community. For instance, they describe "issues around 'institutionalisation'", feeling "vulnerable" and "left to get on with it" due to the lack of "ongoing support or aftercare" (p. 20) when leaving secure inpatient services. These issues were "particularly pronounced for women with childcare responsibilities" (p. 20). The latter point being a welcome addition to this review providing that the majority of participants included in the studies were male (95%). Taken together, this section provides strong evidence that issues relating to discharge and a life in the community form a significant aspect of patients' recovery journeys; being both a future concern and stark reality for many within secure inpatient services.

These findings are even more concerning when considering best practice guidance and standards (NHS, 2021a; 2021b; 2021c; QNFMHS, 2021). For instance, service specifications for secure inpatient services dedicate an entire section to "Discharge and Transition" (NHS, 2021b, p. 17). They emphasise that "discharge planning" must begin early in admission, include "effective and early liaison" with appropriate and relevant local area services (e.g., Community Forensic Teams), and "a comprehensive care plan reflecting a whole person approach to recovery and rehabilitation into the community" (p. 17). The results of this review, combined with those of the Women's Mental Health Taskforce (Department of Health and Social Care, 2018), would suggest that this is not always happening in practice. Or, at the very least, that discharge into the community is not being planned and/or implemented adequately to meet the needs of patients. It also appears that there is very little research focusing specifically on patient experiences of discharge and life in the community. The search strategy employed for this review located three studies ostensibly focusing on discharge. However, a closer look revealed that two of these focused more specifically on transition from high to medium secure services (Madders & George, 2014) and accessing primary health care (Samuels & Moran, 2021). The third (Stuart et al., 2017) focused on "perceptions of recovery, and the barriers to its achievement, as described by eight former inpatients at a medium-secure forensic hospital" (p. 1). The results of which actually act in contrast to those of this review, as a large number of participants expressed a desire for more agency and less restrictions (as opposed to increased support). Regardless, *all* the participants that took part in Stuart et al.'s (2017) study ($n = 8$) spoke of "ongoing elements of struggle and difficulty" (p. 22) in relation to the discharge process. Thus, providing further evidence that this aspect of care is of significant importance to patients themselves.

Returning more broadly to a focus on recovery - the wider literature dictates that the personal recovery model is a strength-based approach that emphasises individuals can live meaningful lives despite the challenges that they may continue to face (Onken et al., 2007; Tomlin & Jordan, 2021). A reduction in or absence of clinical symptoms is not a prerequisite; the "nature of personal recovery is inherently unique to each individual, so there is no consensus on a single definition of it" (Rye, 2017, p. 14). A popular and well-cited framework developed from the general mental health literature credits five key domains: connectedness, hope and optimism about the future, identity, meaning in life, and empowerment (also referred to "CHIME") (Leamy et al., 2011).

However, applicability of the personal recovery model for forensic mental health services has, for many years, been called into question (Rye et al., 2017; Tomlin & Jordan, 2021). This is particularly with regards to the unique challenges and barriers that this population are likely to face; many of which were articulated by participants in this review. The idea of "secure recovery" has been around for some time (Drennan & Alred, 2012). Indeed, as identified from initial scoping reviews, there is a wealth of literature exploring patient accounts of personal recovery (Clarke et al., 2016; Lovell, 2019; McKenzie-Smith, 2019; Senneseth et al., 2022; Shepherd et al., 2016). The most recent of which introduced the CHIME-Secure (CHIME-S) framework (Senneseth et al., 2022). Original CHIME categories have been expanded. For instance, Identity becomes “identity work: coming to terms with trauma and past offences”, and Meaning in Life become “meaningful use of time on the ward and preparing for a meaningful life outside” (p. 11). Additional challenges, representing the *opposite* of the original CHIME factors, were added. For instance, Disconnectedness, Hopelessness, Negative Identity Experience (i.e., stigma), and Lack of Meaning and Disempowerment. The CHIME-S framework seems to be highly accurate in capturing participants experiences, hopes, expectations, worries and fears of recovery within this review; perhaps an expected outcome given the model was built using the voices of patients themselves.

Strengths and Limitations of this Review

A main strength of the review process is that the researcher employed a robust search strategy which sought to minimise publication bias where possible. Namely, manual searches of reference lists and electronic citations, contact with experts and inclusion of grey literature. A main limitation of this process is that only UK-based references were searched for and included in this review. As the researcher applied these limits/filters prior to searching electronic databases, the total number of non-UK studies that may have met the inclusion criteria is unknown. It is also difficult to generalise the findings to other countries. That said, there may be some merit in this approach as legal frameworks and the provision of secure inpatient services can vary across countries (Sampson et al., 2016). Similarly, none of the included references interviewed participants from low secure services, and females were largely under-represented. Although, it was promising to see that the findings of the Women’s Mental Health Taskforce (Department of Health and Social Care, 2018) – which included only female participants, some of which had experience of secure inpatient services – strongly complemented participants’ narratives from this review. This suggests that the results are, at least in part, generalisable beyond male participants residing in medium and high secure settings. In addition, the demographic breakdown of participant age, length of stay and ethnicity (etc.) was generally varied. The sample sizes of the individual studies, and thereby the total number of participants included ($N = 65$), is regarded as a strength of this review. This is especially true when considering the practical difficulties inherent in recruiting participants from secure inpatient settings (Völlm et al., 2017).

Only one researcher conducted the quality assessment and data synthesis, which increases the risk of bias. The specific methodological strengths and weaknesses of the included studies have already been explored in detail. However, it is worth highlighting that one of the main methodological weaknesses was limited information pertaining to data collection (i.e., full content of the interview schedule). Although it is acknowledged that the quality of all published studies – regardless of methodology – will inevitably vary, this is disappointing; considering qualitative-only studies were intentionally included within this meta-aggregative review as they are expected to offer sufficient research context and qualitative detail (Hannes & Lockwood, 2011). Without full transparency relating to the interview schedule, it is not possible to claim with absolute certainty that all participants were truly able to discuss any/all topics in relation to their care. Indeed, many of the studies were interested in recovery, which could have biased responses towards the more positive aspects of care. On a similar note, it is also acknowledged that the exclusion of qualitative data from mixed methods studies can be said to be a limitation of this review. Whilst this was done intentionally to meet the aims of this review, increase the transparency and credibility of findings, and stay as close as possible to the patient voice, it is not possible to claim with absolute certainty that their potential inclusion would not have made some valuable contributions.

The method of data synthesis - meta-aggregation - was specifically chosen as it is an aggregative approach. The role of the researcher was to extract and summarise the data whilst avoiding any re-interpretation; thereby reducing potential for bias. It is particularly positive that almost half of all findings were directly supported by participant quotes as this provides a high level of transparency and credibility. Yet, it is not possible to achieve neutrality in qualitative research (Braun & Clarke, 2006). It is impossible to fully separate the role of the researcher from the data. This area of research was novel to the researcher, and they had no predetermined judgements or ideas as to the possible results. Nonetheless, the researcher's academic interests and professional experience will have introduced some degree of bias when interpreting the results of this review.

Another limitation relates to the imbalance of power in secure settings that is likely to have impacted on the ability to hear the authentic voice of the patient (Dixon-Woods et al., 2005). It is possible that participants chose to discuss certain topics because they anticipated possible benefits and/or consequences in relation to their care. Indeed, the participants in this review may have been motivated to take part in the research studies for various reasons. Some participants may have chosen to omit certain topics because they did not feel comfortable or safe talking about them during interview. Thus, although this review has established the order of frequency in which certain topics appear within the literature, assumptions should be made with caution. It would be naïve to make the definitive conclusion that some of these topics are definitively more or less meaningful to participants when considering their experiences of secure inpatient care.

Implications for Practice and Suggestions for Future Research

In consideration of the links found between this review and the FORensic oUtcome Measure (FORUM) (Ryland et al., 2021), it is logical to recommend that future work is done to evaluate and establish its psychometric properties. A particular focus should be on establishing its meaningfulness to patients from other secure inpatient services, and its utility for integration into practice. The authors of the tool suggest it could be "used to help patients track their progress over time, facilitate care planning, and evaluate interventions" (p. 14). Practically, the FORUM could be completed within keyworker sessions, every three to six months (i.e., prior to Care Plan Approach [CPA] meetings). Over time, with evidence of its efficacy, key stakeholders (i.e., policy makers and commissioners) should consider integrating the FORUM into national guidelines and standards (i.e., NHS 2021a; QNFMHS, 2019) for use as additional and complimentary outcomes measure alongside those with a clinical and risk focus. A similar recommendation could be to replicate the type of work by the Women's Mental Health Taskforce (Department of Health and Social Care, 2018), which provides a valuable example of how service specifications, policy and/or guidance documents can actively seek out, genuinely listen to, and meaningful engage with the patient voice. Ultimately, both of these recommendations would ensure that greater attention and evaluation is paid the aspects of care that are important to patients themselves in both research and practice.

Other, more specific recommendations relating to the three most prevalent findings of this review are detailed below.

Relationships on the Ward

All staff should recognise the importance of their relationships with patients outside of formal or structured interventions. They should understand how and why their day-to-day interactions on the ward can be a powerful force in influencing change, both positively and negatively. This could be achieved via a service development project and/or training package, perhaps through the lens of relational security, to highlight the potential benefits in reducing level of distress and risk on the ward. Ideally, this would be planned, designed and/or implemented with patients to include specific examples; akin to those presented within this review. Services should also recognise the importance of and maximise opportunities for peer support. NHS service specifications for low, medium, and high secure settings (NHS, 2021a; NHS, 2021b; NHS, 2021c) note some female services have created paid roles for peer support workers. The same can be said for family, friends, and carer involvement. The Carer Support and Involvement in Secure Mental health Services Toolkit (NHS, 2018) is a key document to consult here.

Future qualitative research may wish to focus on further exploring the intricacies of ward-based relationships (both staff and peers) from the perspectives of patients themselves. This, again, could be through the lens of relational security; to establish “exactly *how* [emphasis added] relational issues affect security” (Chester et al., 2017, p. 358). A similar approach could be taken for patient experiences of contact with family and friends in the community, as this appears to be particularly under-researched. Researchers could also look to examine the psychometric properties of alliance tools, with a view to establish appropriateness for use within secure inpatient services. This would allow services to measure staff-patient relationships as part of a service evaluation project or as a regular patient outcome measure.

Re-Enactment of Adverse Early Life Experiences and Survival Strategies

A shift towards trauma-informed research and practice is very clearly essential here. But first, it is important to establish the current state of the literature relating to TiC within secure inpatient services in more detail. This is addressed in Chapter Three of this thesis, titled: What Does The Literature Base Tell Us About Trauma-Informed Care Within Secure Inpatient Services?: A Systematic Review. Meanwhile, the findings of this review - coupled with the those of the Women’s Mental Health Taskforce (Department of Health and Social

Care, 2018) – can be used to make some more specific and practical recommendations that would start the transition towards becoming more trauma-informed. The first of which is for services to consider further service development projects and/or training programmes that focus on the various ways in which the secure inpatient environment can be re-traumatising. That is, the ways in which it can re-create situations, trigger reminders, and generate feelings associated with past experiences of trauma (e.g., feeling unsafe, humiliated, helpless, dominated, vulnerable, disempowered, dehumanised, and experiencing a lack of control). Initial service development projects could help to identify, reduce and/or eliminate such harmful practices. There are numerous areas for consideration based on participants' narratives from this review. One of the more obvious areas could be ensuring that physical security procedures are in line with best practice standards (QNFMHS, 2021). This would address participants' concerns regarding the sense of threat they experienced from other patients (e.g., exposure to illegal drugs and violence on the ward). Mirroring the recommendation outlined above, some of the more subtle - although equally, if not more, impactful – areas to explore could be relationships on the ward through the lens of relational security. Another example could be for services to evaluate how they are promoting patient empowerment; ensuring that patients have as much choice and control over their care as possible and are able to engage in active, collaborative decision making. This would address the challenges participants expressed regarding loss of liberties and a lack of control over their care. Services may also wish to identify additional areas for consideration, by obtaining feedback and recommendations from patients themselves.

Subsequent training programmes could then be developed. Ideally, planned, designed and/or implemented collaboratively with patients themselves to include specific examples, akin to those presented within this review. The content of which should emphasise *why* the potential changes staff are being asked to make to their day-to-day are important. It should be made clear that certain practices are harmful because they serve to reinforce the necessity of coping and survival strategies (i.e., avoidance, aggression, violence, self-harm) that patients developed – whether consciously or not – in response to past trauma; thereby increasing the risk of distress, aggression, and violence on the ward. Integration of the PTMF (Johnstone et al., 2018) could also be used as a tool to aid staff understanding of this. A focus should be on encouraging curiosity and trying to understand patients in the context of their lives (i.e., what has happened and what is happening to them); as opposed to locating the problem within them, as a symptom of illness or disorder (Markham, 2021b). In addition to training, the PTMF (Johnstone et al., 2018) could underpin team formulation and group reflective practice sessions. This would help to further embed any changes that are made to practice, and hopefully encourage services to identify additional and continued opportunities in-line with a trauma-informed approach. Thus, paving the way for meaningful and sustainable change. The findings of this review also indicate that patients themselves are likely to benefit from knowledge of the PTMF in helping them to make sense of their own experiences, should they not find diagnoses helpful. This could be via psychoeducational group material, or as an individual piece of therapeutic work (i.e., psychological formulation).

Personal Recovery

It is already best practice for all patients to have an individualised care plan with a focus on personal recovery (NHS, 2021a). The CHIME-Secure (CHIME-S) framework (Senneseth et al., 2022) would be a useful source of guidance and inspiration here. For patients, it is likely to offer confirmation and validation regarding their own recovery journey challenges, as well as fostering realistic hope for the future. For staff, it is likely to provide improved insight and understanding; as well as holding on to said hope during times it may not be easy for patients to do so themselves. The CHIME-S could be disseminated via psychoeducational material or interactive groups on the ward. A particular focus could also be providing patients with opportunities to reflect, expand, and build upon their identities beyond that of a forensic mental health patient. This could be fostered through day-to-day interactions with staff, formal psychological interventions, and - as guidance states - via access to meaningful “social, educational, occupational and vocational opportunities” (NHS, 2021a, p. 17). Future research could look to evaluate the CHIME-Secure (CHIME-S) framework in practice. Perhaps, an evaluation of its practical utility (i.e., integration into individualised care plans) from both staff and patient perspectives.

A more specific recommendation relates to the concerns raised by participants in this review - and again by those that took part in the Women’s Mental Health Taskforce (Department of Health and Social Care, 2018) - relating to discharge. It would be beneficial to conduct qualitative research focusing explicitly on patient views and experiences of the discharge process and life in the community. Ideally, this would encompass both the planning and preparation that took place during patients’ time within secure inpatient services, as well as the types of support and/or restrictions that were put in place post discharge. It would be useful to capture this information through a longitudinal design to measure progress and the impact of discharge plans over time (e.g., over the first few days, weeks, months). It would be helpful to then compare these findings with, for example, "Discharge and Transition" (NHS, 2021b, p. 17) service specifications, in order to determine if services are putting this into practice. This could also be achieved in practice, perhaps via a quality improvement project which could directly involve patients. The insights and knowledge gained from this work could help to ensure that discharges from secure inpatient services are being planned and/or implemented in a way that gives patients the best chance of building, and sustaining, a life in the community.

Chapter Three

What Does The Literature Base Tell Us About Trauma-Informed Care Within Secure Inpatient Services?: A Systematic Review

Abstract

In response to the key findings and recommendations outlined in Chapter Two, the purpose of this review was to establish and improve understanding of what the literature base tells us about trauma-informed care within secure inpatient services. The more specific aims of this review were: (i) to determine how TiC has been defined within the literature base; (ii) to identify the specific components of TiC that have been operationalised and/or implemented; (iii) to identify any evaluations of TiC including both the potential and/or actual impact of implementation; (iv) to identify future recommendations regarding TiC for both practice and research; and (v) to identify any additional and relevant key findings or discussion points that provide deeper insights into the discourse surrounding use of the term TiC.

Initial scoping searches of the wider TiC literature landscape revealed it to be a rapidly growing yet formative and highly complex field of academic study. A large majority of existing reviews sought to identify operational or field- specific definitions; citing concerns regarding misunderstandings of the term trauma-informed and noting the lack of quality and quantity of information relating to actual implementation and evaluation. Only two existing reviews were found to have been conducted within the domain of forensic mental health; neither of which had been to locate literature specific to secure inpatient services using narrow search criteria. This review conducted a more in-depth and up-to-date search of the literature using broader search terms and inclusion criteria. A comprehensive search strategy was employed: (1) four electronic databases; (2) eight online journals; (3) grey literature; (4) manual hand searches; and (5) contact with experts. Studies were included if terms used synonymously or interchangeably with trauma-informed were found within the study aims, findings and/or discussion (i.e., recommendations); and the focus of the study was relevant to TiC.

Eleven studies met the inclusion criteria and remained following quality assessment. These comprised eight peer-reviewed research papers and three Doctoral theses. Study aim/s and phenomenon of interest varied considerably: three focused specifically on TiC; one claimed to assist in improving TiC by assessing the frequency of diagnosed post-traumatic stress disorder (PTSD); and the remaining seven explored links between trauma histories and various outcomes (i.e., psychiatric diagnoses). All eleven studies made recommendations for

TiC based upon their findings. As such, data was extracted from both the results and discussions sections of the included studies if it made direct reference to TiC (as determined by the authors of the included studies), or indirect reference to TiC (i.e., what the author/s found and/or discussed that led them to conclude that TiC is important). Key themes from the data are presented and further interpreted with reference to the five specific aims of this review.

Overall, the findings of this review provide evidence that the literature is growing, but still very much still in its infancy. The picture presented is complex and contradictory in parts; findings are both in-keeping and – to a larger degree - incompatible with a trauma-informed approach. The latter indicates TiC has become misunderstood and oversimplified; that it is under-developed and has perhaps been misrepresented by some within the academic field. There is also little acknowledgement or clarity on how TiC may translate specifically into secure inpatient environments. An interpretation of these findings is provided, along with an exploration of the systemic and interpersonal factors that pose as barriers to a shift towards TiC. To conclude this review, recommendations for future research and implications for practice are made.

Introduction

Emergence of TiC

Original impetus for the trauma-informed care (TiC) movement emerged from a piece of research conducted over two decades ago: the “Adverse Childhood Experiences (ACE) Study” (Felitti et al., 1998). The landmark study collected data from a sample of approximately 17,000 adults (mostly white, middle-class, educated) registered with a US health maintenance organisation who had sought routine health checks at an outpatient clinic. Participants were emailed and asked to retrospectively record the presence of ten pre-determined ACEs. These included childhood abuse and neglect (emotional, physical, or sexual) and household dysfunction (parental separation or divorce, witnessing violence against mother, living with household members who had problems with drugs or alcohol, were mentally “ill” or suicidal, or ever went to prison). The authors also asked participants to provide details of their medical history and overall physical health.

The results revealed that ACEs were vastly more common than expected. Approximately two thirds of participants had experienced at least one ACE; an eighth had experienced four or more. The authors also found a strong positive correlation between the number of reported ACEs and adult health risks factors (i.e., smoking cigarettes, suicide attempts) and physical diseases (i.e., cancer, diabetes). Participants who had experienced four or more ACEs were significantly more likely to demonstrate health risk factors and have physical health problems. Disturbingly, they also found that, on average, people with six or more ACEs were more likely to die 20 years earlier than those with none. Naturally, publication of the ACE study was monumental and shocking to many (Leitch, 2017). It pushed large-scale “concrete” evidence of the widespread prevalence and long-term impact of childhood trauma into public consciousness. Armed with the new recognition that a large majority of people accessing mental health, social, and criminal justice services have experienced trauma, the concept of TiC began to emerge as a model for more effective human service delivery (Procter et al., 2017).

TiC was first introduced by Harris and Fallot (2001) within their influential publication *Using Trauma Theory to Design Service Systems: New Directions for Mental Health Services.* The United States Federal Substance Abuse and Mental Health Services Administration (SAMHSA) established a “National Centre for Trauma-Informed Care” in

2005 (Sweeney et al., 2016, p. 180). Some years later, SAMHSA published the first comprehensive framework offering guidance on what a trauma-informed service should look like (SAMHSA, 2014); how "systems may help to resolve or exacerbate trauma-related issues" (p. 3). It was designed intentionally broad to be applicable across a variety of health, social, educational, and criminal justice settings.

The utility of SAMHSA's framework has been monumental in the field. Google searches of "TiC" began around 2004 and saw "a noticeable uptick" from 2011 onwards (Becker-Blease, 2017, p. 131). After publication, an extensive literature base began to emerge, deepening understanding into the long-term negative impact of childhood trauma (i.e., Bellis et al., 2014; Butler et al., 2011). More recently, there has been an emergence of research into buffering, protective and strength-based factors; furthering understanding into how individuals are able to endure, adapt, heal, recover, and thrive following trauma (Crandall et al., 2019; Merrick & Narayan, 2020). There has also been a raise in awareness and acceptance of "survivor voices", or those with lived experience. Grassroot organisations and groups of individuals have pushed to educate researchers and clinicians alike on the harmful and re-traumatising impact of services, particularly within the field of mental health (Sweeney et al., 2019). Naturally, there is now a burgeoning interest in and enthusiasm to adopt TiC across all health, social, educational, and criminal justice settings (Covington, 2022).

What is "Trauma-Informed Care"?

TiC represents a multi-layered, whole-systems approach to organisational change (SAMHSA, 2014). It is intended to transform services (Sweeney et al., 2018); a new way of thinking, being, relating, and working (Triesman, 2021). At its very core, TiC represents a shift in ideology from the implied judgement of "what is *wrong* with this person?" to "what has *happened* (or is *happening*) to this person?" (Butler et al., 2011).

Attempts to define "trauma" within academic and clinical fields go back over 100 years (Herman, 1992) and are still ongoing today (Read & Harper, 2020). Dominant narratives and understanding of trauma have been powerfully shaped by the psychiatric profession within diagnostic classification systems, as post-traumatic stress disorder (PTSD) (American Psychiatric Association [APA], 1980; 1987; 1994; 2013; 2022); and, more recently, complex PTSD (World Health Organisation [WHO], 2019). Here, trauma is restricted to a definition of "actual or threatened death, serious injury, or sexual violence" (APA, 2013, as cited in North et al., 2016, p. 201); and a series of events that are "extremely threatening or horrific in nature" (WHO, 2019, as cited in Hyland et al., 2021, p. 19).

SAMHSA (2014) provides a more progressive definition, focusing on the individualised nature of trauma: "an event, series of events, or set of circumstances that is *experienced by an individual* [emphasis added] as physically or emotionally *harmful or life threatening* [emphasis added] and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (p. 7). Experiencing something as "traumatic" depends upon a range of factors, such as: how an individual labels, makes sense of, and assigns meaning to their experiences; and the availability of protective factors, such as comfort and support from others. The effects or impact of trauma extend far beyond PTSD diagnostic criteria (Rossiter, 2012). They may occur during, immediately after, or have a delayed onset of days, weeks, months, even years later. Often, the individual and those around them may not recognise the link between trauma and its effects. Some may be more "obvious" than others.

Naturally, an understanding of what we mean by trauma – as outlined by SAHMSA (2014) above – is the very foundation of TiC. However, it must also be acknowledged that an overreliance on the term trauma can be misleading, unhelpful, exclusionary, and sometimes harmful (Johnstone & Boyle, 2018). This is especially the case if service providers operate under the medical model's narrow definition of trauma being an extreme or isolated event (i.e., "big T" category) (Shapiro, 2001). As such, some promote use of the terms stress, adversity, and/or trauma, independently or interchangeably (Johnstone & Boyle, 2018; Read & Harper, 2020). These additional terms allow for recognition of the cumulative impact of the more discrete, normalised, "little t" category experiences that are embedded within everyday lives (Shapiro, 2001).

Being flexible with terminology and adopting a curious mindset in this way allows for a more genuine awareness and understanding of peoples presenting problems in the context of their lives. With this in mind, the "trauma" of TiC can refer - but is by no means exclusive - to events and/or circumstances that occur: before birth (i.e., in utero lifestyle factors); during childhood (i.e., various forms of abuse and neglect, parental loss, witnessing domestic violence, parental drug/alcohol problems, moving house multiple times); into adulthood and across the lifespan (i.e., bullying, sexual violence, assault, war trauma, contact with the criminal justice system, being sectioned under the Mental Health Act [MHA]). It also includes historical, cultural, social traumas and intersectionality, such as poverty, racism, homophobia, isolation, disability, urban living, and immigration (Read & Harper, 2020; Sweeney et al., 2018).

Key Assumptions and Principles of TiC

TiC is grounded in four key assumptions: Realises, Recognises, Resists, and Responds (SAMHSA, 2014):

(1) Realises

All staff should have a basic realisation of the widespread impact of trauma (SAMHSA, 2014). Whilst it should not be assumed that all people who access services have experienced trauma, it is expected that many will have (Read & Harper, 2020). The principles of TiC apply regardless (Sweeney et al., 2018).

(2) Recognises

Staff should be able to recognise the signs of trauma. That is, the various responses, reactions, and adaptations that people develop – whether consciously or not – to cope, protect themselves, and survive. As previously mentioned, these extend beyond diagnostic criteria for PTSD (Rossiter, 2012). Signs of trauma may include various forms of nervous system dysregulation (flight, fight, freeze survival states), psychological distress, unusual experiences, and risky or harmful behaviours (Johnstone & Boyle, 2018). Some signs are more likely to attract psychiatric diagnostic labels (i.e., depressed mood, self-harm, suicidality, hearing voices, being suspicious of others) than others (i.e., isolation, using drugs and alcohol, aggression and violence, criminal behaviour). This assumption also includes being aware of the often “hidden” physical health implications caused by chronic elevations of stress hormones and suppression of the body’s immune response (i.e., increased risk of autoimmune disorders) (Stojanovich & Marisavljevich, 2008).

It is important to note here that TiC does not seek to simply *replace* diagnostic categories within the context of the medical model (Isobel, 2021; Willmot & Jones, 2022). Rather, it seeks to highlight its limitations (i.e., locating the problem *within* someone), and offer a deeper understanding by situating people in the context of their lives (Read & Harper, 2020). As Ramsden (2019) writes, to restore the “functional links that are often obscured by psychiatric classification” (p. 131).

(3) Resists

TiC asks practitioners to “do no (more) harm” (Butler et al., 2011, p. 188). Staff - particularly those working within mental health and criminal justice services - operate in positions of power (Sweeney et al., 2018). Given that loss of power is central to the experience of trauma, there are many ways in which “helping” can, however inadvertently or subtly, be retraumatising. Staff must actively seek to identify, reflect on, and – where possible - reduce practises that can re-create situations, trigger reminders, and generate feelings associated with past trauma; those that naturally reinforce the necessity of trauma responses and coping strategies (Covington, 2022). “Obvious” examples include locked doors, seclusion, body searches, restraint, forced medication (Sweeney et al., 2018). More “subtle” examples may include treatment planning without collaboration, imposition of the medical model (i.e., an emphasis on what is wrong with someone), interactions that are mirroring, defensive, dismissive, or disrespectful, and forcing someone to disclose past trauma or repeat one’s story with no follow-up action or change (Filson, 2011).

(4) Responds

TiC responds by integrating and adopting all the above into practice. This applies to all staff, at all levels. Change is accomplished and maintained through committed leadership, a separate and dedicated budget, and staff training. It should be reflected and displayed within policies, mission and ethos statements, handbooks, manuals, handouts, and posters (Triesman, 2021).

TiC also requires alignment with six key principles (SAMHSA, 2014). These have been summarised into Table 8 below.

Table 8.

Six Key Principles of TiC (SAMHSA, 2014, combined with Triesman, 2021)

Principle	Definition
(1) Safety	• Understanding physical and emotional safety is a priority. • Everyone (staff and people accessing services) should feel safe. • This applies to the physical environment and interpersonal interactions.
(2) Trustworthiness and transparency	• Decisions and feedback processes about people that access services should be done in a way that establishes and maintains trust. • Meaningful communication, feedback, transparency, openness, and accountability (i.e., what might happen, what is happening, and why)
(3) Peer support	• "Peers" refers to people with lived experience of trauma and/or services. Also known as "survivors" or "experts by experience". • Services should facilitate avenues for support between peers and integrate those with lived experience into the organisation.
(4) Collaboration and mutuality	• In recognition of power imbalances, people that access services should – wherever possible - be involved in and actively contribute to decisions about their care. • Focus on doing *with*, rather than being done *to* (Triesman, 2021).
(5) Empowerment, voice, and choice	• Recognise and build upon and strengths, resilience, and the ability to grow and heal from trauma; as opposed to pathology, determinism, and "symptoms" of disorders. • Services should aim to generate empowerment and build realistic hope for the future.
(6) Cultural, historical and gender Issues	• Move past stereotypes and biases based on race, ethnicity, religion, age, sexual orientation, gender, social class (etc). • Create services that are gender responsive and promote cultural connections • Recognise and address historical or intergenerational trauma.

Misunderstandings of TiC

Whilst it can be argued that TiC represents “competent practice or just plain common sense” (Becker-Blease, 2017, p. 132), it is a complex phenomenon to navigate considering many, if not most, mental health services have been built upon and function according to the dominance of the medical model; a framework that emphasies “pathology and inadvertently gives the impression that there is something wrong with a person” (Elliot et al., 2005, p. 467). Becoming trauma-informed therefore requires significant investment, work, time, and commitment (Triesman, 2021). It has become somewhat of a tokenistic trend and buzzword; its core values having become diluted, leading to oversimplified misunderstandings. Some services and research projects are simply paying lip-service by re-naming themselves or identifying with the term trauma-informed (Isobel et al., 2021). By way of example, TiC is not a checklist or a prescriptive step-by-step process (SAMHSA, 2014); nor is it a “theorised call for practitioners to ‘be nicer’” (Sweeney & Taggart, 2018, p. 383); or a call for services to push for trauma disclosures, generate “ACE scores” and reduce restrictive practice (Muskett, 2014). It is also not the same as trauma-*specific* services. This refers to specific types of direct interventions, such as Eye Movement Desensitization and Reprocessing *(*EMDR), or Trauma-Focused Cognitive-Behavioural Therapy (TF-CBT) (Butler et al., 2011). It is for these reasons that there are calls within the literature to focus on developing service- or field-specific operational definitions, along with practical, concrete, and applicable examples of genuine TiC (Becker-Blease, 2017; Bendall, et al., 2020).

TiC within Secure Inpatient Services

As stated within Chapter Two of this thesis, TiC is not just important for secure inpatient services, but essential. The link between offending behaviour and trauma is “abundantly obvious”, even amongst popular culture (Willmot & Jones, 2022, p. 1). Practitioners having worked within secure inpatient services for any length of time will be acutely aware that trauma histories are commonplace in the lives of those they work with. This is supported by an extensive literature base (Mckenna et al., 2019), and by participants’ narratives in Chapter Two of this thesis. The very nature of admission criteria means a level of distress and risk must be present (NHS, 2021); self-harm, threats, aggression, and violence can be common occurrences (Willmot & Jones, 2022). Participants in Chapter Two described these as being the long-term impact of past experiences (i.e., survival responses); the necessity of which can sometimes be reinforced due to the challenges of the secure inpatient environment. Whilst monitoring, control, exclusion, isolation, restrictions, and enforcements are – to some extent – necessary and unavoidable, services must be aware of their potential impact. Indeed, the work of the Women's Mental Health Taskforce[1] (Department of Health and Social Care, 2018) - set up in 2017, to define, address and improve the "mental health of women, and their experiences of mental health services" (p. 15) – pertinently corroborates these points and makes an urgent call for trauma-informed care across all mental health, justice, and social care services. Part of this work involved hearing from the voices of women themselves, some of which had experiences of secure inpatient services. The key themes of the report detail "alarming cases" (p. 13) of "deeply traumatised" (p. 27) women who had been re-traumatised – made to feel disempowered, unsafe, distressed, triggered, and humiliated – by their experiences of both general and secure inpatient services. Despite the clear link between women's experiences of interpersonal abuse and violence and "poor mental health" (p. 24), the stories the Women's Taskforce heard indicate that many services fail to make this connection and are "not operating in a trauma-informed way" (p. 24).

For staff working within secure inpatient services, the intense nature of the working environment alone elevates the risk of stress, burnout, compassion fatigue, direct and vicarious traumatisation (Brown et al., 2017; Pirelli et al., 2020). It is therefore imperative that services navigate the balance between the provision of therapeutic care with the management and reduction of risk to ensure the safety and wellbeing of everyone concerned (Kurtz & Jeffcote, 2011). This, of course, is the fundamental purpose of TiC.

Rationale for the Current Review

The direction of the current review was generated from a broad scoping search conducted in 2021 (see Appendix H for full results). This was completed using the free-text phrase "trauma-informed". An additional free-text phrase or limit of "review" was applied where possible. Searches using the following bibliographic databases, organisations and internet search engines were conducted on 2nd and 4th July 2021: Campbell Collaboration Library of Systematic Reviews; Centre for Reviews and Dissemination (DARE); Cochrane Library; Cumulative Index of Nursing and Allied Health Literature (CINAHL) Plus; Google

---

[1] The Women's Mental Health Taskforce: Final Report (Department of Health and Social Care, 2018) was briefly introduced within Chapter One (p. 23) and explored throughout the Discussion section of Chapter Two. Its findings and recommendations will be explored further throughout the Discussion section of this review.

Scholar; National Institute for Health and Care Excellence (NICE) Evidence; ProQuest Dissertations and Theses (Global); Psychological Information Database (PsycINFO); and Web of Science. Citation searches of reviews relating to forensic mental health, general mental health and the criminal justice system were also conducted using the Times Cited function in Google Scholar.

The results revealed a total of 49 reviews published between 2010 and 2021. The reviews generally fell into the following domains (in consecutive order): general mental health; schools and education; criminal justice; residential care for children and/or adolescents; and physical health. A large majority were published in the US, followed by Australia, the UK and Canada. It is noteworthy that a significant proportion aimed to review the literature for domain-specific operational definitions of TiC; many noted the lack of quality and quantity of information relating to actual implementation and evaluation. Findings often referred to the "complexity of grasping the nature of the research being conducted" in the field (Lowenthal et al., 2020, p. 180); that TiC "has become a familiar term for many professionals; however, its operating definition lacks clarity" (Bendall et al., 2020, p. 313). This indicates that TiC is a rapidly growing yet formative and highly complex field of academic study.

Only two reviews were found specific to the domain of TiC within forensic mental health[2]. One review was titled *A Systematic Review on Implementing Education and Training on Trauma-Informed Care to Nurses in Forensic Mental Health Settings* (Maguire & Taylor, 2019). However, "no studies implementing trauma-informed care in forensic mental health settings were identified" (p. 247). The authors explored *implications* of the delivery of trauma-informed education and training for nurses working within forensic settings, based upon general mental health settings. Search terms were limited to "trauma-informed training" (p. 243). Findings were relatively vague, indicating that there must be a service-wide commitment to fully implementing TiC. The authors suggest TiC training should be prioritised for nursing staff, who could train colleagues and peers. Training should focus on understanding patient's trauma, improving relationships on the ward, and collaborative care. The second review looked at "how trauma informed approaches have been implemented

---

[2] Refer to Definitions of Terminology Used Throughout the Thesis (p. 13) for further clarification regarding the term forensic mental health.

within forensic environments and what the outcomes for both service users and staff members were" (Stamatopoulou, 2019, p. 32). Similarly, search terms were limited to trauma-informed care, practise, or model. Only one study conducted within a secure inpatient setting was retrieved - an unpublished service evaluation in the UK (n.d.). Other studies mainly came from the US, within juvenile services (Elwyn et al., 2015; Kramer, 2016; Kubiak et al., 2017; Messina & Calhoun, 2014; McEvedy et al., 2017; Olafson et al., 2018). Findings include benefits of implementing TiC, such as observed increase in safety and reduction in symptoms of trauma. Most studies demonstrated an understanding that TiC relates to the whole system (i.e., relationships, safe environment), as opposed to the outcome of direct interventions (i.e., trauma-specific). All studies highlighted the feasibility of implementing TiC across forensic services. Some accounted for gender responsive elements. There was also reference to the importance of investing in staff training and wellbeing.

In sum, initial scoping searches found an absence of literature relating to TiC within secure inpatient services when narrow search criteria are applied. A second scoping exercise was conducted using slightly broader criterion. This included words or phrases that are used synonymously and/or interchangeably with TiC: trauma* informed* or trauma adj3 (sensitiv* or respons* or focus* or intervention* or aware* or treat* or care or approach* or reduc* or principle* or value* or think*). This exercise yielded several additional references, indicating that a more in-depth and up-to-date search could retrieve sufficient data to perform the current review.

Aims of the Current Review

The overarching aim of this review was to establish and improve understanding of what the literature base tells us about trauma-informed care within secure inpatient services. Considering the formative and complex nature of the research topic, more specific aims were developed. The intended focus of each aim was specific to secure inpatient services:

i. To determine how TiC has been defined within the literature base.
ii. To identify the specific components of TiC that have been operationalised and/or implemented.
iii. To identify any evaluations of TiC including both the potential and/or actual impact of implementation.
iv. To identify future recommendations regarding TiC for both practice and research.

v. To identify any additional and relevant key findings or discussion points that provide deeper insights into the discourse surrounding use of the term TiC.

Methodology

Search Terms

Relevant key words and phrases were generated by the researcher using existing knowledge of the trauma-informed domain, the references identified during initial scoping exercises, and SAMHSA's (2014) key assumptions and principles. Adjacency/proximity and wildcard operators were applied to maximise the number of relevant results. Modifications were made to accommodate the specific requirements for different databases and platforms.

Ideally, this review would have only searched for and included studies that focused on patient views and experiences (owing to the aims of this thesis and mirroring the search terms employed within Chapter Two). However, due to the emergent state of the literature (as identified from initial scoping searches), search terms for this review were intentionally designed to be broad in scope, focusing instead primarily on the *setting* of secure inpatient environments[3]. Inclusion of the key word "inpatient" here was considered but not utilised, as this produced extensive additional results relating to general mental health inpatient settings. The approach used ensured that searches were able to identify literature that included both patient and/or staff participants. After running the search strategy and applying the inclusion criteria, a decision was made to retain all studies - regardless of participant type – in the interest of furthering understanding of what the literature base tells us specifically about "trauma-informed care" within secure inpatient services.

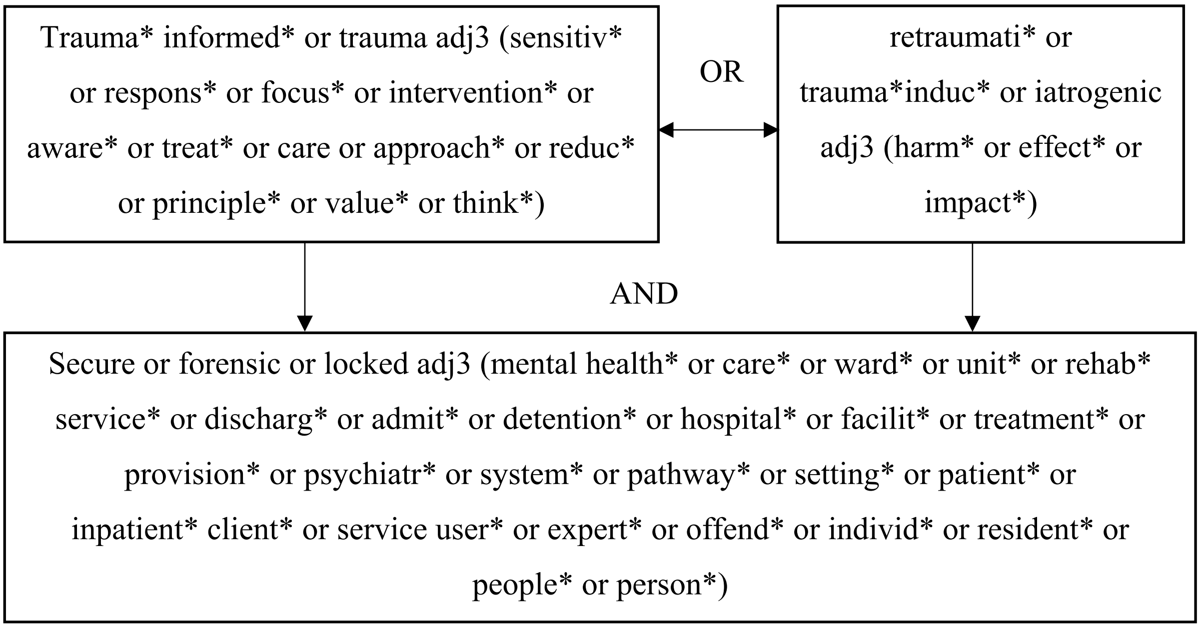
To verify the approach outlined above, the search terms used (see Figure 5) were further explored and re-run with specialist library staff for psychology from the University of Birmingham. It was confirmed they were appropriately designed to capture the intended setting of secure inpatient services, including patient and/or staff participants.

---

[3] Refer to Definitions of Terminology Used Throughout the Thesis (p. 13) for further clarification regarding the term secure inpatient.

Figure 5

Search Terms used for Electronic Database Searches



Search Strategy

The search strategy was designed to be comprehensive owing to the complexity of the research topic and aims of the current review. It was comprised of five stages, all of which took place in November 2021 (see Appendix I for more details).

(1) Electronic Database Searches

Four electronic databases were chosen by the researcher according to subject coverage: Applied Social Sciences Index and Abstracts (ASSIA) (2011 to 2021); CINAHL (2011 to 2021); PsychINFO (2000 to 2021); and Web of Science (1990 to 2021).

(2) Journal Searches

Eight journals were chosen by the researcher after running preliminary searches of the electronic databases mentioned above. A decision was made based on number of relevant publications and subject coverage. Six journals covering the field of forensic mental health included: Journal of Forensic Psychiatry and Psychology; International Journal of Forensic Mental Health; Journal of Forensic Psychology Research and Practice; Journal of Forensic

Social Work; Criminology and Criminal Justice; and Criminal Behaviour and Mental Health. Two journals covering the topic of trauma included: Journal of Aggression, Maltreatment and Trauma; and Journal of Trauma and Dissociation.

(3) Grey Literature Searches

Grey literature sources were searched to limit publication bias. Two were chosen according to subject coverage following initial scoping exercises: ProQuest Dissertations and Theses and NICE Evidence.

(4) Manual Searches

The researcher hand-searched the reference lists of all articles that met the inclusion/exclusion criteria. Citation searches of all these articles were conducted using the cited by function in Google Scholar and the Times Cited function in Web of Science.

(5) Contacting Experts

Contact was made with experts that had conducted research relevant to the wider field of TiC within general and/or forensic mental health. An email was sent requesting for any references relevant to the current review. The inclusion/exclusion criteria were attached to the email. Four experts were contacted: Dr Angela Sweeney, Dr Joanne Ramsden, Lawrence Jones, and Dr Kerry Hinsby. Two responded.

Selection and Screening

Selection and Screening Tool (SST)

The SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research type) (Cooke et al., 2012) framework was deemed to be the most appropriate for assessing the suitability of studies for inclusion in this review. This was chosen over a Population, Intervention, Comparison, Outcome (PICO) framework. The latter is recommended for studies assessing the effectiveness of interventions using quantitative methodology, whereas the SPIDER is flexible to mixed methods. The inclusion/exclusion criteria can be found in Table 9.

Table 9

Inclusion and Exclusion Criteria Using the SPIDER Tool (Cooke et al., 2012)

	Inclusion	Exclusion
Sample	<u>Setting</u> Primary focus on: - Secure inpatient services <u>Population</u> - Patients / staff - Male and/or female - Adults (over 18 years of age)	<u>Setting</u> Primary focus on: - Community forensic services - Prison or alternative criminal justice agencies (i.e., probation) - Secure residential care for children/adolescents - General mental health inpatient or community settings <u>Population</u> - Children or adolescents (under 18 years of age)
Phenomenon of interest	- Terms used synonymously/interchangeably with "trauma-informed" included within study aims, findings and/or discussion (i.e., recommendations) AND - The focus of the study (i.e., phenomenon of interest) was relevant to TiC[4].	Primary focus on: - Staff burnout/vicarious trauma - Direction psychological interventions (1:1 or group). For instance, EMDR, TF-CBT, DBT, CFT (etc)
Design	- Any	
Evaluation	- Any (including the absence of evaluation measures)	
Research type	- Any	
Publication type	Empirical research: - Published or unpublished empirical research - Doctoral theses	- Undergraduate or Masters level dissertations or theses Non-empirical research: - Conference abstracts or presentations - White papers, policy, guidance - Service evaluations - Book chapters - Editorials/opinion papers - Case studies

---

[4] See page below for further detail regarding phenomenon of interest.

Further Clarification of Inclusion Criteria - Phenomenon of Interest

The criterion "phenomenon of interest" was, in part, developed retrospectively, after conducting the search strategy. Initially, the researcher set out to capture studies that undertook a primary focus on at least one element of TiC, as defined by SAMHSA's (2014) four key assumptions. However, this approach revealed itself to be too broad and subjective. A considerable number of studies retrieved would have met the inclusion criteria, regardless as to whether they referred directly to TiC or not. With this approach, it is also arguable that many other additional aspects of service provision can be conceptualised as falling under the umbrella of trauma-informed (i.e., patient choice, collaborative decision making, relationships on the ward, psychiatric diagnoses). Again, regardless as to whether they referred directly to TiC or not. Thus, the scope of this review would have been too large and complex; undermining its utility in being able to improve understanding of what the literature base tells us specifically about "trauma-informed care" within secure inpatient services.

As such, a more specific approach was decided upon. That is, to include studies if *both* the following criteria were met: (i) terms synonymous and/or interchangeable with "trauma-informed" were used within the aims, findings and/or discussion (i.e., recommendations); and (ii) the focus of the study (i.e., phenomenon of interest) was relevant to TiC.

The first criterion was designed to accommodate how the researchers had defined or described TiC within their own studies; therefore avoiding imposing the author of this review's own presumptions about what is, and what is not, deemed to be "trauma-informed" (as outlined in the Introduction with reference to SAMHSA [2014], and explored further within the Discussion section of this review). This approach is consistent with existing literature reviews (as identified during initial scoping searches), that have focused on TiC within other domains. For instance, that of Bendall et al. (2020), who conducted a review of TiC within outpatient health services for young people. One of their aims was to "clarify what trauma-informed care is" (p. 313) and how it has "been defined and operationalised" (p. 314) in the literature base. For their inclusion criteria, they describe being led by the authors' descriptions to "determine whether the intervention did in fact represent trauma-informed care" (p. 314). Bendall et al.'s (2020) results are then interpreted with reference to SAMHSA's (2014) framework. The second criterion was designed to ensure specificity. For instance, studies that had made only passing reference to the term trauma-informed within a single sentence in the absence of further elaboration, with no direct link to the main focus of the study, were not included.

The reason for adopting this approach was due to the complexities of the research topic. More specifically, concerns regarding misunderstandings of the term trauma-informed (as mentioned within the Introduction section of this review) and the lack of operational or field- specific definitions across the TiC literature landscape (as highlighted by initial scoping searches). Thus, this approach was adopted to meet the specific aims of this review.

Screening and Selection Process

Searches of databases, journals, and grey literature returned a total of 4,686 hits. All titles and abstracts were screened and removed if they were clearly unrelated to the review topic (n = 4,564). Following removal of duplicates (n = 27), this left 95 references. Full texts were obtained, and the inclusion/exclusion criteria applied. This left nine references for inclusion. Manual searches retrieved an additional eight potential references, six of which did not meet the inclusion criteria when the full texts were obtained. In total, 11 studies were included in this review. A diagrammatical representation of the screening process can be found in Figure 6. Appendix J provides a list of the full-text references (n = 86) that were excluded, along with their reason/s for exclusion. For clarity, Table 10 details reasons for inclusion, with reference to phenomenon of interest criteria.

Figure 6

Flow Diagram of the Selection and Screening Process

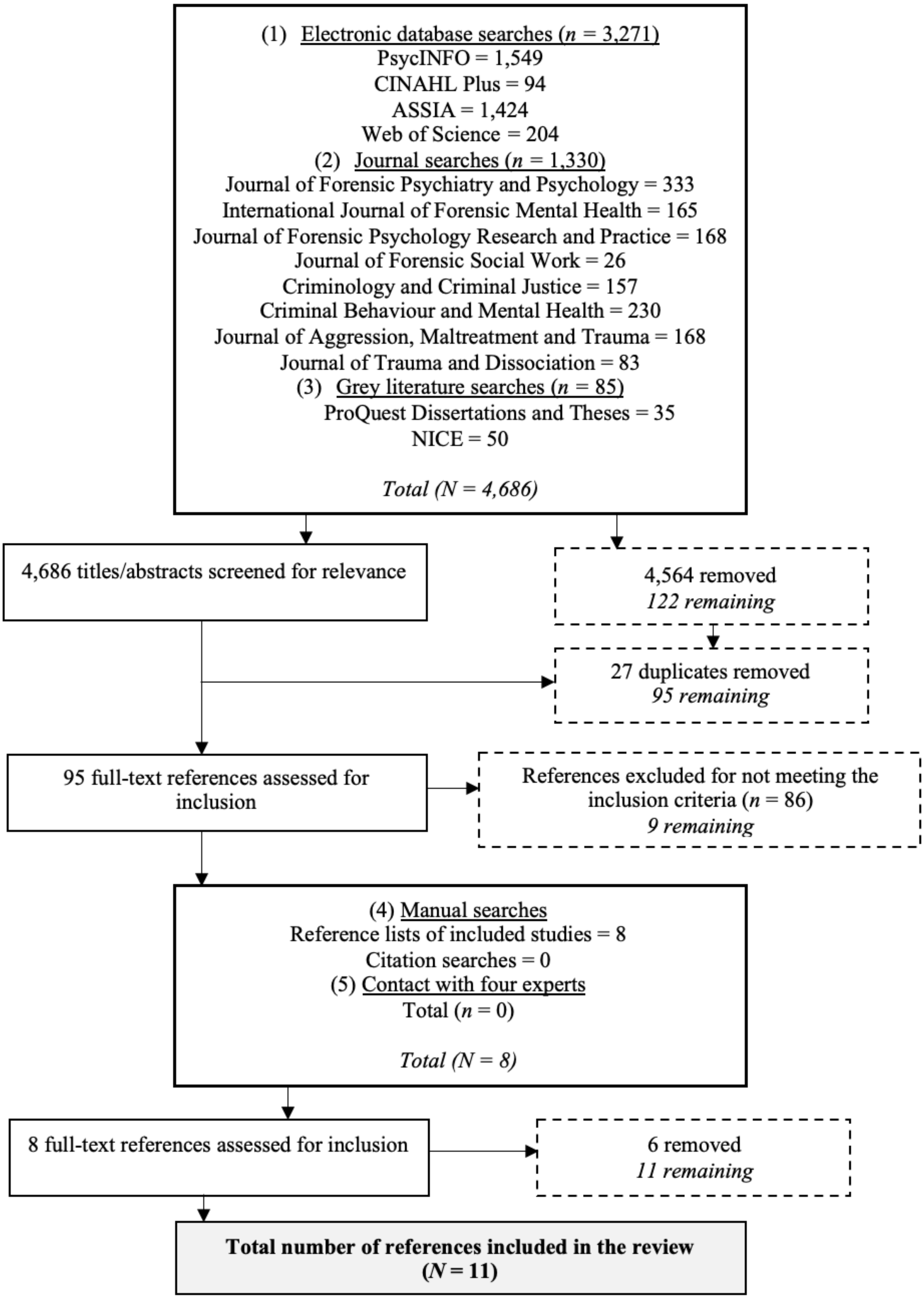


Table 10

Reasons for Inclusion Using the Criteria "Phenomenon of Interest" ($N = 11$)

Study	**Phenomenon of interest**			
	Phenomenon of interest evidently relevant to trauma-informed care	Terms used synonymously/interchangeably with "trauma-informed" within:		
		Aim/s	Findings	Discussion (i.e., recommendations)
Alexander et al. (2016)	Rates of diagnosed PTSD	✓		✓
Bohle and de Vogel (2017)	Gender differences in victimisation			✓
Brackenridge and Morrissey (2010)	Trauma experiences and post-trauma symptoms			✓
Cartwright (2020)	Patient experiences of adversity and relationship to secure care		✓	✓
Fosse et al. (2021)	Childhood victimisation and community violence			✓
Karatzias et al. (2019)	Psychiatric diagnoses and childhood adversity			✓
McKenna et al. (2019)	Exposure to trauma			✓
Morris et al. (2019)	ACE's, Developmental Trauma Disorder, and PTSD			✓
Owens (2021)	Patient perceptions of TiC	✓	✓	✓
Stamatopoulou (2019)	Staff perceptions of transitioning to a TiC	✓	✓	✓
Stinson et al. (2021)	ACE's and psychiatric/criminal outcomes			✓

Notes on Included Studies

Ideally, this review would have only included studies set within secure inpatient services in the UK, as this is the context throughout which the thesis is set. However, due to uncertainties regarding the state of the literature for TiC within secure inpatient services, limits restricting outputs to studies set within the UK were *not* applied prior to conducting the search strategy. After running the search strategy and applying the inclusion criteria, a decision was made to retain studies that were set both inside ($n = 7$) *and* outside ($n = 4$) of the UK. Considering the emergent nature of the research topic, this decision was made with a view that all studies – regardless of geographical location - would add utility to this review in being able to establish and improve understanding of what the literature base tells us about TiC within secure inpatient services.

Five studies, set within the UK, collected data from “high”, “medium”, and/or “low secure” inpatient settings (Brackenridge & Morrissey, 2010; Cartwright, 2020; McKenna et al. 2019; Owens, 2021; Stamatopoulou, 2019). One study, set within Norway, also collected data from a “medium secure” inpatient setting (Fosse et al. 2021). Three studies, set within the US and Netherlands, collected data from “forensic psychiatric inpatient” or “secure care” settings (Alexander et al., 2016; Bohle & de Vogel, 2017, Stinson et al., 2021). The rationale for including these three studies is that, outside of the UK, secure inpatient services are not always differentiated according to three levels of security. Instead, they may be “encapsulated in one ‘single service’ and labelled as ‘forensic psychiatric’ inpatient services” or secure care (Edworthy et al., 2016, p. 5)[5]. One study, set within the UK, collected data from low and medium secure settings, as well as a locked rehabilitation ward (Morris et al., 2019). The final study, also set within the UK, collected data from high, medium, and low secure inpatient settings, as well as forensic inpatients from “rehab units, and intensive psychiatric care units (IPCUs)” (Karatzias et al., 2019, p. 2). The rationale for including these two studies is that they retained a primary focus on secure inpatient services; only a small minority of participants came from other settings. In consideration of the formative and complex nature of the research topic, it was decided that both Morris et al. (2019) and Karatzias et al. (2019) would still offer meaningful contributions to this review.

It is also worth noting that Alexander et al. (2016) compared their data with non-forensic samples from other, pre-existing studies. The researcher chose to include this study as it retained a primary focus on a secure inpatient setting and would still offer meaningful contributions to this review.

---

[5] Refer to Definitions of Terminology Used Throughout the Thesis (p. 13) for further clarification regarding the term secure inpatient.

Quality Assessment

The eleven studies (seven quantitative cross-sectional, three qualitative, and one mixed methods) were subject to quality assessment by the researcher. Inter-rater reliability was not employed due to time constraints. Three separate tools were chosen: (1) the AXIS (Downes et al., 2016); (2) the Critical Appraisal Skills Programme checklist for qualitative research (CASP) (2018); (3) and the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018). It is acknowledged that quality assessment for multi-method research is an ongoing topic of debate. A decision was made to utilise these three oft-cited tools because they have been purposely designed to capture the unique nature of each methodology (Harrison et al., 2021). Examples of all three quality assessment tools can be found in Appendix K.

The researcher modified all three tools by adding a numerical scoring system (*Yes* = 2, *Can't tell* = 1, *No* = 0) for the sake of brevity and to aid comparison between studies. Assessors are discouraged from calculating overall scores and making direct comparisons between studies using different quality assessment tools. Thus, there are limitations to this approach. "Can't tell" was chosen when where there was a lack of/only partial information that prevented the researcher from making a sound judgement. On occasion, when there was evidence for and against the criterion, half scores were assigned (1.5). Total scores were used to calculate a percentage for each study. Quality cut-off scores were judged as follows: 90% or above = *Excellent*; 80 to 89% = *Very good*; 70 to 79% = *Good*; 60 to 69% = *Moderate*; 59% or below = *Low*.

Prior to commencing quality assessments, the researcher made the decision that only those studies that obtained a score of 59% or less would be excluded. This was with the view that all the studies identified – unless of exceptionally low quality - would make a meaningful contribution to this review.

Table 11 provides a summary of the quality ratings for all eleven studies. The quality scores ranged from 65 to 97.5 per-cent, with an average of 85 per-cent. Of note, two studies (Brackenridge & Morrissey, 2020; Bohle & Vogel, 2017) provided more details of the study design, method, and results in separate reports (Brackenridge & Morrissey, 2009; de Vogel et al., 2016); the former being unpublished and therefore inaccessible to the researcher. For the sake of consistency, their quality was judged only according to the information documented in the original studies that have been included in this review. Specific details for each study can be found in Appendix L.

Table 11

Summary of Quality Ratings for Included Studies (N = 11)

Study	Quality score (%)	Overall judgement criteria
Alexander et al. (2016)	76.25%	Good
Bohle and de Vogel (2017)	85%	Very good
Brackenridge and Morrissey (2020)	65%	Moderate
Cartwright (2020)	95%	Excellent
Fosse et al. (2021)	97.5%	Excellent
Karatzias et al. (2019)	75%	Good
McKenna et al. (2019)	86.25%	Very good
Morris et al. (2019)	73.75%	Good
Owens (2021)	80%	Very good
Stamatopoulou (2019)	97.5%	Excellent
Stinson et al. (2021)	97.5%	Excellent

Overview of Studies

A data extraction form was developed to capture important information from each study (Table 16). This included general study characteristics, sample demographics, methodology, and findings.

Study Characteristics

Most of the studies included were peer-reviewed empirical research papers ($n = 8$). The remaining three were Doctoral theses (Cartwright, 2020; Owens, 2021; Stamatopoulou, 2019). Most studies were published recently, between 2019 and 2021. The location of the studies came predominantly from the UK, with two from the US (Alexander et al., 2016; Stinson et al., 2021), one from the Netherlands (Bohle & de Vogel, 2017), and one from Norway (Fosse et al., 2021).

Table 12

Aims and Phenomenon of Interest for All Studies Included in This Review (N= 11)

Author	**Phenomenon of interest**					
	TiC	Prevalence and/or type of traumatic experiences	Trauma-responses/ “symptoms”	Psychiatric diagnoses	Experiences of secure inpatient care	Psychiatric and/or criminal outcomes
Alexander et al. (2016)				✓		
Bohle and de Vogel (2017)		✓		✓		
Brackenridge and Morrissey (2010)		✓	✓			
Cartwright (2020)	✓	✓	✓		✓	
Fosse et al. (2021)		✓				✓
Karatzias et al. (2019)		✓	✓	✓		✓
McKenna et al. (2019)		✓			✓	
Morris et al. (2019)		✓		✓		
Owens (2021)	✓				✓	
Stamatopoulou (2019)	✓					
Stinson et al. (2021)		✓		✓		✓

The aims and/or phenomenon of interest varied across all studies. Three explicitly focused on TiC (Cartwright, 2020; Owens, 2021; Stamatopoulou, 2019). The first considered patient experiences “from a trauma-informed approach” (p. 6) by exploring how patients “make sense of their past adverse experiences” and whether they “related to their detention in secure care” (p. 73); the second explored “what trauma-informed care means to service users” (p. 14); and the third aimed to explore staff perceptions of a TiC pilot project. Alexander et al. (2016) claimed to “assist in improving trauma-informed care” (Alexander et al., 2016, p. 459) by exploring the prevalence of patients that would meet the criteria for PTSD. The other seven studies focused on exploring links between trauma histories and: (i) psychiatric diagnoses or symptoms; and (ii) various psychiatric and offending outcomes (see Table 12).

Participant Characteristics

There were 2,995 participants across the eleven studies[6] (see Table 13). Of these, 2,917 (97%) related to patient records. Only 58 patients and 20 staff members actively took part and engaged in the studies (via interviews, focus groups, and self-report measures). The sample size across studies varied. The smallest was eight patients who took part in interviews for a qualitative study (Cartwright, 2020), and the largest was 1,508 patient records accessed for retrospective review (Alexander et al., 2016).

The research setting for most studies (*n* = 8) was labelled as high, medium and/or low secure inpatient (see Table 13). As noted on page 107, three studies collected data from settings labelled as forensic psychiatric inpatient or secure care settings (Alexander et al., 2016; Bohle & de Vogel, 2017, Stinson et al., 2021). Two studies, in addition to collecting the majority of their data from secure inpatient settings, also collected data from a locked rehabilitation ward (Morris et al., 2019), and "rehab units, and intensive psychiatric care units (IPCUs)" (Karatzias et al., 2019, p. 2).

All eleven studies reported gender demographics. A large proportion of participants were male (2,305, 77%). Only 670 (23%) were female. The demographic data relating to age of participants was heterogenous. One study did not report any age-related data (Morris et al., 2019). The lowest age was 18 (Bohle & de Vogel, 2017; Karatzias et al., 2019) and the highest age was 76 (Karatzis et al., 2019).

---

[6] One study (Brackenridge & Morrissey, 2010) did not specify if independent or repeated samples were used across the five different data collection methods. The researcher has assumed repeated samples were used and calculated 40 individual participants.

Table 13

Sample Size and Setting for All Studies Included in this Review (N= 11)

Author & year	**Sample size**	**Setting**				
		High Secure	Medium secure	Low secure	Forensic psychiatric inpatient or secure care	Other
Alexander et al. (2016)	1,508				✓	
Bohle and de Vogel (2017)	436				✓	
Brackenridge and Morrissey (2010)	40	✓				
Cartwright (2020)	8		✓	✓		
Fosse et al. (2021)	52		✓			
Karatzias et al. (2019)	422	✓	✓			✓
McKenna et al. (2019)	194	✓				
Morris et al. (2019)	123		✓	✓		✓
Owens (2021)	10			✓		
Stamatopoulou (2019)	20 (staff)		✓	✓		
Stinson et al. (2021)	182				✓	
Total = 2,995						

Two studies did not provide any data relating to the ethnicity of participants (Brackenridge & Morrissey, 2010; Morris et al., 2019). Overall, a large majority of participants were White British/Caucasian American. This ranged from 40% (Alexander et al., 2016) to 100% (Cartwright, 2020). The second most prevalent ethnicity was African American, with representations of 40% (Stinson et al., 2021) and 28% (Alexander et al., 2016).

Methodology

Design

The primary methodological design was quantitative (n = 7), all of which were cross-sectional, relying solely upon secondary patient data (see Table 14). Three studies were qualitative in design, relying solely upon primary data (Cartwright, 2020; Owens, 2021;

Stamatopoulou, 2019). One was mixed, utilising both primary and secondary data (Brackenridge & Morrissey, 2010).

Table 14

Design and Method of Data Collection for All Studies Included in this Review (N= 11)

Author & year	**Design**	**Methods of data collection**			
		Secondary data	Primary data		
			Self-report standardised measures	Interviews	Focus groups
Alexander et al. (2016)	Quant	✓			
Bohle and de Vogel (2017)	Quant	✓			
Brackenridge and Morrissey (2010)	Mixed	✓	✓	✓	
Cartwright (2020)	Qual			✓	
Fosse et al. (2021)	Quant	✓			
Karatzias et al. (2019)	Quant	✓			
McKenna et al. (2019)	Quant	✓			
Morris et al. (2019)	Quant	✓			
Owens	Qual				✓
Stamatopoulou (2019)	Qual				✓
Stinson et al. (2021)	Quant	✓			

Secondary Data

Eight studies accessed secondary patient data. The specific types of data accessed varied. Six studies provided examples or full details (see Table 15).

Variations were also found between the type of variables extracted and coded. Six studies extracted data on psychiatric diagnoses (whether formally diagnosed or found mentioned; Alexander et al., 2016; Bohle & de Vogel, 2017; Brackenridge & Morrissey, 2010; Karatzias et al., 2019; McKenna et al., 2019; Morris et al., 2019). Two studies (Alexander et al., 2016; Morris et al., 2019) used diagnostic criteria to assign their own additional diagnoses (as judged by the researchers themselves). Three studies collected data on additional psychiatric and/or offending variables (Fosse et al., 2021; Karatzias et al., 2019; Stinson et al., 2021).

Table 15

Type of Secondary Patient Data Accessed (n = 8)

Author & year	Secondary data type
Alexander et al. (2016)	Not reported
Bohle and de Vogel (2017)	"Police records, diagnostic reports, and treatment evaluations" (p. 415). Quality of information available rated from "0 'insufficient' to 100 'excellent'" (only files scored about 50 were utilised) (p. 415).
Brackenridge and Morrissey (2010)	All social care and psychology files, as well as "electronic care records" and obtaining "informant accounts of events and symptoms for the last 12 months" (p. 51).
Fosse et al. (2021)	HCR-20V3 reports and summary notes by specialists in Psychology.
Karatzias et al. (2019)	Not reported
McKenna et al. (2019)	"Most recent Mental Health Tribunal and CPA reports and HCR-20v3 violence risk assessments" (p.3)
Morris et al. (2019)	"CPA, tribunal, and managers' reports, Structured Professional Judgment (SPJ) risk assessment reports, specialist psychological reports, psychological formulations, clinical records, and routinely collected psychometric measures relating to wellbeing and psychopathology" (p. 39).
Stinson et al. (2021)	Participant self-report, family interviews, psychiatric and social services admission and annual reports, discharge summaries, and police legal and court reports.

Primary Data

Sources of primary data included interviews (Brackenridge & Morrissey, 2010; Cartwright, 2020), focus groups (Owens, 2021; Stamatopoulou, 2019) and self-report measures (Brackenridge & Morrissey, 2010). Cartwright's (2020) semi-structured interview schedule detailed main questions and prompts that asked about participants past adverse experiences and whether they consider these experiences to be related to their detention in secure care. Participants were also provided with a sheet detailing common adverse experiences. Both Owen's (2021) and Stamatopoulou (2019)'s focus groups were structured according to an open-ended interview schedule, developed based on a Harris and Fallot's (2001) TiC framework. Owen (2021) asked additional questions about the policies and procedures that enable or limit service users in adapting in positive ways after trauma.

Data Analysis Methods

Four studies analysed qualitative data. This was completed using thematic analysis (Brackenridge & Morrissey, 2010; Owens, 2021; Stamatopoulou, 2019) and Interpretative phenomenological analysis (IPA) (Cartwright, 2020). The remaining eight studies analysed quantitative data. All provided descriptive statistics and conducted chi-square and/or t-tests. Brackenridge and Morrissey (2010) was the only study to not provide details of the specific statistical tests used. McKenna et al. (2019) was the only study to utilise non-parametric Mann-Whitney U tests. Additional statistical tests included: *z* tests, Student t-tests and ANOVA (Bohle & de Vogel, 2017); multiple regression (Fosse et al., 2021); logistic regression (Karatzias et al., 2019); Fishers Exact (Morris et al., 2019); and ANOVA and logistic regression (Stinston et al., 2021).

Table 16

Summary of Studies Included in this Review (N= 11)

Author(s), year, country, publication type, quality assessment score	Aim/s	Sample demographics	Methodology	Study findings
Study 1 Alexander et al. (2016) US Peer-reviewed empirical study Quality score 76.25% (good)	To ascertain the frequency of diagnosed PTSD	*N* = 1,508 patient records **Setting** Forensic psychiatric hospital **Participant characteristics** Gender Male = 1,191 (78%) Female = 317 (21%) Age (years) Mean age of participants diagnosed with PTSD (*n* = 21) = 43 (range = 26 to 66) Ethnicity White/Caucasian American = 606 (40%) African American = 420 (28%) Hispanic = 379 (25%) Asian/Pacific Islander = 84 (5.6%) Native American = 9 (0.60%) Other = 9 (0.6%) Unknown = 1 (0.7%) Legal status Not guilty by reason of insanity = 522 (34.6%) Incompetent to stand trial = 466 (30.9%) Post-parole mentally disordered offenders (MDOs) revoked in outpatient court-ordered treatment during parole = 285 (18.9%)	**Design** Quantitative cross-sectional **Data collection methods** File review **Data source** Hospital records from 2012 maintained by IT department. **Data extraction** Not reported **Variables extracted** 1. **Psychiatric diagnoses**: according to the DSM-IV-TR (APA, 2000) (made by unit psychologists upon admission) **2. DSM-IV-TR Global Assessment of Functioning Scores (GAF)**	**Analysis** Not reported in methodology. Findings include descriptive statistics and a series of chi-square tests of goodness of fit to compare the base rates of diagnosed PTSD with samples from other studies of "nonforensic serious mental illness patients" (p. 454). **Summary of results** Prevalence rates of PTSD "significantly underrepresented" (p. 454). Underdiagnosing is an issue in both forensic and non-forensic settings. Main findings Only 21 (1.4%) had received a diagnosis of PTSD. Only 3 (14.3%) of those patients (0.2% of the entire sample) had PTSD as primary diagnosis of record. 9 other patients (42.9%) had a diagnosis of PTSD listed on their record. Base rate comparisons Proportion of participants diagnosed with PTSD "significantly lower" than the non-forensic populations (p. 452).

		Newly committed MDO's committed as condition of initial parole = 60 (4%) Other commitment types (e.g., under sexually violent predator statuses/conservatorship) = 175 (11.6%) Other reported Education, psychiatric diagnoses		

Author(s), year, country, publication type, quality assessment score	**Aim/s**	**Sample demographics**	**Methodology**	**Study findings**
Study 2 Bohle and de Vogel (2017) Netherlands Peer-reviewed empirical study Quality score 85% (very good)	To explore gender differences in victimisation Note Study part of a larger research project on females in Dutch forensic psychiatric care. More details of this study found in de Vogel et al. (2016) .	*N* = 436 patient records **Setting** Gender-mixed forensic psychiatric institutions **Participant characteristics** Gender Female = 218 Male = 218 Age (years) Females: Mean = 35.5 SD[7] = 9.7 Range = 18–65 Males: Mean = 34.9 years SD = 9.8 Range = 18–67 Ethnicity (country of birth) Female: Netherlands ("most") Suriname (3.7%) Male:	**Design** Quantitative cross-sectional **Data collection methods** File review **Data source** Case files (i.e., police records, diagnostic reports, and treatment evaluations) of patients admitted between 1984 and 2014. Quality of file information all scored above 50 (0 = insufficient, 100 = excellent) **Data extraction** Completed by 11 researchers (two leading senior psychologists and trained research assistants) **Variables extracted** 1. **History of victimization**: childhood (before age of 17) and adulthood. Grouped according to: (i) emotional; (ii) physical (containing abuse and neglect); and (iii) sexual. Definitions	**Analysis** Chi-square tests with supplementary *z* tests, Student t-tests and Anova tests. **Summary of results** Prevalence of victimization higher for female than male patients (childhood and adulthood) Prevalence and complexity of victimisation during childhood • Female patients experienced sexual abuse 2x as often as male patients • No gender differences for other types of victimisation • Most patients experienced multiple types of victimisation Prevalence and complexity of victimisation during adulthood • Female patients experienced sexual abuse 10x more than male patients. • Female patients experienced physical abuse 3x more than male patients. • Female patients experienced significantly more victimisation across the lifespan than male patients. Victimisation and personality pathology • Male patients significantly more likely to be diagnosed with antisocial personality disorder and narcissistic personality

---

[7] SD = Standard deviation

		Netherlands (“most”) Suriname (10.6%) Morocco (5.5%) Legal status All admitted under “TBS-order (terbeschikkingstelling” translated as ‘detained under treatment order’)” (p. 415): committed a serious violent offense; diminished responsibility; high risk of recidivism Other reported Index offence	of abuse specified. Scored as present or absent (maximum score of 3). 2. **DSM-IV (APA, 1994) diagnoses and Psychopathy Checklist-Revised (PCL-R; Hare, 1991) ratings**: existing diagnoses made during first 6 weeks of admission. Instruments used for psychological assessment differed across units.	disorder. Patients with these diagnoses significantly more likely to have history of victimisation. • Female patients significantly more likely to have a diagnosis of borderline personality disorder. Also more likely to have history of victimisation. Specifically, sexual abuse.
Author(s), year, country, publication type, quality assessment score	**Aim/s**	**Sample demographics**	**Methodology**	**Study findings**
Study 3 Brackenridge and Morrissey (2010) UK Peer-reviewed empirical study Quality score 65% (moderate)	Service evaluation re “trauma experiences and post-trauma symptoms” in forensic learning disability population (p. 49) Note Purpose of this paper is to further discuss findings from main study. Original findings found in Brackenridge and Morrissey (2009)	*N* = 40 (assumed - number of participants varied for each of the various data collection methods used). **Setting** Rampton Hospital (Learning Disability service) **Participant characteristics** Gender All male Age (years) Mean = 38 Ethnicity Not reported Legal status Not reported Other reported Mean IQ = 63	**Design** Mixed methods **Data collection methods** File reviews (*n* = 40), standardised measures, and interviews (*n* = 22, respectively) **Data source** Social care and psychological files and patient self-report **Data extraction** Not reported **Variables extracted** File reviews • “Physical, psychological, sexual, institutional, discriminatory, and financial abuse” and neglect (p. 51) • Other potential traumas derived from Diagnostic Manual – Intellectual Disability (Fletcher et al., 2007)	**Analysis** Quantitative Descriptive statistics Qualitative Thematic analysis **Summary of results** File reviews • 100% participants experienced potential trauma across lifespan • Physical abuse most common (75%); sexual abuse and neglect (50% respectively); financial and discriminatory least common. • > one type (95%); ≥ five types of abuse (42.5%) • Mention of PTSD (15%); only 1 primary diagnosis • “Very high levels of pathology” (psychiatric diagnoses) (p. 52) • Significant subgroup experienced “repeated and chronic abuse and trauma” (p. 51) • Circumstances of and responses to (e.g. severity, frequency etc) “rarely available” in files and “impossible to code accurately” (p. 51)

			- "Potential PTSD-related symptoms" (p. 51) Standardised measures - Posttraumatic Stress Diagnostic Scale (PDS) (Foa et al, 1995) – modified version - Lancaster and Northgate Trauma Scales (LANTS) (Wigham, 2007) – Self Report and Informant Scales Interviews - "Groups of PTSD-related symptoms (re-experiencing events, hyperarousal, and avoidance)" (p. 51) - "Physical health status, self-esteem, trauma-related anger and self-harm, offence-related trauma, and post-traumatic growth" (p. 51) **Conduction of interviews** Not reported **Interview content** Interview guide not included	Interviews - Trauma-related symptom presentation extends beyond current DSM-IV criteria for PTSD (APA, 1994). - Variety of trauma responses serving important protective function. For example, continuous search for meaning, "extreme anger…low self-esteem…shame and guilt…hearing voices…self-harming" (etc) (p. 53). - "No-one identified post-traumatic growth or resilience" (p. 53)

Author(s), year, country, publication type, quality assessment score	**Aim/s**	**Sample demographics**	**Methodology**	**Study findings**
Study 4 Cartwright (2020) UK Doctoral thesis Quality score 95% (excellent)	Patient experiences of adversity and relationship to detention in secure inpatient services	*N* = 8 patients **Setting** Medium secure ward = 4 Low secure ward = 4 **Participant characteristics** Gender Female = 2 Male = 6 Age (years) 20 to 29 = 3 30 to 39 = 3 50 to 59 = 1	**Design** Qualitative **Data collection method** Semi-structured interviews **Conduction of interviews** Conducted by researcher "on private room off the ward" (p. 78). Psychologist based at the hospital also in the room due to lone working policy. Interviews lasted 25 to 50 minutes.	**Analysis** Interpretative phenomenological analysis (IPA). **Summary of results** "All participants described experiencing multiple adversities throughout their lives" (p. 94). Clear differences in how patients understood and related past experiences to admission into secure services. Four master themes and various subthemes: 1. Living amongst adversity ("it was the worst time") (p. 81) 2. Managing adverse experiences ("that person [I] was hurting so much") (p.84)

		60+ = 1 Ethnicity White British = 8 Legal status Transferred to hospital from prison = 6 Transferred from secure hospitals = 2 Other reported Length of stay in secure inpatient services, length of stay at current hospital, psychiatric diagnoses	**Interview content** Main questions and prompts asked participants about “past adverse experiences” and “detention in secure care” (p. 6). Participants were also provided with a sheet detailing common adverse experiences. Interview schedule themes: 1. Before admission 2. Admission 3. Present	3. Making sense of being admitted into secure inpatient services (“all life experiences sort of shape you”) (p. 87) 4. Coping with past today (“I sit with these things on a daily basis”) (p. 90)

Author(s), year, country, publication type, quality assessment score	Aim/s	Sample demographics	Methodology	Study findings
Study 5 Fosse et al. (2021) Norway Peer-reviewed empirical study Quality score 97.5% (excellent)	To explore “associations between childhood victimisation and community violence” prior to admission (p. 2)	*N* = 52 patient records **Setting** 12-bed medium secure forensic ward **Participant characteristics** Gender All male Age (years) Mean = 35.7 SD = 8.8 Ethnicity Norwegian = 29 (55.8%) Other European = 5 (9.6%) African = 8 (15.4%) East Asian = 10 (19.2%) Legal status Not reported Other reported Psychiatric diagnoses	**Design** Quantitative cross-sectional **Data source** Quality assurance registry encompassing all patients admitted between 2016 and 2019. Included Historical Clinical Risk Management-20, Version 3 (HCR-20 V3) (Douglas et al., 2013) and summary notes by specialists in psychology. **Data extraction** Completed by two of the researchers. **Variables extracted** **1. Abuse and neglect in childhood:** defined by Maltreatment and Abuse Chronology of Exposure (MACE) scale (Fosse et al., 2020) merged into 6 categories: emotional abuse; physical abuse; emotional or physical neglect/care failure; sexual abuse; witness to violence; verbal or physical	**Analysis** Independent t-tests and multiple linear regression. **Summary of results** Exposure to several childhood adversity types significantly “associated with more incidents of community violence” prior to admission (p. 4). - 32 patients (61.5%) experienced at least one of the six childhood adversity types. Mean 2.1 types per patient. - 11 patients (21.2%) experienced war trauma - 36 patients (69.2%) experienced childhood adversity/war trauma - 50 (96.2%) patients had at least 1 violent attack in community prior to admission

			bullying. Scored as present or absent (maximum score of 6). 2. **War trauma:** reports of "persecution, kidnapping and being held as hostage, torture, directly threatened with weapons, physically injured, and having witnessed violent war situations" (p. 3). Scored as present or absent (maximum score of 1). 3. **Community violence:** number of acts in community before being admitted. Definition of violence taken from HCR-20 V3.	

Author(s), year, country, publication type, quality assessment score	Aim/s	Sample demographics	Methodology	Study findings
Study 6 Karatzias et al. (2019) UK Peer-reviewed empirical study Quality score 75% (good)	To investigate the frequency of primary psychiatric diagnoses and childhood adversity; and "whether childhood adversity experiences significantly predict a range of criminal and psychiatric outcomes" (p. 1).	*N* = 422 patient records **Setting** High and medium secure. Also forensic inpatients from "low secure units, rehab units, and intensive psychiatric care" (p. 2) **Participant characteristics** Gender Male = 384 (91%) Female = 38 Age (years) Average = 41.47 Range = 18 to 76 SD = 11.83 Ethnicity British = 402 (95.3%) Legal status All detained under a criminal section of mental health legislation	**Design** Quantitative cross-sectional **Data source** Data drawn from the "Scottish Forensic Network Inpatient Census" (p. 2). Patient data from 2013. **Data extraction** Completed by Responsible Medical Officers (RMO) and "senior medical trainees with support from other members of clinical team" (p. 2) **Variables extracted** 1. **Childhood trauma and adversity**: 19 different types of experiences prior to 18 (i.e., physical abuse, sexual abuse, parental drug/alcohol misuse, bullied in school). Scored as present or absent (maximum score of 19). 2. **Criminal convictions** 3. **Animal abuse**	**Analysis** Descriptive statistics, independent samples *t*-tests, Pearson chi-square tests, and 2x five logistic regression. **Summary of results** Population characterised by "extremely high rates of psychotic illness and childhood adversity" (p. 5). Psychiatric diagnoses • Psychotic-based disorders highest prevalence (86.3%, *n* = 374). • Schizophrenia "most frequency recorded primary diagnosis" (p. 3) (70.0%, *n* = 303) Childhood adversity • 275 (80.74%) participants indicated exposure to "at least one adverse event during childhood" (p. 3). Mean number of experiences = 2.53 • Most common experience physical abuse (40.1%, n=145) Childhood adversity and criminal / psychiatric outcomes Sig associated with increased risk of: • Criminal convictions • Animal abuse • Suicidal or self-harm behaviour

		Other reported Marital status, children, and education	**4. Past admission to psychiatric services:** none or at least one **5. Suicidal and self-harm behaviour** **6. Drug and alcohol use**: "(i) non-intravenous drugs, (ii) intravenous drugs, and (iii) alcohol." (p. 3).	• Drug or alcohol use
Author(s), year, country, publication type, quality assessment score	**Aim/s**	**Sample demographics**	**Methodology**	**Study findings**
Study 7 McKenna et al. (2019) UK Peer-reviewed empirical study Quality score 86.25% (very good)	To investigate the frequency and type of trauma (childhood and adulthood)	*N* = 194 patient records **Setting** High secure hospital **Participant characteristics** Gender All male Age (years) Mean = 37.35 Range = 19 to 60 Ethnicity White British = 139 (71.6%) Other White background = 15 (7.7%) White and Black Caribbean = 6 (3.1%) Another other Black background = 6 (3.1%) Any other Asian background = 4 (2.1%) Legal status Section 47/49 = 75 (38.3%) Section 37/41= 73 (37.2%) Section 3 = 17 (8.7%) Section 37 = 16 (8.2%) Section 45A/LD = 8 (4.1%) Section 48/49 = 4 (2.0%) Other reported Primary psychiatric diagnoses, admission history (length of	**Design** Quantitative cross-sectional **Data source** Patient reports (i.e., Mental Health Tribunal, Care Plan Approach reports, HCR-20 V3 violence risk assessments) from 2017. **Data extraction** Not reported **Variables extracted** 1. **Trauma in childhood**: childhood Trauma Questionnaire (CTQ; Bernstein et al., 1994): "emotional abuse, emotional neglect, physical abuse, physical neglect, and sexual abuse" (p. 2). Scored as present or absent (maximum score of 25). 2. **Trauma in adulthood**: Trauma History Questionnaire (THQ (Green, 1996): crime-related events, general disasters, physical and sexual experiences. Scored as present or absent (maximum score of 24). Excluded cumulative trauma. 3. **Whether patients found own offence/s traumatising:** obtained via	**Analysis** Descriptive statistics and independent samples Mann-Whitney *U* **Summary of results** 100% patients had experienced trauma (childhood and adulthood) Trauma in childhood • 75% exposed to trauma • Physical (57%), sexual (34%), emotional (46%) abuse • Emotional (60%) and physical (34%) neglect • 10% experienced single trauma type • Death of significant other (30%) • Time in Local Authority Care (40%) Trauma in adulthood • 63% experience single trauma type • 7% experienced trauma in childhood, but not adulthood • 26% physical abuse, and 3% sexual abuse • Death of significant other (41%) Trauma exposure and hospital variables No significant differences between childhood trauma and admission length, seclusion, segregation, or incidents.

		stay, seclusion, segregation, incidents) and type of index offence	ward liaison psychologists. Scored as present or absent (maximum score of 1).	

Author(s), year, country, publication type, quality assessment score	**Aim/s**	**Sample demographics**	**Methodology**	**Study findings**
Study 8 Morris et al. (2019) UK Peer-reviewed empirical study Quality score 73.75% (good)	To investigate level of exposure "to adverse childhood events and the prevalence of Developmental Trauma Disorder (DTD)" (p. 35).	*N* = 123 patient records **Setting** Secure specialist forensic Intellectual Disability (ID) service: 2 medium-secure, 2 low-secure, and 1 locked rehab **Participant characteristics** Gender Male = 63 Female = 60 Age (years) Not reported Ethnicity Not reported Legal status Section 3 = 48 Section 37 = 21 Section 37/41 = 49 Section 47/49 = 5 Other reported Psychiatric diagnoses, primary risk (violence to others, arson, sexual violence, self-harm)	**Design** Quantitative cross-sectional **Data source** "Retrospective case note review of seven years of consecutive admissions" (p. 38). Minimum data: "CPA, tribunal, managers' reports, structured professional judgement risk assessment reports", psychological reports, records, and psychometric tests (p. 38). **Data extraction** Completed by all 3 authors **Variables extracted** **1.** **Exposure to at least 1 ACE**: definitions not provided. Scored as present or absent (maximum score of 1). **2.** **Exposure to repeated ACEs**: prolonged or multiple exposure. Scored as present or absent (maximum score 1). **3.** **Prevalence of DTD**: van der Kolk et al. (2019) criteria. **4.** **Prevalence of PTSD:** based on ICD-10 criteria.	**Data analysis** Chi-squared analyses and Fisher's Exact. **Summary of results** High levels of childhood adversity and pathology Exposure to adverse experiences (childhood) • 89 (72%) experienced at least 1 ACE • 81 (66%) had been exposed to "multiple or prolonged adverse events in childhood" (p. 39). Prevalence of DTD • 80 (65 %) met DTD criteria. • 72% of which had experienced 1 ACE • 100% of which had experienced multiple ACEs PTSD • 58 (47%) met criteria for PTSD. • 65% of which had experienced 1 ACE • 72% of which had experienced "multiple or prolonged exposure to ACEs" (p. 41). PTSD and DTD • 58 (47%) met criteria for DTD and PTSD. • 22 participants "who did not meet criteria for PTSD, met criteria for DTD" (p. 41).

Author(s), year, country, publication type, quality assessment score	**Aim/s**	**Sample demographics**	**Methodology**	**Study findings**
Study 9 Owens (2021) UK Doctoral thesis Quality score 80% (very good)	To explore "what trauma-informed care means" to patients (p. p. 14)	*N* = 10 patients **Setting** 3 low secure units **Participant characteristics** Gender Male = 9 Transgender female = 1 Age (years) Mean = 44.7 Range = 37 to 58 Ethnicity White British = 8 (80%) Indian = 2 (20%) Legal status Section 37/41 = 4 Section 3 = 2 Section 47/49 = 2 Section 37 = 2 Other reported Psychiatric diagnoses, length of stay in unit (months)	**Design** Qualitative **Data collection method** Focus groups **Conduction of focus groups** Conducted by researcher on the ward. Duration of 45 to 60 minutes. **Focus group content** Semi-structured interview guide developed with Fallot and Harris' (2009) framework of TIC. Also included questions regarding "practises that enabled or restricted them in adapting positively after trauma" (p. 28). For example, "Is there anything that happens on the ward that reminds you of previous traumatic experiences?" (p. 187)	**Analysis** Thematic Analysis (Braun & Clarke, 2019) **Summary of results** Findings presented according to the following research questions (data largely fit into the third): 1. "What do Fallot and Harris' (2009) guiding principles of TIC mean to service users?" 2. "How do service users experience these principles within the FMH and FID service?" 3. "What practices and procedures in the FMH and FID service enable or restrict service users in adapting positively after experiences of trauma?" (p.23). Three master themes and various subthemes: • "Promoting a sense of safety": protection, empathy, trustworthiness, boundaries • "Fostering a sense of belonging": support from peers, creation and ending of relationships • "Encouraging the development of an autonomous identity": feelings of powerlessness, self-development, supported coping, being infantilised, and invalidated (p. 33).
Author(s), year, country, publication type, quality assessment score	**Aim/s**	**Sample demographics**	**Methodology**	**Study findings**
Study 10 Stamatopoulou (2019)	To "explore staff perceptions of transitioning to a trauma-informed	*N* = 20 staff members **Setting**	**Design** Qualitative **Data collection method** Focus groups	**Analysis** Thematic Analysis (Braun & Clarke, 2006) **Summary of results**

UK Doctoral thesis Quality score 97.5% (excellent)	forensic unit" (p. 60)	Low and medium secure and medium secure Learning Disability **Participant characteristics** Gender Female = 100% Age (years) Range = 24 to 62 Ethnicity White British = 18 (90%) Mixed race = 1 (5%) Asian British = 1 (5%) Legal status N/A Other reported Length of time working on the unit	**Conduction of focus groups** Conducted by researcher, 3 to 7 staff members attended. Duration of 45 to 90 minutes. **Focus group content** Open-ended interview schedule developed based on TiC framework (Harris & Fallot, 2001). For example, "what is your understanding of trauma-informed care?", "Do you think that TIC has had any impact on your relationships with colleagues/managers and service users?" (p. 177).	Staff perceptions of integrating a trauma-informed care pilot scheme and the impact of this change on them. Four master themes and various subthemes: 1. "Reconstructing your professional identity" 2. "Redefining group dynamics" 3. "Navigating new practices'" 4. "Managing longer term challenges of trauma- informed change" (p. 81)

Author(s), year, country, publication type, quality assessment score	Aim/s	Sample demographics	Methodology	Study findings
Study 11 Stinson et al. (2021) US Peer-reviewed empirical study Quality score 97.5% (excellent)	To "examine prevalence, distribution, and correlates of ACEs" with various psychiatric and criminal outcomes (p. 374)	N = 182 patient records **Setting** Secure forensic psychiatric facility **Participant characteristics** Gender Male = 147 (81%) Female = 35 (19%) Age (years) Mean = 43.59 Range = 24 to 74 SD = 13.22 Ethnicity	**Design** Quantitative cross-sectional **Data source** Patient archival records admitted since 2005. For instance, psychiatric, social services, police, legal and court records, and files. This contained participant self-report and family interviews. **Data extraction** Completed by 3 trained research assistants. **Variables extracted** 1. **Psychiatric codes:** diagnoses made by facility psychiatrists. Collapsed into	**Data analysis** "Descriptive statistics, chi-square, analysis of variance (ANOVA), and logistic regression" (p. 374). **Summary of results** Exposure to ACEs: • 80% of participants experienced ACEs (average 2.63, range 0-8) • "Significant degree of childhood disruption not captured by ACE score alone" (e.g., 25.9% had previous investigations of child abuse or neglect and 23.5% had been in foster care or group home) (p. 379). ACEs and associated outcomes: ACE scores "significant predictors" of age aggression started, violent arrest. and psychiatric hospitalisation. Also included

		Caucasian = 101 (65%) African American = 73 (40%) Hispanic = 4 (2%) Mixed race/other = 4 (2%) Legal status Transferred to higher security due to aggression = 97 (53.3%) Not fit to stand trial = 37 (20.3%) Admitted from department of corrections = 21 (11.5%) Risk to self not manageable in another setting = 4 (2.2%) Pretrial evaluation = 3 (1.6%) One-year renewable civil commitment = 1 (0.5%) Other or unidentified = 19 (10.4%) Other reported Age at time of admission/discharge, length of admission, psychiatric diagnoses, history, and age of suicide attempts	symptom categories (i.e., mood disorders, psychotic disorders). 2. **Childhood adversity:** in accordance with 10-item ACE survey (Felitti et al., 1998). Emotional and physical neglect collapsed into single category. Scored as present or absent (maximum score of 9). 3. **Additional information: "**whether or not a child protective services investigation had ever been initiated, if the participant had been in foster care, age at first foster care placement, and number of out-of-home placements prior to the age of 18" (p. 378). 4. **Additional outcomes:** histories of aggression, arrest, and psychiatric hospitalisation.	placement in foster care and investigations for child abuse or neglect at home (p. 378). Average age of: • Onset aggression = 14.75 • First psychiatric hospitalisation = 16.26 • First arrest = 20.66 • First violent offence = 23.02 • Average number of admissions to psychiatric institutions = 14.78

Narrative Data Synthesis and Findings

In consideration of the heterogeneity of studies includes in this review and complexity of the research topic, it was deemed most appropriate to perform a narrative review (Popay et al., 2006). Data were extracted from both the results and discussion sections of each study, providing that key information relating to TiC was – for many studies - included within the latter. The researcher extracted information that directly referred to "trauma-informed care" (labelled as explicit), as well as data that indirectly referred to "trauma-informed care" (labelled as implicit). Further clarification as to the type of data that was extracted in accordance with the specific aims of this review is provided in Table 17 below. The data was then organised into key themes. Inter-rater reliability was employed by a Clinical Psychologist at the researcher's place of work. They were provided with three studies and asked to highlight the information they would include within this review. A discussed ensued which revealed strong agreement regarding the types of data that were relevant to extract for the purpose of this review.

Table 17

Types of Data Extracted to Meet the Specific Aims of this Review

	Specific aims of this review	**Type of data extracted to meet specific aim**
Direct reference to "trauma-informed care" (e.g., explicit)	(i) To determine how TiC has been defined within the literature base	Text that appeared to be a definition of trauma-informed care (as determined by the authors of the respective studies).
	(ii) To identify the specific components of TiC that have been operationalised and/or implemented	Text that describes what trauma-informed care looks like and/or how it has been delivered in practice (as determined by the authors of the respective studies).
	(iii) To identify any evaluations of TiC including both the potential and/or actual impact of implementation	Text that describes markers of feasibility, efficacy, or effectiveness prior to, during, or after implementation of trauma-informed care (as determined by the authors of the respective studies). This includes both those that the authors anticipate or observed.
	(iv) To identify future recommendations regarding TiC for both practice and research	Text that offered recommendations to improve or advance the field of trauma-informed care (as determined by the authors of the respective studies).
Indirect reference to "trauma-informed care" (e.g., implicit)	(v) To identify any additional and relevant key findings or discussion points that provide deeper insights into the discourse surrounding use of the term TiC.	Text that described what these studies found and/or discussed that have led them to conclude that trauma-informed care is important. This was left intentionally broad, owing to the formative and complex nature of the research topic and heterogeneity of studies included in this review. For many studies, key information relevant to trauma-informed care was included in both the results *and* discussion sections. This was deemed important as the main focus of this review is to gain a better understanding of what the literature base tells us about trauma-informed care within secure inpatient services.

Explicit Findings Making Direct Reference to TiC

The key themes within this section represent findings that made *direct* reference to TiC, as determined by the authors of the included studies. These findings address the first four specific aims of this review: (i) to determine how TiC has been defined within the literature base; (ii) to identify the specific components of TiC that have been operationalised and/or implemented; (iii) to identify any evaluations of TiC including both the potential and/or actual impact of implementation; and (iv) to identify future recommendations regarding TiC for both practice and research.

Definitions of TiC

Six studies provided definitions of TiC (Bohle & Vogel, 2017; Cartwright, 2020; Karatzias et al., 2019; McKenna et al., 2019; Owens, 2021; Stamatopoulou, 2019), all of which differed greatly. McKenna et al. (2019) and Owens (2021)[8] provided the most comprehensive definitions. Both studies described it as a model of care, whole system approach, and framework. McKenna et al. (2019) specified that it seeks to better understand patients and change provision of care accordingly. For instance, an individual's history of trauma and adversity, and the impact this can have upon functioning, emotional experiences, and relationships. Change can occur by identifying and eliminating practice that inadvertently recreates or reinforces experiences from the past. Owens (2021) specifies that it seeks to understand people's perception of safety following trauma; how they behave, react and cope. They emphasise the importance of social climate and staff relationships that are "consistent, boundaried, respectful and validating" (p. 45); the purpose being to eliminate patterns of "misunderstanding, reactions and counter-reactions", as well as uses of power, authority and restrictions that can be (re)traumatising (p. 19). Both studies alluded to key principles of TiC. For this, Owens (2021) referenced Fallot and Harris (2009), whereas McKenna et al. (2019) did not provide a reference.

Both studies acknowledged that TiC translates differently into forensic environments. McKenna emphasised that it "does not minimise legal or moral guilt" (p. 5). Rather, it allows trauma histories to be used to inform, understand, and reduce risk. Owens (2021) goes one

---

[8] This was extracted from the Introduction section of Owens (2021) as an exception, in consideration of its relevance to this review.

step further. They suggest that current TiC frameworks (Fallot & Harris, 2009; SAMHSA, 2014) are not adequate in representing the factors that service users (within secure inpatient intellectual disability [ID] services) feel are important. In addition to the obvious shift from asking "'what is wrong with you?' to 'what happened to you?'", they recommend definitions of TiC should also ask "'what helps you to feel safe?', and 'what helps you to feel like you belong here?'" (p. 46).

Stamatopoulou (2019) referred to TiC as being model of organisational change; one that seeks to improve the culture of an organisation - its values, beliefs, and behaviours. Cartwright (2020) described TiC as a way of delivering services that acknowledge the impact of trauma at all ages; using this to influence organisation-wide change and trauma-focused interventions. Bohle and de Vogel (2017) used the terms trauma-informed and gender-responsive synonymously. This was simply described as services that are adapted for male and female patients. Karatzias et al. (2019) described TiC as creating a safe environment by modelling healthy boundaries and non-threatening interactions.

What Does TiC Look Like in Practice?

Two studies provided details of what TiC looks like in practice. The first, Owens (2021), provided examples from patients themselves, according to the principles of safety and belonging. Feeling physically safe was aided by staff actions in response to threats of physical violence and bullying from other patients. Feeling emotionally safe was aided by the nature of relationships with staff. Patients valued non-judgemental attitudes and empathic responses. For instance, staff taking time to listen and help patients understand their problems. They also valued highly structured environments, clear and consistent boundaries enforced with explanation, alongside swift consequences. All experiences were underpinned by trust, which Owens (2021) suggests is of critical importance for those within secure inpatient settings. A sense of belonging was aided by connections between peers, via shared experiences and activities, which reduced feelings of isolation. Staff were noted to believe in patient's potential and abilities, which inspired hope. Specific examples included offering support to develop new coping strategies and skills for the future to become more autonomous and live independently.

The second, Stamatopoulou (2019), provided specific examples that were implemented as a TiC pilot scheme. The first step involved a "two-day development and training programme" (p. 64). This was designed to improve staff knowledge and advance their practical day-to-day and crisis intervention skills for understanding and working with trauma. It was suggested that staff apply said skills to resist retraumatisation and create a welcome and safe environment. Practitioners developed collaborative "safety plans" (using five sessions of Cognitive Analytic Therapy) to identify patient "triggers, emotions, and coping strategies to prevent and manage crises" (p. 64). The service offered core sessions of "art, occupational activities, self-soothing, emotional regulation and mindfulness" (p. 64). Patients were given individual debriefs after incidents (i.e., self-harm, restraint, seclusion). The purpose of this was to "promote healing, recovery and learning, as well as re-establishing" relationships with staff (p. 64). A staff role of Trauma Champion was created to ensure sessions facilitated on the ward reflected the needs of patients. The Trauma Champion monitored a "passport system" that helped to identify which activities were "re-energising" and "grounding"; as well as any other issues to be raised (p. 64). Finally, they offered fortnightly reflective groups. Weekly supervision was offered to staff to enable them to explore issues concerning implementation of the pilot scheme.

What Does TiC* Not *Look Like in Practice?

Owens (2021) was the only study to provide examples of practices that are *not* trauma-informed. As above, these examples were provided by patients themselves, according to the principles of safety and belonging. Threats to physical safety came from being exposed to physical violence and bullying from other patients. Threats to emotional safety came from staff when they were contradictory in enforcing and maintaining boundaries (e.g., not explaining rules of the ward properly). Conflict in achieving a sense of belonging came from staff not considering the creation and loss of relationships. For instance, patients not being introduced to a new member of their care team, or no facilitation for appropriate mourning when peers moved on.

Specific practices and procedures that were found to be unhelpful or harmful related to restrictions imposed and staff's tendency to infantilise patients. Restrictions imposed by the MHA and Ministry of Justice (MoJ) created a loss of identity. Feeling invalidated and infantilised was experienced when patients experienced a removal of choice. For instance, staff making assumptions and acting on decisions that they discern to be in patients' best interests.

Positive Impact of Implementing TiC

One study highlighted the positive changes of implementing a TiC pilot scheme, as perceived by staff (Stamatopoulou, 2019). Staff reconstructing their own identities; unpicking and unlearning well-ingrained negative and unhelpful attitudes towards patients. Staff had previously understood distress through the lens of diagnostic criteria; they were not used to seeing through a trauma-lens and making links to patients' lives. Most staff claimed being unaware of how widespread traumatic experiences are. They started to discover a shared humanity as opposed to an "us and them" (p. 94) mentality, which they say can be firmly entrenched within forensic services.

Prior to the TiC pilot project, staff felt fear and anxiety around sharing some control and allowing increased patient choice. This was in stark contrast to manging risk using restrictive practice; for example, an over-reliance on managing incidents with high doses of medication and seclusion. With a deeper understanding of patients, they feel able to respond to incidents by talking. This reduced overall levels of risk on the unit (i.e., number of incidents). Previously, staff were unsure about what they had to offer patients in helping them to progress. The new structure provided them with a purpose; it added a new value and feeling of motivation to their day. It helped staff to recognise that all interactions can be therapeutic.

Staff identified burnout as being part of the underlying culture within forensic services. The TiC pilot scheme created an increase in support, such as reflective practice, debrief sessions, and practical support for staff wellbeing. This helped staff to recognise the impact of working with distress, aggression, and violence and gave them permission to admit they struggled too. This learning reignited a sense of purpose, pride, and achievement.

Challenges of Implementing TiC

One study highlighted the challenges of implementing a TiC pilot scheme (Stamatopoulou, 2019). The initial implementation was overwhelming and evoked feelings of uncertainty. There was difficulty in translating a general framework into practice, as concrete, operational principles. Whilst expectations were high, staff soon realised that TiC does not provide immediate results and is not the answer to everything. Rather, it is a continuous learning process. At a service level, change was greatly hindered by the dominance of the medical model. This created conflict and tension, particularly with medical professionals, who promoted understanding through psychiatric diagnoses. Staff wondered about the impact this was having on patients.

Longer-term challenges related to concerns about consistency, efficacy, and sustainability of the model. Low staffing levels meant having to resort back to restrictive practices due to "lack of adequate human resources" (p. 118). A major challenge stemmed from the lack of resources within the NHS, which staff described as an organisation that does not offer enough time or money for new service development projects to create meaningful change.

Future Recommendations for What TiC Should Look Like in Practice

Eight studies made recommendations for how TiC should look like within secure inpatient settings, based on their research findings. The following section outlines these in consecutive order.

(1) Impact of Trauma. Five studies advocated more generally for greater recognition and understanding of the long-term impact of trauma. This was further clarified as understanding the aetiology of psychiatric symptoms, violence risk and interpersonal functioning (Fosse et al., 2021; McKenna et al., 2019; Morris et al., 2019; Stinson et al., 2021). Some referred to developmental trauma (Cartright, 2020; Morris et al., 2019), trauma at the psychological and neurobiological level (McKenna et al., 2019), and biopsychosocial correlates (Morris et al., 2019).

(2) Importance of Staff-Patient Relationships. Four studies highlighted the importance of staff relationships. This involved recognising the impact of trauma on individuals' ability to form relationships (i.e., feel safe and trust others), as well as recognising the significance staff play in facilitating recovery (Cartwright, 2020; Stinson, et al., 2021; Morris, et al., 2019; Morris et al., 2019). Two studies acknowledged the impact of perpetual changes and disruptions to staffing, which may recreate conditions that warrant distress (Cartwright, 2020; Morris et al., 2019). Cartwright (2020) also encouraged consideration that many participants have felt let down and unsupported by staff from community mental health services. Morris et al. (2019) emphasised staff roles in understanding and maintaining appropriate boundaries.

(3) Staff Training. Four studies proposed staff training. Training topics included trauma-informed approaches (Cartwright, 2020; Stinson et al., 2021) and attachment theory (Cartwright, 2020). McKenna et al. (2019) put forward the need for staff training to increase knowledge "of the likelihood of patient trauma" (p. 5). Brackenridge and Morrissey (2010) recommend training on PTSD, the impact of trauma, both "classic" and "atypical" (p. 55) trauma responses, and to endorse compassionate and person-centred responses to behaviour that may be linked to early trauma.

(4) Treatment Models & Management Plans. Four studies referred more generally to the development of treatment models and management plans specifically targeted towards trauma histories. Bohle and de Vogel (2017) mention programmes designed for females, such as Beyond Violence (Covington, 2013). Morris et al. (2019) were more specific to developmental trauma, acknowledging the importance of: physical touch and exercise, right-brain (i.e., non-verbal interventions), diet, and pharmacological treatment. Both Morris et al. (2019) and Fosse et al. (2021) acknowledge that care can be fragmented and disjointed. Thus, there is a need for individualised and collaborative treatment and risk management plans. For instance, integrating both physical and mental health.

(5) Trauma History Assessments. Four studies recommend obtaining more detailed trauma histories from patients. Brackenridge and Morrissey (2010) and Karatzias et al. (2019) suggest that this should take place early upon admission. Fosse et al. (2021) suggests a general increased focus on assessing patient life stories. Morris et al. (2019) was the only study to offer consideration as to how this information is gathered and disseminated. They highlight both ethical and practical issues, particularly for individuals diagnosed with ID's. These include ensuring interviews consider communication needs, the wellbeing and potentially destabilising impact of this process on patients, and implications for family relationships following unreported historical abuse.

(6) Trauma-Based Diagnoses. Three studies advocated for more “diagnostic accuracy” (Alexander et al., 2016, p. 448) in the form of PTSD (Alexander et al., 2016; McKenna et al., 2019) and developmental or complex trauma (Morris et al., 2019). Morris et al. (2019) focused specifically on patients diagnosed with a learning disability. They suggested that lower intellectual functioning may, for some, be more attributable to the effects of chronic traumatisation and should therefore be understood as “acquired brain injury” (p. 37).

(7) Psychological Treatment. Three studies made recommendations for specific psychological treatment. TF-CBT and EMDR were recommended for “simple PTSD”; and psychotherapy for long-term, repeated trauma (Brackenridge & Morrissey, 2010, p. 54). Cartwright (2020) recommended: Compassion Focused Therapy (CFT) to address feelings of shame following trauma; Dialectical Behavioural Therapy (DBT) to address emotional regulation and interpersonal difficulties; and schema focused therapy to target maladaptive schemas and associated coping strategies. Karatzias et al. (2019) suggest patients should be provided with opportunities to learn emotional regulation, reflection, and new coping skills.

(8) Gender- & Race-Informed. Two studies recommend more attention be paid to gender- and race-informed practice (Stinson et al., 2021; Bohle & de Vogel, 2017). Stinson et al. (2021) suggests women present with greater vulnerabilities and need for safety on the ward. Examples of female-specific treatment needs include improving self-esteem, belief in self, interpersonal relationships, and regulation of emotions. Examples of male-specific treatment needs include skills to regulate of emotions and behaviour and the development of social skills (Bohle & de Vogel, 2017). Bohle and de Vogel (2017) also emphasise the importance of assessing the risk of victimisation from other patients on gender-mixed wards. No clarifications were offered for race-informed practice.

(9) Enhancing Patient Understanding. Two studies suggested supporting patients to make links between past experiences and present circumstances (Cartwright, 2020; Owens, 2021). Services could do this by facilitating team formulations, psychological training, and reflective practice. This shared understanding would enable staff to see patients as a whole person and increase their empathy. Each patient should have an individual formulation that steers away from the medical model (i.e., what is wrong with you?) to one that is trauma-informed (i.e., what has happened to you?). Owens (2021) suggests the Power Threat

Meaning Framework (PTMF) (Johnstone & Boyle, 2018) could be a way for patients to develop more hopeful narratives of their lives, "instead of seeing themselves as blameworthy, weak, deficient or mentally ill" (p. 47).

(10) Other (Continued Evaluation, Staff support, Environmental Factors & Joint Working). Continued evaluation of TiC was noted as key to monitor the potential impact on seclusion, segregation, and incident rates, as well as patient engagement (McKenna et al., 2019). Cartwright (2020) recommended more staff support, such as staff reflective practice and trauma-informed supervision. Fosse et al. (2021) highlighted the necessity of joint working between secure inpatient and addiction services.

Future Recommendations for TiC Research

Five studies made recommendations for research specifically focusing on TiC. Owens (2021) suggests research on TiC should focus on operationalising specific attitudes and skills that are commensurate with this approach. They also advocate for a "multi-layered", "360-degree review" whereby "service users and staff from every rank and discipline" are approached with the same questions about the service (p. 50). Cartwright (2020) made a similar recommendation. Alexander et al. (2016) suggested examining barriers to implementation, such as staff attitudes in relation to the impact of trauma on people with "comorbid serious mental illness" (p. 457). Stamatopoulou (2019) and Bohle and de Vogel (2017) stated it would be valuable to conduct further longitudinal evaluation research on the impact of TiC (i.e., after two, or five years). Stamatopoulou (2019) also indicates that it would be beneficial to conduct research on staff wellbeing. For instance, exploring the impact after hearing or discovering trauma histories of patients, as well as their role in restrictive practice.

Implicit Findings Making Indirect Reference to TiC

The key themes within this section represent findings that made *indirect* reference to TiC. For instance, what the author/s found and/or discussed that led them to conclude that TiC is important. These findings address the fifth specific aim of this review: to identify any additional and relevant key findings or discussion points that provide deeper insights into the discourse surrounding use of the term TiC.

Trauma Histories

Eight studies provided details of participants' trauma histories. Overall, the picture presented is one of extremely high rates of trauma. Remarkable gender differences were found. Females, in comparison to males, were significantly more likely to have been subject to victimisation (Bohle & de Vogel, 2017), receive higher ACE scores (Stinson et al., 2021), and experience more prolonged and/or multiple ACEs (Morris et al., 2019). They were also twice as likely to have been subject to sexual abuse in childhood, ten-times more likely to have been subject to sexual abuse in adulthood, and three-times more likely to have been subject to physical abuse in adulthood (Bohle & de Vogel, 2021). Only one study reported on racial differences. According to Stinson et al. (2021), no significant differences were found between white and non-white participants with regards to mean and total ACE scores.

Beyond Trauma "Symptoms"

Two studies looked beyond psychiatric diagnoses and symptoms. Cartwright's (2020) analysis explored the impact of traumatic experiences and the strategies participants developed to cope with difficultly, unbearable distress, and pain. For instance, extreme internalising or self-destructive strategies to escape, seek support, or simply get a response from others. This included suicide attempts, self-harm, and misusing substances. Others externalised their distress with aggression and violence. This was used to physically release, express, and get rid of the pain, protect themselves from further vulnerability, and to provoke others to hurt or kill them.

Brackenridge and Morrissey (2010) acknowledged the possibility that trauma goes unrecognised and overlooked because the connection between life events and symptoms has been lost. They say that the symptoms of people who have experienced trauma and abuse extend beyond PTSD. Brackenridge and Morrissey (2010) go on to identify the range of different, individualised trauma symptoms For instance, low self-esteem, feelings of self-loathing, guilt, shame, constant fear, withdrawing socially, mistrust and suspicion, exhaustion, under-achievement, hearing voices, illegal drugs, self-harming, changed sexual preferences, confusion in relation to sexual identity, severe relationship problems, emotional alienation, disconnection, loneliness, profound and unrelenting anger, and violence (towards self or others).

Protective Factors

Three studies made passing reference to protective factors, mostly in the form of social support (Brackenridge & Morrissey, 2020; Cartwright, 2020; Morris et al., 2019). Brackenridge and Morrissey (2020) briefly mentioned it being “possible” that some will achieve “full restoration to former health” following trauma, by drawing on “personal resources and strengths” (p. 54). Morris et al. (2019) remarks on the concept of resilience as a buffer for the effects of ACEs. The authors imply that resilience “may be diminished or limited in the ID population”; the explanation being that “resilience is associated with above average IQ” (p. 42).

Psychiatric Diagnoses

Six studies reported on the presence of various, multiple psychiatric diagnoses in their results (Alexander et al., 2016; Bohle & de Vogel, 2017; Brackenridge & Morrissey, 2010; Karatzias et al., 2019; McKenna et al., 2019; Morris et al., 2019). Three studies specifically analysed the relationship between trauma and psychiatric diagnoses and documented high rates between the two. Bohle and de Vogel (2017) conclude childhood trauma “may play an important role” in the aetiology of personality disorders (p. 422). Brackenridge and Morrissey (2010) highlight various diagnoses and “very high levels of pathology”, suggesting these presentations could be better understood as ‘complex PTSD’ (p. 52). Morris et al. (2019) suggested that Developmental Trauma Disorder may offer a more inclusive and accessible framework than ID for those individuals with histories of trauma. The other three studies explored the prevalence of psychiatric diagnoses, in the absence of or without directly examining the relationship to trauma histories. Alexander et al. (2016) primarily focused on PTSD and concluded its prevalence was significantly lower when compared to other “non-forensic serious mental illness patients” (p. 454). They conclude PTSD is under-represented and under-diagnosed. Similarly, Mckenna et al., (2019) remarks that none of the patients had a primary diagnosis of PTSD. This, they say, is far too low and conceals the extent of trauma histories; a concept they termed “diagnostic overshadowing” (p. 4).

Important gender differences were also found. That is, females were more likely to receive a diagnosis of borderline personality disorder, and males are more likely to receive a diagnosis of antisocial personality disorder or schizophrenia-spectrum disorders (Bohle & de

Vogel, 2017; Mckenna et al., 2019; Karatzias et al., 2019). No further interpretations or conclusions are offered.

Trauma and Other Variables

Four studies explored the relationship between trauma and various criminal and/or psychiatric outcomes (Fosse et al., 2021; Karatzias et al., 2019; Stinson et al., 2021; McKenna et al., 2019), all of which demonstrated clear linearity between the two. Notably, Stinson et al. (2021) found a model emerged that classified participants as either being arrested or hospitalised first (accounting for 79.2 per-cent). In sum, this indicated that participants who are non-white are 73 times more likely to be arrested than admitted to a psychiatric hospital.

Limitations of Trauma Research

Five out of the seven studies that collected and quantified trauma from patient records acknowledged limitations of this approach, to varying degrees. There was an awareness that trauma being scored dichotomously as *present* or *absent* according to predetermined categories cannot capture the circumstances, responses, patterns, severity, frequency, duration, or cumulation of experiences (Brackenridge & Morrissey, 2010; Fosse et al., 2021; Stinston et al., 2021). This information is “impossible to score accurately” (Brackenridge & Morrissey, 2010). Stinson et al. (2021) was the only study to acknowledge and expand upon limitations of the ACE questionnaire itself (Felitti et al., 1998). Considering the continuously elevated scores of the secure inpatient population, total ACE scores do not offer useful information.

Other limitations mentioned included patient self-report and the possibility of trauma being under-reported. The most common suggestion was a reluctance or hesitancy to disclose or share vulnerable information from the past (Bohle & de Vogel, 2017; Fosse et al., 2021; McKenna et al., 2019; Stinson et al., 2021). In contrast, the two studies that collected data via semi-structured interviews found significantly fewer methodological limitations and were able to identify numerous benefits (Brackenridge & Morrissey, 2010; Cartwright, 2020). For instance, participants felt able to open-up and felt truly listened to.

Discussion

Overview

The overarching aim of this review was to establish and improve understanding of what the literature base tells us about trauma-informed care within secure inpatient services. Due to the formative and complex nature of the research topic, the more specific aims of this review were: (i) to determine how TiC has been defined within the literature base; (ii) to identify the specific components of TiC that have been operationalised and/or implemented; (iii) to identify any evaluations of TiC including both the potential and/or actual impact of implementation; (iv) to identify future recommendations regarding TiC for both practice and research; and (v) to identify any additional and relevant key findings or discussion points that provide deeper insights into the discourse surrounding use of the term TiC. A total of eleven studies were included. These comprised of eight peer-reviewed research papers and three Doctoral theses. Most of the studies were published recently (between 2019 and 2021), within the UK. Two originated from the US, one from the Netherlands, and one from Norway. Study aim/s and phenomenon of interest varied considerably. Three studies focused explicitly on TiC (Cartwright, 2020; Owens, 2021; Stamatopoulou, 2019). One study (Alexander et al., 2016) claimed to "assist in improving trauma-informed care" (p. 459) by assessing the frequency of diagnosed PTSD and comparing this to non-forensic populations. The remaining seven studies explored links between trauma histories and: (i) psychiatric diagnoses or symptoms; (ii) and various psychiatric and criminal outcomes (Bohle & de Vogel, 2017, Brackenridge & Morrissey, 2010; Fosse et al., 2021; Karatzias et al., 2019; McKenna et al., 2019; Morris et al., 2019; Stinson et al., 2021). All eleven studies made recommendations for TiC based upon their findings.

Interpretations of Findings

Overall, results suggest that the literature relating to TiC within secure inpatient services has started to grow but is still very much in its infancy. The picture presented is complex and contradictory in parts; evidence is both in-keeping and, to a larger degree, incompatible with a trauma-informed approach. There is little acknowledgement or clarity on how TiC may translate specifically into secure inpatient environments. The following section will attempt to further interpret the most salient findings, with reference to the specific aims of this review.

Explicit Findings that Made Direct Reference to TiC

The findings within this section represented data that made *direct* reference to TiC, as determined by the authors of the included studies. The first specific aim of this review was to determine how TiC has been defined within the literature base. As detailed within the key theme *Definitions of TiC*, six out of eleven studies offered definitions, none of which used SAMHSA's as a reference (SAMHSA, 2014). The definitions provided differed in quantity and quality, indicating a lack of clarity, and understanding. Only two studies (McKenna et al., 2019; Owens, 2021) acknowledged that TiC may look different in a forensic environment than, for example, a general mental health setting. Mckenna et al. (2019) clarifies that TiC "does not minimise legal or moral guilt" (p. 5). Owens (2021) suggests secure inpatient populations would benefit from being asked "'what helps you to feel safe?' and 'what helps you to feel like you belong?'" (p. 46). Whilst useful starting points, it is argued that these do not effectively capture the uniqueness of secure inpatient services. There is a marked absence of reference to balancing the provision of therapeutic care with the management of risk (Kurtz & Jeffcote, 2011).

The second specific aim of this review was to identify the components of TiC that have been operationalised and/or implemented in practise. Two key themes were found to address this aim: *What Does TiC Look Like in Practice?* and *What Does TiC* not *Look Like in Practice?*. Only two studies (Owens, 2021; Stamatopoulou, 2019) provided examples of what TiC looks like in practice. Examples from Owen (2021) relate to the principles of safety and belonging. Feelings of safety (both physically and emotionally) were aided by staff-patient relationships; a sense of belonging by peer-relationships. Stamatopoulou's (2019) examples are ostensibly more concrete, taken from a TiC pilot scheme. This involved a two-day development and training programme. Whilst some details of the changes that were made to the service are provided, they are still left slightly vague. It would have been helpful to know more specific details about how trauma was defined, as well as practical examples about, for example, the training programme that was designed to improve staff knowledge on the impact of trauma. By way of illustration, Covington (2022) provides a valuable exemplar of what trauma-informed training looks like for women in prison. Her training for staff involves asking them to take part in "a series of exercises that use everyday activities to compare trauma-informed *and* [emphasis added] not-trauma-informed methods of engaging" (p. 177). The training also helps staff to understand typical triggers for those who have experienced trauma, such as shouting, loud noises, restraint, being touched in pat-down or strip searches, and medical exams. Concrete and practical examples of what TiC does *not* look like in secure inpatient settings would be a valuable addition to the field in order to address misunderstandings of TiC; those that were highlighted towards the beginning of this review and have, to a large degree, been substantiated from its results. Whilst overlooked by most of the studies included in this review, Owens (2021) offered a handful of suggestions. These are particularly useful in that they are accompanied by an explanation as to *why* certain practices can be unhelpful or harmful. For instance, staff making assumptions about patients' best interests, which led to patients feeling invalidated and infantilised.

The work of the Women's Mental Health Taskforce (Department of Health and Social Care, 2018) is also worth mentioning here. As referenced earlier in this review, the Taskforce was set up in 2017 to define, address and improve the "mental health of women, and their experiences of mental health services" (p. 15), and makes an urgent call for trauma-informed care across all mental health, justice, and social care services. Their report documents a project that took place over 17 months, whereby the Taskforce "sought evidence from key experts and heard from women with lived experiences through focus groups and meetings" (p. 15); some of which had experience of secure inpatient services. The key themes of the report detail "alarming cases" (p. 13) of "deeply traumatised" (p. 27) women who had been re-traumatised – made to feel disempowered, unsafe, distressed, triggered, and humiliated – by their experiences of both general and secure inpatient services. Based on this evidence, the Taskforce developed a set of nine trauma-informed principles for all women's mental health services, accompanied by descriptions of what each principle looks like in practice. To provide examples: the principle relating to safety is operationalised as "staff understand how services can be re-traumatising and minimise the use of restraint and one to one observations" (p. 38); the principle relating to respectful and trusting relationships with staff is operationalised as "women have a choice of a female worker" (p. 37); and the principle relating to empowerment and co-production is operationalised as "promotion of self-advocacy and advocacy for women who need support to ensure their voices are heard" (p. 39). In addition, at various points throughout the report, the Women's Taskforce make reference to practices that are *not* trauma-informed, sometimes followed by an explanation as to *why* this is the case. For example, "for women who had experienced violence and abuse, to be physically restrained or put under one to one observation, often by male staff, could be profoundly distressing, triggering and humiliating" (p. 24). Other examples include not being able to build trusting relationships with staff; incidents on the ward not being responded to appropriately; having no voice or control over their care; various forms of restrictive practice; and "being left to 'get on with it' when they left hospital" (p. 3). Whilst the work of the Women's Mental Health Taskforce offers another valuable exemplar of how TiC can be operationalised in practice (for women's mental health services), it also serves to reinforce the findings and conclusions drawn from this review. That is, disappointingly, the literature base offers little clarity and falls short in being able to tell us what TiC actually looks like in practice, specifically for secure inpatient services. There is also perhaps an argument that the addition of a new set of trauma-informed principles adds to the confusion in trying to understand exactly what is meant by the term trauma-informed. The principles set out by the Women's Taskforce hold immense value as they have been created from the voices of women themselves. However, they differ in some ways to the widely accepted principles outlined by SAMHSA (2014); those that have been referenced throughout this review. This reinforces the findings and conclusions drawn from initial scoping searches which highlight that the academic field is still in the early stages of development and has not yet managed to reach a consensus regarding operational or field-specific definitions of TiC.

The third specific aim of this review was to identify any evaluations of TiC including both the potential and/or actual impact of implementation. Key themes drawn from the data that addressed this aim were *Positive Impact of Transitioning to TiC* and *Challenges of Implementing TiC.* One review highlighted the positive impact of transitioning to a TiC pilot scheme (Stamatopoulou, 2019). The perspectives and reflections offered by staff here are of great importance, as this appears to be the only study to have offered an evaluation of the actual impact of a trauma-informed approach within secure inpatient services. Noteworthy themes mention staff unpicking and unlearning negative, unhelpful, and arguably harmful attitudes, and ways of working. For instance, only understanding distress through the lens of diagnostic criteria, over-reliance on restrictive practice, and normalisation of staff burnout. Despite forming a minority of this review, these findings offer a promising, refreshing, and alternative addition to the TiC literature. They demonstrate how TiC has the potential to improve the lives of both patients and staff; fostering a culture of curiosity and critical thinking towards deep-rooted ideologies and harmful practices that may have become the "norm".

The same study (Stamatopoulou, 2019) also highlighted the challenges of implementing a TiC pilot scheme, with reference to systemic barriers. Two noteworthy themes were found here. Firstly, conflict and tension with the medical model. This is well-documented topic of contemporary debate within the general TiC literature (Wilson et al., 2020); and one that has been ongoing for decades within the general mental health literature (Barnes et al., 2022). Secondly, the noticeable lack of resources (time, money, high staff turnover, support) and subsequent concerns around sustainability of TiC. This, again, is a well-documented phenomenon within the general TiC literature (DeCandia & Guarino, 2015).

The findings of Stamatopoulou (2019) do not, however, acknowledge the individual or interpersonal factors that are likely to pose as barriers to the adoption of TiC. For some staff, adopting TiC is "akin to opening Pandora's Box" (DeCandia & Guarino, 2015, p. 16). It may feel too harrowing and overwhelming to contemplate the "boundless ocean of suffering" (i.e., realities of extensive trauma histories) of those they work with (Willmot & Jones, 2022, p. 3). It may be "too difficult to consider that a person can be both a perpetrator and victim of crime…" (Willmot & Jones, 2022, p. 4). Some would argue that positioning the problem within someone is much easier as it shifts all blame and responsibility onto the patient; away from staff, the service, and society (DeCandia & Guarino, 2015). Staff may be forced to face the way their own practice has – however unintentionally or inadvertently - impacted and potentially further harmed those they work with. Denial, resistance, reluctance, and uncertainty are all likely to serve as important personal protective factors here.

The fourth specific aim of this review was to identify future recommendations regarding TiC for both practice and research. Eight studies made recommendations for how TiC should look in practice. The volume of information here is impressive and does include several key recommendations. The first and most prominent three sub-themes – (1) *Impact of Trauma*; (2) *Importance of Staff-Patient Relationships*; (3) and *Staff Training* – are the most relevant and in-keeping with TiC. For instance, Stinson et al. (2021) proposes greater understanding of the impact of secure inpatient environments; ones often characterised by high degrees of stress and violence exposure. Two studies, in recognising the significance of staff-patient relationships in facilitating recovery, consider how constant changes or disruptions to staffing can be distressing (Cartwright, 2020; Morris et al., 2019).

Brackenridge and Morrisey (2010) made specific recommendations for training to focus on both "classic" and "atypical" (p. 55) (i.e., beyond PTSD) trauma responses.

However, taken together, recommendations for practice across this section do feel somewhat vague and disjointed. Three sub-themes are largely incompatible with TiC: (5) *Trauma History Assessments*; (6) *Trauma-Based Diagnoses*; and (7) *Psychological Treatment*. Four studies recommended obtaining more detailed trauma histories from patients. This should be interpreted with caution as it is not a requirement of TiC (SAMHSA, 2014). Whilst it is important to have an awareness and understanding of patients' life stories, to be trauma informed is to hold a basic realisation of the widespread impact of trauma (Read & Harper, 2020). Routine assessments run the risk of becoming part of a prescriptive trauma-informed checklist (Isobel, 2021). Pushing for early or further disclosure is invasive and "may result in more harm than benefit" (Butler et al., 2011, p. 186). Similarly, three studies advocated for further "diagnostic accuracy" (Alexander et al., 2016, p. 448) in the form of PTSD. This, again, is not compatible with a trauma-informed approach and represents a dangerous linearity or simplicity of thought (Willmot & Jones, 2022). Recommendations for specific types of psychological treatment (i.e., TF-CBT, EMDR, CFT, DBT, schema therapy) were made by three studies. This is more in keeping with trauma-*specific* services; a common misunderstanding (Covington, 2022) but an important distinction to make so as not to confound the evidence base (DeCandia & Guarino, 2015). It is also highly disappointing that only one study (Cartwright, 2020) recommended patient involvement. Without this, the focus remains on patients being done to, rather than done with (Triesman, 2021). No studies explored, recognised, or recommended strength-based approaches as being an essential ingredient of TiC. This is significant. Whilst it is important to recognise the long-term negative impact of trauma, this represents only one part of the picture. It is essential that both staff and patients are aware of the ways in which people can endure, adapt, heal, recover, and thrive following trauma (Merrick & Narayan, 2020); as these are the foundations for hope and change.

Future recommendations relating to research were relatively brief, yet – in comparison to those made for practice – were more in-keeping with a trauma-informed approach. Two studies (Owens, 2021; Cartwright, 2020) made similar recommendations to work towards operationalising what it means for a service to be trauma-informed by gathering the perspectives of both patients and staff, across all levels of a service. Alexander et al. (2016) also introduced the idea of exploring staff attitudes as potential barriers to the implementation of TiC. Both of these recommendations, as the results of this review have evidenced, would be ideal starting points to advance the academic study and practical application of TiC within secure inpatient services. Conversely, two studies (Bohle & de Vogel, 2017; Stamatopoulou, 2019) advocated for longer-term evaluations of TiC post implementation (i.e., after two, or five years). Whilst essential, this recommendation is somewhat ambitious considering the results of this review have found that the academic field is still in its infancy and is yet to reach a consensus on what TiC could, should, or does look like within secure inpatient services. That said, the Women's Mental Health Taskforce Final Report (Department of Health and Social Care, 2018) states that they have "secured commitments" from a number of "important organisations" (p. 43) (e.g., NHS England, Public Health England, Care Quality Commission, NHS Improvement, Health Education England) to push for trauma-informed change across mental health, criminal justice, and social care services for women; some of which are specific to secure inpatient services. For instance, they mention NHS England has agreed to pilot "a new model of women's forensic inpatient services and introducing a financial incentive (through the Commissioning for Quality and Innovation Payment Framework) for trauma informed care"; and have considered "whether it would be helpful to broaden the focus of their annual conference on women's mental health in secure care services to look across the whole care pathway (not just secure care services) in the future" (p. 43). Whilst not practical or research recommendations per se, these commitments do present a promising opportunity for future research into the implementation and longer-term evaluation of TiC within secure inpatient services. Juxtaposed with the findings of this review however, they also indicate a potential discrepancy between the state of the academic literature and the practical field of TiC within secure inpatient services; the former perhaps being less developed than the latter.

Implicit Findings that Made Indirect Reference to TiC

The findings within this section represented data that made *indirect* reference to TiC. These addressed the fifth and final specific aim of this review: to identify any additional and relevant key findings or discussion points that provide deeper insights into the discourse surrounding use of the term TiC. In other words, what the author/s of the studies found and/or discussed that led them to conclude that TiC is important. Only two studies looked beyond psychiatric diagnoses and symptoms (Cartwight, 2020; Brackenridge & Morrissey, 2010); a core component of TiC that promotes sense-making beyond the medical model (i.e., what's *wrong* with someone). Brackenridge and Morrissey (2010) explicitly acknowledged the possibility that trauma goes unrecognised and overlooked because the connection between life events and symptoms has been lost. The details provided by these studies very clearly demonstrate the benefits of adopting a trauma-informed approach. They offer a much deeper understanding of the individualised nature of trauma responses and coping strategies, alongside the various functions that they may serve. This is not something that can be achieved with psychiatric diagnoses alone. The PTMF (Johnstone & Boyle, 2018) is relevant here as it asks, among other questions, "what happened to you?" and "what did you have to do to survive?". The importance and potential value of secure inpatient services adopting a trauma-informed approach guided by the PTMF has accumulated throughout this thesis. It was mentioned by Owens (2021) in this review, has been documented previously from a clinician perspective (Ramsden, 2019), and was a key recommendation from Chapter Two of this thesis.

A significant proportion of additional findings relevant to – although not directly referencing – TiC invested in exploring the prevalence of trauma histories (i.e., generating "scores") and relationship to psychiatric diagnoses. It is insinuated that the answer to being more "trauma-informed" lies in diagnosing fewer people with personality disorders and psychosis; and more people with "trauma-related psychiatric illness", such as PTSD or complex PTSD (McKenna et al., 2019, p. 4). Presumably because the latter creates a more "obvious" contextual link by specifying traumatic experiences within their diagnostic criteria. This is a misunderstanding of TiC and, as already mentioned, represents a dangerous linearity or simplicity of thought (Willmot & Jones, 2022). As has hopefully been made clear throughout this review, presentations associated with a diagnosis of PTSD represent only one of the many ways in which people can be impacted by and respond to trauma. The purpose of TiC is not to *prove* the prevalence of trauma, but to *Realise* that many people entering services will have experienced trauma (SAMHSA, 2014). The focus of these findings are disappointingly comparable to TiC's formative years (i.e., quantifying trauma and linking these to health risk factors and physical diseases): the ACE study conducted over twenty years ago (Felitti et al., 1998). Thus, providing further evidence this field of academic study is very much still in its infancy.

The noticeable gender differences found across five studies cannot be overlooked. In short, females were significantly more likely to have a history of trauma (particularly of a sexual nature) and have received a diagnosis of borderline personality disorder. For males, it was antisocial personality disorder or schizophrenia-spectrum disorders. It is intriguing that none of these studies remark on the possible reasons for this. Application of a trauma-informed approach here would consider social gender norms and expectations. For instance, why males are more likely than females to display outward aggression and commit crimes (Willmot & Jones, 2022). Even further, it would acknowledge the historical context of such diagnoses; born from roots of misogyny (Shaw & Proctor, 2005) and racism (Metzl, 2010), issues that so far, remain unsuccessfully addressed within the secure inpatient population (Willmot & Jones, 2022). Although, that is certainty not to say that some of these conversations are not taking place more widely. In fact, the work of the Women's Mental Health Taskforce (Department of Health and Social Care, 2018) devotes space to highlighting and exploring gender-related differences in how people experience and respond to trauma. In setting the context and outlining the argument for why women's mental health services (including secure inpatient) can be "inadvertently discriminatory towards women because they have been designed, whether consciously or unconsciously, around the needs of men" (p. 3) (and are therefore not trauma-informed), the report presents several stark statistics pertinent to the findings of this review. Namely, gender-based violence: women are twice as likely than men to have a history of sexual and/or violent trauma. More specifically, over one million women in the UK have "experienced an extensive pattern of physical and sexual violence and abuse across their life, including being sexual abused or severely beaten in childhood by a parent or carer", and "being raped as adults and suffering severe violence from a partner" (p. 23). The report also dedicates a section to raising concerns about the lack of understanding around the ways in which women are more likely to respond to said trauma and the psychiatric diagnoses that these responses attract. Diagnoses such as "somatisation disorder (and 'Medically Unexplained Symptoms'), dissociative disorder, anxiety disorder, depression, bipolar 2 disorder and emotionally unstable or borderline personality disorder" (p. 26) are common and, more often than not, serve to create increased stigma and discrimination for those accessing services; positioning women as "mentally ill" as opposed to offering a "plausible explanation" for their difficulties (p. 26). Refreshingly, the Women's Mental Health Taskforce also admits that the list of diagnoses "may not be representative of the women's current understanding and preferred descriptors of their struggles, but can act as a list of diagnoses at various points of their life through their contact with services" (p. 60).

Thus, acknowledging some of the more "subtle" ways in which services can cause further harm, such as via imposition of the medical model. Taken together, the work of the Women's Mental Health Task detailed here certainly serves to reinforce the striking gender differences that were found across the five studies in this review. Yet, it also serves to further highlight how the academic discourse surrounding use of the term TiC within secure inpatient suffers, at least in part, from a lack of curiosity and critical thinking.

Positively, some additional implicit findings were much more demonstrative of TiC. Five studies acknowledged the limitations of trauma research (albiet to varying degrees). Notably, Stinson et al. (2021) highlighted limitations of utilising the ACE questionnaire and focusing on subsequent ACE score. This is another misunderstanding of TiC. It was never designed or intended to be used in practice as a predictor or determinant of an individual's future (Lacey & Minnis, 2020). As McGuire et al. (2022) write, a "focus on the number of ACE's an individual "ticks" will only lead to partial and perhaps off-centre interpretations of a person's experiences…" (p. 356).

Strengths and Limitations of This Review

This review is unique in being the first to have explored TiC within secure inpatient services. A comprehensive search strategy was employed to capture studies that may have otherwise remained hidden. A notable limitation of this review is the complexity and abstract nature of the subject area. Whilst it was intentionally designed to establish and improve understanding of what the literature base tells us specifically about "trauma-informed care" within secure inpatient services (as determined by the authors of the included studies), it meant that numerous relevant studies were excluded on the grounds of not including or making only passing reference to the term trauma-informed (i.e., within a single sentence in the absence of further elaboration, and/or with no direct link to the main focus of the study). For example, those that focused on specific topics relevant to the domain of TiC (i.e., patient choice, collaborative decision making, relationships on the ward, psychiatric diagnoses). Many of these topics also resemble the personal recovery model (Drennan & Alred, 2012). Thus, it would be naïve to conclude that some of the underlying values of TiC are not already being implemented in practice or considered in the academic field, without being labelled explicitly as trauma-informed. This is also not to say that the conversations and groundwork for TiC is not taking place more widely, across the broader fields of mental health, criminal justice, and social care services. For example, the report by the Women's Mental Health Taskforce (Department of Health and Social Care, 2018) states that these ideas are "not new"; "there are those who have been calling for these changes for many years" (p. 2).

Another strength of this review is that all studies meeting the inclusion criteria were included. Quality assessments scores were mostly in the range of Very good to Excellent. Only one study (Brackenridge & Morrissey, 2020) was scored as Moderate. Further details of this study were included in a separate, unpublished report. It is possible that its quality was much higher than what was reported. Whilst a second independent quality assessor would have been valuable, the overall quality assessment indicates the studies in this review are trustworthy, valid, and reliable (Hong et al., 2018).

A further benefit is the large sample size of almost 3,000 participants. These came from a well-balanced mix of research settings and included a range of participant ages. Nevertheless, females and those from non-white ethnic backgrounds are largely under-represented. It is a concern that the review cannot be generalised far beyond a white, male population; even more so considering minority ethnic backgrounds are, when compared to data from the general population, over-represented in the forensic mental health system (Nuffield Trust, 2022).

To minimise risk of bias and increase validity of the review findings, the researcher employed a second rater to help decide which data to extract. Whilst TiC is not new to the researcher, this specific area of research was. As such, the researcher had no pre-conceived ideas or expectations as to what the review might find. Whilst this review was designed to meet five specific aims, these were exploratory in nature in response to the results of initial scoping exercises and the emergent nature of the research field. The researcher was not looking to prove, or disprove, a particular hypothesis; rather, to gain a better understanding of what the literature base tells us about TiC within secure inpatient services. Nevertheless, neutrality with this approach does not exist (Braun & Clarke, 2006). The researcher is aware that unconscious biases will have impacted on the type of data that was extracted and how it was presented to the reader. Involving a second reviewer at all stages of this process would have been beneficial and added weight to the validity of the findings.

Another limitation of this review relates to the design of included studies. Whilst there is merit in combining multiple methodologies (Harrison et al., 2021), the majority (*n* = 7) adopted a cross-sectional design and therefore relied upon secondary data in the form of patient records (often notes or reports written by clinicians). This meant that - of the 2,985 participants included - only 58 patients and 20 staff (three per-cent) actively took part in this review. The strengths and weaknesses of cross-sectional research are well-known; a notable advantage being its generous sample size (Wang & Cheng, 2020). Whilst it can be argued that this design was appropriate for achieving the individual aims of the seven studies, its predominance is highly disadvantageous for the purpose of this review. Secondary data places participants as passive recipients and removes the "human" element from research. This is in stark contrast to core values of TiC. Ideally, this review would have included a better balance of quantitative and qualitative research, both of which relying upon primary data. This would have greatly enhanced its utility.

Conclusions and Recommendations

Based on the findings of this review, it seems that TiC has been misunderstood and misapplied, that it is under-developed and has perhaps been misrepresented by some in the academic field. A nuanced operational definition or framework that is specific to and considers the unique complexities of secure inpatient services would be instrumental in moving the field forwards; addressing and ironing out the discrepancies between academic and practical domains that have become apparent throughout the discussions held within this review. This would ensure that any progress that *is* taking place in practice is in-line with a true trauma-informed approach; and thus, lay the necessary foundations for meaningful and sustainable change. The most effective way to do this is to involve and listen to the people that receive and work within these services; a combination of both lived and clinical experience, guided by SAMHSA (2014) and other influential authors in the field of TiC (i.e., Johnstone & Boyle, 2018; Triesman, 2021). Emphasis should be placed on how to balance the provision of therapeutic care with the management of risk (Kurtz & Jeffcote, 2011); promoting a broader understanding of self-harm, hearing voices, aggression, violence, and offending behaviour (etc) beyond diagnostic criteria and within the personal, social, cultural, and political context of people's lives; and the potential impact of both living and working in a secure inpatient environment. Practical, concrete, and applicable examples of what is and what is not trauma-informed would also be ideal; akin to (Covington, 2022) and the

Women’s Mental Health Taskforce (Department of Health and Social Care, 2018). As would similarities and differences between high, medium, and low levels of security. A variety of methodological approaches could be used. For instance, semi-structured interviews or focus groups to generate rich, qualitative information, and the Delphi method to help reach a consensus.

All of this could be developed into a practice guidance document to be used at an individual practitioner or whole service level. With time, wider implementation of TiC would open-up more opportunities for research and service evaluation. It is hoped that evidence of its efficacy in improving the lives of those receiving and delivering secure inpatient services would attract further awareness and investment of key stakeholders and national policy makers. This would need to be in addition to the commitments that the Women’s Mental Health Taskforce (Department of Health and Social Care, 2018) have already secured from the NHS to pilot a new trauma-informed model of secure inpatient services for women. Wider awareness and investment across *all* secure inpatient services would set an expectation for TiC to become best practice. Further support for all services to adopt TiC from commissioning services in the form of a dedicated budget would be needed to catalyse progress. Although, it is recognised that this will take some time. It is, unfortunately, an idealistic recommendation under the current economic and political climate. For now, the best chance of change is by taking a “bottom-up” approach (as outlined above).

As is the case with any significant paradigm or cultural shift, systems are “strongly resistant to change” (DeCandia & Guarino, 2015, p. 19); they are likely to fall back on default patterns for the sake of ease, comfort, and familiarly. The findings of this review suggest such defaults within secure inpatient services are an over-reliance on the medical model, restrictive practice, and normalisation of staff burnout. It is therefore imperative that the field dedicates time and space to recognise and unpick the various systemic and interpersonal factors that pose a barrier to the adoption of TiC. One study from this review (Stamatopoulou, 2019) laid important foundations for this work. Further qualitative research would offer invaluable insights into both patient and staff experiences, views, expectations, fears, recommendations, and hopes for the provision of TiC within secure inpatient services. The commitments secured by the Women’s Mental Health Taskforce (Department of Health and Social Care, 2018) present a promising opportunity here. This should also be a focus in practice, for instance within supervision and group reflective practice.

In the meantime, there are several ways in which services can start the transition towards becoming more trauma-informed. Echoing some of the recommendations made in Chapter Two of this thesis (p. 82), service development projects and/or training programmes that focus on some of the more concrete and practical components of TiC touched upon throughout this review would be the most efficient approach. For example, reducing restrictive practices by reviewing how seclusion, physical restraint, and forced medication are facilitated or utilised on the ward; and – where possible - replacing blanket rules and restrictions with an individualised, patient-centered approach. A second example could be promoting patient empowerment by ensuring patients have as much choice and control over their care as possible and are able to engage in active, collaborative decision making. A third example could be a focus on staff wellbeing. This could be achieved by helping all staff to understand and recognise the signs of burnout and/or vicarious trauma; as well as ensuring that they are able to access support after responding to or witnessing risk incidents, and receive regular individual supervision sessions and ward-based group reflective practice sessions. Naturally, in-keeping with a trauma-informed approach, all of this work should be planned, designed, and/or delivered with the involvement of patients. Similar to the approach taken by the Women's Mental Health Taskforce (Department of Health and Social Care, 2018), including patient examples and lived experience stories of specific practices that can or have been re-traumatising (if they feel comfortable doing so), would offer a stark yet necessary "human" element and undoubtedly aid the learning process for staff.

However, whilst essential starting points, the recommended changes to practice outlined above are not, on their own, enough to effect true, meaningful, and sustainable trauma-informed change; a shift in thinking from "what is wrong with this person?" to "what has happened (or is happening) to this person?" (Butler et al., 2011) is needed. In order to achieve such a cultural shift, staff need to be supported to develop a deeper understanding as to why the changes they are being asked to make to their day-to-day practice are important. Whilst the field develops a nuanced operational definition or framework that is specific to and considers the unique complexities of TiC within secure inpatient services, services could start ripples of systemic shifts in other ways. One of the ways in which this could be achieved is via a comprehensive TiC training program. The contents of which could be mirror the Introduction section of this review (i.e., emergence of TiC; what is TiC?; key assumptions and principles of TiC; misunderstandings of TiC; and the relevance and importance of TiC within secure inpatient services). The format of which could be similar in scope to the TiC pilot scheme implemented by Stamatopoulou (2019) included in this review (i.e., “a two-day development and training programme”) (p. 64); and the example referenced by Covington (2022) in the discussion section of this review (i.e., “a series of exercises that use everyday activities to compare trauma-informed *and* [emphasis added] not-trauma-informed methods of engaging”) (p. 177). The training programme should be designed and delivered by practitioners with a genuine understanding of a true trauma-informed approach, guided by SAMHSA (2014) and other influential authors in the field of TiC (i.e., Johnstone & Boyle, 2018; Triesman, 2021), and again, with the involvement of patients. Initial systemic shifts could also be achieved more indirectly by integrating the PTMF into various areas of practice. For example, PTMF informed therapeutic interventions (i.e., psychoeducational groups and individual collaborative psychological formulations), team formulations, and group reflective practice sessions.

A final recommendation is for researchers and practitioners to adopt better critical engagement with the existing literature using a trauma-informed lens. Key social issues for the field to address include gender bias, and roots of misogyny and racism. For instance, why minority ethnic backgrounds are over-represented in the forensic mental health system (Nuffield Trust, 2022). It is hoped this would create a much-needed systemic shift within the field; encouraging a culture of curiosity and critical thinking towards deep-rooted ideologies and potentially harmful practices that may have become the “norm”.

Chapter Four

The Working Alliance Inventory – Short Revised (WAI-SR): A Psychometric Critique

Abstract

A focus on relational aspects of care has been a running thread throughout Chapters Two and Three of this thesis. As such, the aim of this critique is to review and critique a tool that has been designed to measure the "alliance": the Working Alliance Inventory – Short Revised (WAI-SR) (Hatcher & Gillasby, 2006). This is with a view to assess its appropriateness for use within secure inpatient settings as a tool to measure the quality of patient-staff relationships. Taking into consideration that care is provided by multiple professionals within these settings, thought will be given to measurement of the alliance at both the individual (i.e., therapist, psychiatrist, key nurse) and collective (i.e., multi-disciplinary team, nurses, health care assistants, all staff on the ward) level. It will begin by providing a conceptual overview of the alliance, followed by a historical account of its operationalisation and measurement over the past several decades. This reveals a large and complex literature base. After noting key contemporary alliance theorists and measurement tools, it addresses critical and alternative perspectives that have arisen over more recent years.

From here, an argument is made for closer investigation of the alliance within secure inpatient settings. Whilst the uniqueness of the alliance within so-called "involuntary" treatment settings has been acknowledged for decades, its measurement remains underdeveloped. There exists no validated or specific tool to measure the alliance within secure inpatient settings. Despite this, at least nine studies were found to have applied alliance tools within secure inpatients services. The findings of which demonstrate strong and/or significant relationships between the quality of the alliance and various additional outcomes (i.e., decreased number of aggressive and violent incidents).

The WAI-SR was chosen for this critique as it has recently been applied within a secure inpatient setting; and is one of the most popular, widely researched, and up-to-date tools. It has also been used as the foundation for early theoretical developments within the involuntary alliance literature. An overview of the WAI-SR is provided, including its development, administration and scoring, and application within the wider literature. An examination of the tool's psychometric properties then follows, with reference to Kline's (2015) recommendations for a "good" psychometric measure: level of measurement; reliability; validity; standardisation and norms; and utility.

Overall, the evidence presented indicates that the WAI-SR does not meet all the criteria for a good psychometric measure. It does not appear appropriate for use, in its current form and as a stand-alone measure, within secure inpatient settings. In consideration of the long-standing complexities and limitations of the alliance literature, alternative recommendations are proposed for both research and practice.

Introduction

Conceptual Overview of the Alliance

The “alliance” – also known as the therapeutic relationship, helping alliance, or working alliance (Flückiger et al., 2018) – is a general term that is used to describe the quality of the relationship between a person providing and a person receiving treatment or care within the context of a helping profession (Horvath, 2018). Broadly speaking, it represents a number of dynamic interpersonal processes and humanistic tendencies that take place within a therapeutic encounter (Elvins & Green, 2008). Norcross (2010) describes the alliance as the attitudes and feelings that a practitioner and patient[1] have towards one another, as well as how these are expressed and thereby experienced. Conventional elements of the alliance include – but are not limited to - empathy, warmth, trust, respect, understanding, friendliness, integrity, collaboration, and commitment (Greenhalgh & Heath, 2010). The presence or absence of these qualities can be felt viscerally (Greenhalgh & Heath, 2010). Naturally, the alliance is a complex, subjective and dynamic phenomenon. No consensual definition exists; the exact meaning of the term remains elusive and open to debate (Horavth, 2018).

In addition to the importance of the alliance being intuitive from humanitarian and clinical perspectives, empirical research has repeatedly found the quality of the alliance to correlate with a number of positive therapeutic outcomes (Horvath, 2018; Ross et al., 2008; Zilcha-Mano, 2017). It is said to be an essential component in bringing about desired change for a person receiving treatment or care, irrespective of the specific modalities or techniques that a provider may employ (Safran & Muran, 2006). Some even argue that it is the “single most important factor” in bringing about change (Osborn & Stein, 2019, p. 115). Within the realm of psychotherapy more specifically, the alliance is positioned as one of the most critical “Common Factors” (Wampold, 2015). The latter describing a model of the shared relational factors, variables, or ingredients that are “responsible for the lion’s share of what makes therapy “work” (Horvath, 2011, p. 125). Whilst there is still an ongoing debate as to what constitutes *the* Common Factors, both historical and contemporary theorists alike tend to group them according to three categories: client contribution (e.g., expectations, cultural beliefs, support system); clinician contribution (e.g., empathy, experience, competence); and

---

[1] To reflect a range of helping professions, the terms patient and client shall be used interchangeably throughout this chapter.

the relationship between the two (e.g., alliance) (Drisko, 2013; Elkins, 2022; Wampold, 2015).

Needless to say, the alliance continues to be a prominent research topic and is arguably a core part of service evaluation amongst many disciplines; most notably psychological therapies, but also medicine, nursing, education, psychiatry, and physical therapy (Horvath, 2018; Ross et al., 2008).

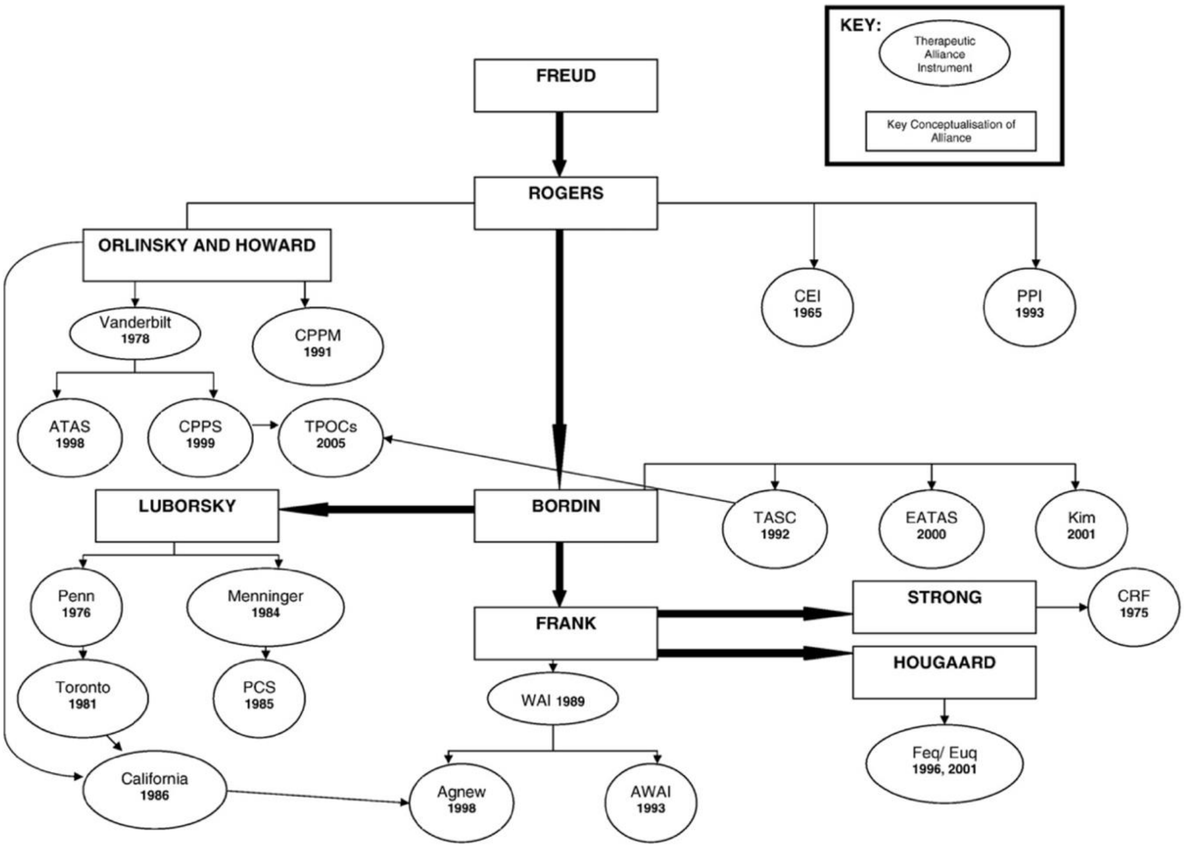
Historical Overview of the Alliance: Operationalisation and Measurement

The importance of relational factors within helping professions has been acknowledged since ancient times (Horvath, 2018). Credit for the first formal in-depth conceptualisation of a recognisable alliance concept is said to be rooted in the work of Freud (1912). Freud – coining the term transference - acknowledged the value of conscious positive feelings between patient and therapist within psychotherapy and, in doing so, highlighted specific elements of interest; such as therapist warmth and kindness (Horvath, 2018). A plethora of subsequent theorists attempted to re-name, expand, and re-operationalise the concept of the alliance over the next several decades; within and then beyond its psychotherapeutic roots (i.e., Bordin, 1979 Rogers, 1965; Frank & Frank, 1991; Hougaard, 1994; Luborsky & DeRubeis, 1984; Orlinsky & Howard, 1975; Strong, 1968). Naturally, with the development of different alliance operationalisations came an abundance of different alliance measurement tools. Many of which have been adapted and/or shortened for use across general and within more specific helping professions (Elvins & Green, 2008). Today, a conservative estimate proposes there to be in excess of 70 different tools available; the evaluation and development of which still continues (Horvath, 2018).

Suffice to say, the alliance literature has “grown so large and complex that even a simple catalogue of important contributions would require far more space than this paper could accommodate” (Horvath, 2018, p. 508). It is therefore beyond the scope of this critique to provide a full historical account of the alliance in addition to that given above. As an alternative, Figure 7 (Elvins & Green, 2008, p. 1169) provides a representation of the most influential theorists and the subsequent measures that have been developed over the past several decades (see Appendix M for theorist publications and an expansion of acronyms).

Figure 7

A Genealogy of Alliance Concepts (Elvins & Green, 2008, p. 1169)



Contemporary Key Alliance Theorists and Measures

According to Ross et al. (2008), the Working Alliance, developed by Bordin (1979), is the most prominent theory amongst the alliance literature. According to Horvath (2018) the four most frequently used alliance measures, which encompasses their derivatives, are as follows (in order of publication): the Vanderbilt Therapeutic Alliance Scale (VTAS) (Hartley & Strupp, 1983); the Working Alliance Inventory (WAI) (Horvath & Greenberg, 1989); the California Psychotherapy Alliance Scale (CALPAS) (Gaston & Marmar, 1994); and the Helping Alliance Questionnaire (HAQ) (Alexander & Luborsky, 1986). The WAI and its derivates accounts for more than half of the alliance literature (Flückiger et al., 2018).

Critical and Alternative Perspectives of the Alliance

Given the continuing scope and complexity of the alliance literature, it is perhaps not surprising that critical and alternative perspectives have emerged over more recent years. There exists a critical argument that, if no single alliance theory or unifying set of measures has emerged in over 50 years, we should accept that the alliance – as a standalone conceptual term – is simply not capable of capturing the true profundity of therapeutic relationships; that it has outlived its usefulness, is beyond measure and should be abandoned (Elvins & Green, 2008; Greenhalgh & Heath, 2010; Safran & Muran, 2006; Zilcha-Mano, 2017). Attempts to redefine the concept, critically evaluate, develop, and utilise new and/or existing measurement tools are said to be futile. Instead, it may be more appropriate to focus research and clinical efforts solely and more broadly "on understanding the role that relational factors play in the change process" (Safran & Muran, 2006, p. 288). For instance, using qualitative research investigations and obtaining written or verbal feedback – both formally and as part of day-to-day conversations - from patients about their experiences of their relationship with their treatment and/or care provider.

However, others have recognised that there is a risk in accepting the alliance is beyond measurement. Alliance tools are essential for gaining insights into and improving the quality of helping professional services (Greenhalgh & Heath, 2010). It is easy to see how such an essential ingredient could be ignored or neglected without the use of alliance measurement tools (Ross et al., 2008). Practically, relying on qualitative research investigations and written or verbal feedback alone may be - due to time and resource constraints - an arduous and unrealistic expectation for patients, researchers, clinicians, and policy makers alike.

Others have recognised that "there is no simple or correct solution" and have adopted a more pragmatic approach (Greenhalgh & Heath, 2010, p. 6). This line of argument suggests that the alliance should remain a prominent research topic amongst helping professions (Elvins & Green, 2008; Ross et al., 2008; Zilcha-Mano, 2017); that we need to understand and celebrate "the phenomenon in all its complexity" (Ross et al., 2008, p. 477). It tasks future researchers with developing refined alliance conceptualisations and making it a priority to identify the strengths and limitations of various alliance tools across different service settings (Greenhalgh & Heath, 2010). Furthermore, it asks future researchers to explore additional process factors that may illuminate how the alliance develops, how it is maintained and how it engenders positive change (Ross et al., 2008). These tasks are perhaps best achieved using mixed-method investigations of practitioners and patient experiences (i.e., alliance tools and qualitative data). Practically, for now, this approach encourages clinicians and service providers to utilise alliance tools with caution (i.e., clinical judgement) and supplementary resources (i.e., free-text boxes or a "preliminary checklist for reflection") (Greenhalgh & Heath, 2010, p. 31). These examples may prompt further insights that should, in turn, generate helpful conversations between patients, practitioners and service providers regarding their relationships with each other.

Rationale for this Critique

Further to the argument outlined above, this critique proposes the need for closer investigation of the alliance measurement within secure inpatient settings for three key reasons. Firstly, the findings of the review in Chapter Two clearly indicated that the nature and quality relationships on the ward are, for patients, one the most important aspects of their care. Both positive and negative, some arguably harmful, interactions were described. Despite this, qualitative research relating to staff-patient relationships from the perspectives of patients themselves is limited (Bennett & Hanna, 2021). Secondly, the review in chapter Three continued to highlight the importance of relational aspects of care, through the lens of TiC. It is widely known that the secure inpatient population is characterised by extremely high rates of trauma (Fosse et al., 2021; Karatzias et al., 2021; Mckenna et al., 2019). As Proctor (2017) writes, staff-patient relationships "are the day to day fabric of trauma recovery and re-traumatisation" (p. 7). And finally, the involuntary, restrictive, and multidisciplinary nature of the secure inpatient environment poses several unique and complex challenges to the development and maintenance of alliances, beyond those that may be encountered within more conventional or voluntary settings (Ross et al., 2008).

Theory and Measurement of the Alliance within Involuntary Settings

Despite the uniqueness of the alliance within the domain of so-called involuntary treatment settings - under which secure inpatient services reside[2] – having been acknowledged for decades, its theoretical application and measurement has been the focus of

---

[2] Refer to Definitions of Terminology Used Throughout the Thesis (p. 13) for further clarification regarding the term secure inpatient.

comparatively little attention (Sturm et al., 2022). That said, some notable, albeit provisional, developments have occurred. Whilst these are not *specific* to secure inpatient services, they do hold some relevance in that they attempt to capture the unique and complex challenges that involuntary settings pose. As such, a brief outline will be provided below. Reference will also be made back to these developments within the Conclusions section of this critique.

Two theoretical developments have occurred. Firstly, Ross et al. (2008), who proposed a Revised Theory of the Therapeutic Alliance (RTTA) specific to working with people who have offended in the context of community (e.g., probation), prison, and other specialist environments (e.g., therapeutic communities). The authors note that theoretical application of the alliance within the involuntary treatment literature has been cast aside as an entirely separate field of study from the conventional, voluntary sector. This, they say, is a misguided assumption, as the alliance "remains a central factor in therapeutic change" regardless of the setting in which it takes place. In fact, offending populations present an "unusually rich" (Ross et al., 2008, p. 363) context by which to complement and enhance the wider alliance literature. To bridge this gap, the authors combined their own clinical experience and observation with existing – albeit limited – research into the various factors that contribute to or hinder therapeutic change when working with offending populations. They then categorised their findings into nine factors and built them around one of the most popular and influential theories of the alliance: the Working Alliance (Bordin, 1979). The result was a formative, "sketched out" (Wampold, 2015, p. 476) visual framework similar in some ways to the Common Factors model, yet different in that it is centred *upon* the alliance, and places emphasis on the inclusion of treatment setting and external factors. The first three factors are borrowed and expanded upon from the Common Factors model: (1) client characteristics; (2) therapist characteristics; and (3) therapist-client interactions. The six additional factors are: (4) setting and contextual factors; (5) system factors; (6) immediate therapy context; (7) role conflict and confusion; (8) programme factors; and (9) group treatment settings. Although a novel and much needed advancement to the involuntary literature base, the authors themselves acknowledge that they were "forced to speculate" (p. 476) about many of the additional factors due to the shortage of existing research. Thus, the RRTA remains unsubstantiated; it requires further "testing and refinement" to become a "fully comprehensive and established theory" (p. 476).

The second theoretical development to have occurred is the Institutional Therapeutic Alliance (ITA) (Pulido, 2011), which is specific to "patients treated in institutional contexts by a multidisciplinary staff" (p. 139). Following a brief review of the literature into the alliance within institutional settings, Pulido (2011) concluded it to be a complex field that has been "neglected, at least from an empirical research point of view" (p. 139). As such, they proposed the need to "distinguish the alliance developed among a patient and the whole staff involved in his/her treatment, from the classical alliance established between a patient and a single therapist (Pulido, et al., 2006)" (p. 142). In a similar manner to the RRTA (Ross et al., 2008) (outlined above), Pulido (2011) used the one of the most popular and influential theories of the alliance - the Working Alliance, developed by Bordin (1979) – as their foundation; clarifying that the ITA offers a descriptive extension, as opposed to a reconstruction, of Bordin's model. In this way, the ITA is defined as "a mutual understanding and agreement about goals and the necessary task of moving toward these goals along with the establishment of bonds to maintain the collaborative work between the patient and the therapeutic staff as a whole" (p. 142). Pulido (2011) also further clarifies that the ITA encompasses two interactive relational levels: the first one being the alliance between the patient and an individual staff member (most likely, but not necessarily, their therapist); the second one being the alliance between the patient and the institution, with the multidisciplinary team as a collective whole. These can be "dissociated or fused" (p. 145). In other words, the ITA acknowledges that patients are likely to develop positive relationships with some individuals and negative relationships with others.

Pulido (2011) then developed the Intuitional Working Alliance Inventory (IWAI) to empirically test their descriptive theory. The IWAI was applied to a preliminary dataset, followed by a longitudinal study (*n* = 55, admission, one week, discharge, three months post discharge) (Pulido et al., 2008). Both datasets were taken from psychiatric hospitals in Italy, which consisted of a "psychiatrist, four to six psychiatric nurses, a social worker, and a few postgraduate psychology students" (p. 145). Mirroring the conclusions drawn from the RRTA (Ross et al., 2008) above, Pulido (2011) noted that both the ITA theory and its subsequent measure, the IWAI, remain unsubstantiated. This is because their empirical testing involved "many methodological limitations" which leaves "so many questions still open that need further empirical inquiry" (p. 149).

In addition to the IWAI (Pulido et al., 2008), five other involuntary treatment alliance tools appear to be in existence (see Table 18). All of these, apart from the IWAI (Pulido et al., 2008), were designed with probation or parole contexts in mind, to measure the alliance between a person who has offended and their probation officer or community supervisor. Unfortunately, just like the provisional theories outlined above, all these tools are either in the early stages of development or have been subject to limited psychometric evaluation.

Table 18

Proposed or Developed Tools to Measure the Alliance within Involuntary Contexts

Alliance measure	Sample and alliance type	Relationship/s measured
Dual Role Relationship Inventory (DRI) (Skeem et al., 2003)	Probation US	Offender and community supervisor
Dual Role Relationship Inventory-Revised (Skeem et al., 2007)		
Dual Role Relationship Short-Form (DRI-SF) (Gochyyev & Skeem, 2019)		
Institutional Working Alliance Inventory (IWAI) (Pulido et al., 2008)	Psychiatric day hospital Italy	Patient and: (i) individual therapist; (ii) all therapeutic staff
Working Alliance of Mandated Clients Inventory (WAMC) (Sturm et al., 2022)	Probation Netherlands	Offender and probation officer
Modified offender version of the WAI-SR (Tatman & Love, 2010)	Probation or parole US	Offender and probation officer

Application of Alliance Tools within Secure Inpatient Services

Currently, there exists no validated or specifically designed tool to measure the alliance within secure inpatient settings (MacInnes et al., 2014). However, a review of the literature[3] identified at least nine studies ($N = 666$) that have utilised alliance tools within secure inpatient services (see Table 19). One study utilised the IWAI (Pulido et al., 2008). The other eight studies utilised the most popular alliance tools - as identified earlier on in this

---

[3] Electronic (Ovid Databases: EMBASE, Medline and PsycINFO) and manual searches (Google Scholar) originally conducted in 2019 and re-run June 2022.

critique - in either their original, shorted, or adapted formats: WAI (Horvath & Greenberg, 1989); HAS (Priebe and Gruyters, 1993); CALPAS (Short form; Gaston, 1991); and WAI-SR (Hatcher & Gillaspy, 2006). Six of the nine studies measured relationships between patients and individual staff members (i.e., therapist, psychiatrist, key nurse). The remaining three studies measured relationships between patients and multiple staff members (i.e., all staff on the ward, nurses).

Whilst it is beyond the scope of this critique to delve further into the findings of these studies, it is noteworthy that all found a strong and/or significant relationship between the alliance and a multitude of additional outcome measures. Notably, increased treatment readiness and motivation, and decreased elements associated with distress (i.e., clinician-rated level of functioning, behavioural disturbance) and level of risk (i.e., number of aggressive and violent incidents). However, if a tool is to be used in practice, it is important that research has demonstrated its reliability and validity within the sample in which it is being used. Thus, further highlighting the need to investigate accurate measurement of the alliance within secure inpatient settings and rationale for this critique.

Table 19

Summary of Studies that have Utilised Alliance Tools within Secure Inpatient Services

Study	Setting and participants	Summary of aims	Alliance tool and relationship/s measured	Other measures	Summary of findings
Bressington et al. (2011)	Medium and low secure forensic units, UK 44 patients	Service user satisfaction and associations with therapeutic relationships and social climate	Helping Alliances Scale (HAS) (Priebe and Gruyters, 1993) Patient and key nurse	Forensic Satisfaction Scale (FFS) (MacInnes et al., 2010) Essen Climate Evaluation Schema (EssenCES) (Schalast et al., 2008)	• 55% of participants noted a level of satisfaction with services • Significant relationship between social climate and satisfaction with services • Strongest significant relationship found between therapeutic relationship and satisfaction with the service
Clercx et al. (2021)	Seven forensic hospitals, Netherlands 103 patients	Therapeutic alliance as a predictor of and treatment motivation	WAI (Horvath & Greenberg, 1989) Patient and therapist	Incidents (i.e., verbal aggression and threats, physical aggression, and acts of violence) Treatment Motivation Scales for Forensic Outpatient Treatment (TMS-F) (Drieschner and Boomsma, 2008)	• Alliance and motivation did not predict treatment outcome (incidents) during the first phase of 18 months Alliance and motivation were significant predictors of treatment outcome (incidents) during the second phase 18 months
Donnelly et al. (2011)	Forensic mental health facility (acute/high, medium, and rehabilitation), Ireland 81 patients	Relationship between alliance and interpersonal trust	WAI (Horvath & Greenberg, 1989) Patient and both psychiatrist and primary nurse	Trust measured using the Interpersonal Trust in Physician (ITP) (Hall et al., 2002) Global Assessment of Function (GAF) American Psychiatric Association (APA) (1994)	• Positive relationship between alliance and interpersonal trust in physician scores • Significant positive relationship between patient-rated alliance and clinician-rated level of functioning • Alliance and interpersonal trust in physicians significantly higher on pre-discharge, lower secure wards

				Positive and Negative Symptom Scale (PANSS) (Kay et al., 1987)	
Gaab et al. (2020)	Long-term forensic psychiatric care facilities, Netherlands 38 patients	Relationship between readiness for treatment, social climate, and therapeutic alliance	IWAI (Pulido et al., 2008) Patient and all staff on the ward	Treatment readiness measured using the Corrections Victoria Treatment Readiness Questionnaire (CVTRQ) (Casey et al, 2007) EssenCES (Schalast et al., 2008)	• Strong correlations between alliance, treatment readiness and therapeutic hold (subscale of social climate) • Therapeutic hold subscale the only strong predictor of internal treatment readiness
Keulen-de Vos & de Vogel (2022)	Seven forensic hospitals, Netherlands 103 patients	Relationship between emotional states and therapeutic alliance	WAI (Horvath & Greenberg, 1989) Patient and therapist	Schema Mode Inventory-Revised (SMI-R) (Lobbestael et al., 2010)	• Change in emotional states (as measured by SMI-R) were predictors of specific elements of therapeutic alliance, but not overall alliance ratings
Korsten & Keulen-de Vos (2022)	Seven forensic hospitals, Netherlands 103 patients	Adverse Childhood Experiences (ACEs) and therapy alliance	WAI (Horvath & Greenberg, 1989) Patient and therapist	Childhood Trauma (CTQ-SF) (Bernstein & Fink, 1998) Schedule for Nonadaptive and Adaptive Personality (SNAP) (Clark, 1993; Keulen-de Vos et al., 2011) Psychopathy Checklist-Revised (PCL-R) (Hare, 2003)	• History of emotional neglect predicted alliance scores • Physical, sexual, and emotional abuse did not predict alliance scores

Long et al. (2011)	Two medium and two low secure wards, UK 65 patients	Social climate, security and ward type, therapeutic alliance, motivation for treatment, and disturbed behaviour	CALPAS (Short form) (Gaston, 1991) Patient and nursing staff	EssenCES (Schalast et al., 2008) Patient Motivation Inventory (PMI) (Gudjonsson et al., 2007) Overt aggression Scale (OAS) (Yudofsky et a., 1986)	• Higher ratings of social climate had a relationship with lower levels of ward security • Higher ratings of social climate had a relationship with higher therapeutic alliance, treatment motivation and engagement, and lower levels of behavioural disturbance
MacInnes et al. (2014)	Two medium secure units, UK 77 patients	Therapeutic relationships and level of satisfaction with services	HAS (Priebe & Gruyters, 1993) Patient and all staff on the ward	Satisfaction measured using the FFS (MacInnes et al., 2010)	• Alliance domains related to respect and being well-regarded had most significant relationships with level of service satisfaction
Otte et al. (2018)[4]	Inpatient forensic and general psychiatric settings, Germany 52 forensic patients 65 general psychiatric patients	Therapeutic relationships in forensic and general psychiatric settings	WAI-SR (Hatcher & Gillaspy, 2006) Patient and therapist	Psychopathy Personality Inventory revised (PRI-R) (Lilienfeld et al., 2005) Psychotherapy Motivation Questionnaire (FPTM) (Schulz et al.,1995) Inventory of Interpersonal Problems – German Version (IIP-D) (Horowitz et al., 2000)	• Overall, "reasonable level of satisfaction with services" (p. 4) • Significant positive relationship between alliance and treatment motivation

---

[4] Article translated from German to English for the purpose of this critique.

Purpose of this Critique

This chapter aims to review and critique a tool that has been designed to measure the alliance, with a view to assess its appropriateness for use as a tool to measure the quality of staff-patient relationships within secure inpatient services. Taking into consideration that care is provided by multiple professionals within these settings, thought will be given to measurement of the alliance at both the individual (i.e., therapist, psychiatrist, key nurse) and collective (i.e., multi-disciplinary team, nurses, health care assistants, all staff on the ward) level. At first glance, a tool specifically designed to measure the alliance within involuntary settings would have been ideal. Specifically, the IWAI (Pulido et al., 2008), as it was intentionally designed for inpatient treatment settings to measure patient relationships with an individual staff member and all staff on the ward. However, as identified earlier, all of these tools are either in the early stages of development or have been subject to limited psychometric evaluation. As such, there would be insufficient literature to base a critique upon.

In lieu of this, the author chose to review and critique the WAI-SR (Hatcher & Gillaspy, 2006). There are multiple reasons for this. Firstly, the WAI-SR has recently been utilised within a secure inpatient setting (Otte et al., 2018). Secondly, it is one of the most popular, widely researched, and up-to-date tools within the alliance literature (Horvath, 2018). This means there is sufficient evidence for which to base a critique upon. Whilst it is acknowledged that the WAI-SR has been designed to measure the alliance in the context of individual patient-practitioner relationships, this critique has already found that other similarly designed tools[5] have been applied within secure inpatient settings to measure the alliance between patients and a variety of staff-patient relationships (i.e., both individual and collective). The WAI-SR arguably stands out from these tools in that it has been built upon one of the most influential theories of the alliance (the Working Alliance) (Bordin, 1979); a theory that was intended to be used both within and outside the context of psychotherapy. To be more specific, one that "could be defined and elaborated in terms that would make it applicable to *any change situation* [emphasis added] including, for example that between teacher and a student" (Ross et al., 2008, p. 463). This is perhaps why it has been used as the

---

[5] The WAI (Horvath & Greenberg, 1989), HAS (Priebe & Gruyters, 1993), and the CALPAS (Short form; Gaston, 1991).

foundation for both of the early theoretical developments that have occurred within the involuntary alliance literature (Ross et al., 2008; Pulido, 2011).

An overview of the WAI-SR will be provided, followed by an examination of its psychometric properties with Kline's (2015) recommendations for a "good" psychometric test in mind. That is, a test should be "…at least an interval scale, be further reliable, valid and discriminating, and either have good norms or fit a Rasch or similar model with high precision, or be expertly tailored to its subjects" (p. 1). Conclusions will then be drawn regarding implications for research and practice, with specific reference to secure inpatient settings.

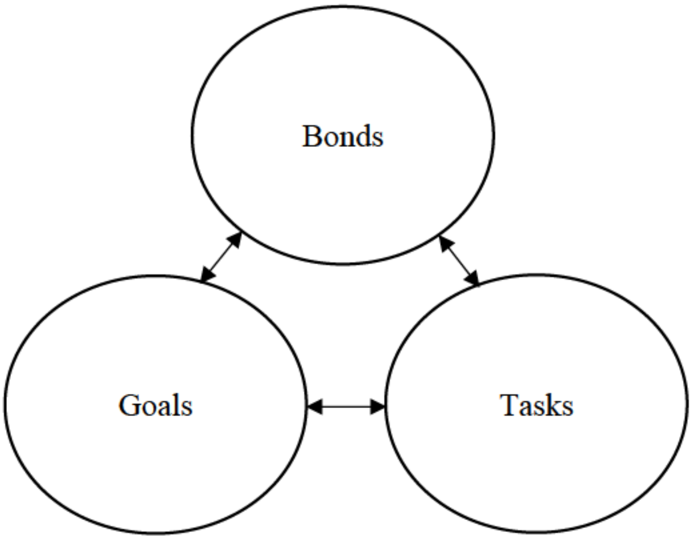
Overview of the WAI-SR

The "Working Alliance"

During the late seventies, Edward Bordin used his knowledge of the psychotherapy literature to develop the concept of the Working Alliance (WA) (Bordin, 1979). Despite its psychotherapeutic influences, the WA was the first extended pantheoretical alliance construct; one that Bordin expressly intended for application across all kinds of helping relationships (i.e., teacher and student) (Ross et al., 2008). It was proposed that the WA is either partly or wholly responsible for treatment effectiveness of any kind (Ross et al., 2008). Bordin described the WA as a collaboration across: agreement on the Goals of therapy (the degree to which the two parties mutually endorse and value the aims of therapy); agreement on the Tasks of therapy (whether both parties see the activities and/or assignments as relevant and effective); and the therapeutic Bond (the quality of the interpersonal interaction). Bordin further suggested that each of the three subdimensions may vary according to the type and length of a relationship.

Figure 8

Diagrammatic Representation of the Working Alliance (Ross et al., 2008, p. 474)



Shortly afterwards, Horvath and Greenberg (1989) noticed that, although there had been increasing enthusiasm towards measurement of the alliance, no tool had, accordingly, a "clearly articulated relation with a specified body of theory" (p. 225). Thus, Horvath and Greenberg (1989) chose to develop an alliance tool based on Bordin's (1979) WA theory.

Development of the WAI-SR

WAI (Horvath & Greenberg, 1989)

Through a series of evaluations of possible items (using seven alliance experts and 21 registered psychologists[6]) a 36-item self-report measure of the WA was developed. Each subscale (Goals, Tasks, Bond) is made up of 12 individual items, with each item being rated on a 7-point Likert-type scale ranging from 1 (*never*) to 7 (*always*). For instance: *I believe ____ liked me*; *I was confident in ____'s ability to help me*; *my relationship with ____was very important to me*. Two versions of the WAI were created: a client version and a therapist version[7].

---

[6] Alliance experts were found from review of the published alliance literature, and registered Psychologists were randomly selected from a "local psychological association" (Horvath & Greenberg, 1989, p. 225).

[7] Copyright permission to include the full WAI was not granted for this critique. The tool can be found at https://wai.profhorvath.com/downloads

The WAI was subsequently administered to four independent samples from Canada (see Table 20) to assess the new tool's reliability and validity. The authors concluded that the WAI is "obviously in the early stages of development insofar as evidence of its validity, reliability, and utility is concerned" (p .231). They specifically noted the high correlations between all three subscales; suggesting the need for more empirical evidence to support the nature of Bordin's multidimensional model.

Table 20

Demographic and General Characteristics for WAI samples (Horvath & Greenberg, 1989)

	Pilot*	**Sample 1****	**Sample 2*****	**Sample 3******
		Clients		
Total (*n*)	29 clients	29 counsellor-client dyads	31 clients 6 counsellors	25 client-counsellor dyads
Gender	-	-	-	-
Age (years)	-	Range (19-65)	-	-
Ethnicity	-	-	-	-
Socioeconomic Status	-	-	-	-
Diagnoses	-	-	-	-
WAI administration	After 3rd interview	After 3rd session	After 3rd session	After 3rd session
		Therapists		
Gender	-	-	-	-
Experience	-	Experienced professionals	2 to 7 years	-
Treatment Approaches Administered	-	Client-centered Analytic Jungian Behavioural Cognitive	Gestalt two-chair technique	Client-centered Gestalt Psychodynamic Cognitive-behavioural Rational-emotive

Note: Hyphens indicate where information was not reported.

*Graduates on counselling psychology programme that took part in peer role-play.

**Part of the normal case load for counsellors.

***People who had responded to an advertisement offering counselling services.

****People who had responded to an appeal to counsellors from various settings (i.e., government, university, or private practice).

WAI-S (Tracey & Kokotovic, 1989)

Tracey and Kokotovic (1989) were the first to examine the multidimensional nature of Bordin's (1979) model using a slightly larger, yet single, sample from the US (see Table 21). Using Confirmatory Factor Analysis (CFA) they found "one overriding alliance factor appears to be the most salient dimension measured by the WAI" (p. 209); as opposed to the three subdimensions that it was designed to measure. These results mirror those of Horvath and Greenberg (1989). Thus, the authors identified the four items that had the highest factor loadings from each of the three subscales to form a new WAI-Short Form (WAI-S).

Table 21

Demographic and General Characteristics for WAI-S Sample (Tracey & Kokotovic, 1989)

	Sample*
Clients	
Total (*n*)	84 clients 15 therapists (rated 123 clients)
Gender	Female (53) Male (31)
Age (years)	Range (17 to 34) Mean (22)
Ethnicity	-
Socioeconomic Status	-
Diagnoses	-
WAI administration	After 1st session
Therapists	
Gender	Male (8) Female (7)
Experience	PhD-level psychologists (13) Interns (2)
Treatment Approaches	Psychotherapy (10) Humanistic (4) Cognitive-behavioural (1)

Note: Hyphens indicate where information was not reported.

*Counselling conducted at a university counselling center at a large midwestern state university.

The resultant WAI-S is a 12-item self-report measure[8]. Each subscale (Goals, Tasks, Bond) is reduced to 4 individual items, with each item being rated on the same 7-point Likert-type scale ranging from 1 (*never)* to 7 (*always*). Two versions of the WAI-S were created: a client version and a therapist version. However, the factor structure of the WAI-S was found to be similar to the WAI; that is, still measuring a single alliance factor. Tracey and Kokotovic (1989) suggested their results were due to "idiosyncratic sample properties" (p. 210) and stressed that future administrations of the WAI-S across varied samples should prove the tool's value.

WAI-SR (Hatcher & Gillaspy, 2006)

Almost twenty years later, Hatcher and Gillaspy (2006) recognised that despite the WAI and WAI-S having been used across a variety of research and clinical settings, the tools had been subject to inadequate empirical testing. They also noted several limitations of Tracey and Kokotovic's (1989) original WAI-S study, such as a small sample size and out-dated statistical techniques. To identify an "alternative short from of the WAI that would more clearly distinguish Bordin's Task, Goal and Bonds dimensions" (p. 17), the authors used Exploratory Factor Analysis (EFA) with two independent samples from the US of responses to the WAI (see Table 22). Hatcher and Gillaspy (2006) found a more defined representation of the three alliance dimensions (i.e., improved model fit) by excluding negatively worded items. For example, items that referred to finding treatment "confusing, frustrating, and worrisome" (i.e., "*I am frustrated by the things I am doing in therapy*") (p. 18). Using Item Response Theory (IRT), they also found that respondents "do not seem to discriminate effectively in the lower ends" (p. 22) of the seven-point scaling system. Thus, they adopted an alternative five-point scaling system.

---

[8] Copyright permission to include the full WAI-S was not granted for this critique. The tool can be found at https://wai.profhorvath.com/downloads

Table 22

Demographic and General Characteristics for WAI-SR Sample (Hatcher & Gillaspy, 2006)

	Sample 1*	**Sample 2****
Total (*n*)	231 (clients and therapists)	235 (64 clients and 171 therapists)
Clients		
Gender	Female (148, 64%) Male (83, 36%)	Male (56, 24%) Female (167, 71%) Unidentified (12, 5%)
Age (years)	Range (18 to 65) Mean (28.5) SD (7.2) Median (27)	Range (18 to 63) Mean (28.4) SD (9.9) Median (25)
Ethnicity	White (219, 95%) African American (4, 1.5%) Hispanic (4, 1.5%) Asian (2, 1%) Unidentified (2, 1%)	White (87%) African American (4%) Native American (2.7%) Hispanic (2%) Asian (1%) Other (3%)
Socioeconomic Status	-	-
Diagnoses	Majority labelled with neurotic problems (i.e., anxiety, depression, relationship difficulties) Some had mild character disorders	-
WAI administration (sessions)	Rage (2nd to 274th) Mean (51) SD = (58) Median (34)	After 3rd session
Therapists		
Gender	Female (68%) Male (32%)	-
Experience	Predoctoral interns with 1-5 years (67%) Postdoctoral fellow with 6 or more years and senior staff (33%)	Trainee psychologists (111, 65%) Registered Psychologists (46, 27%) Social workers (7, 4%) Other (7, 4%)
Treatment Approaches	Psychotherapy	CBT (~33%) Psychodynamic (25%) Person-centered (10%) Systemic (10%) Other (22%)

Note: Hyphens indicate where information was not reported.
*Clinic for adult psychotherapy at a large midwestern university.
**Various counselling centers and outpatient clinics from southwestern US.

Structure, Administration, and Scoring of the WAI-SR

The WAI-SR is a 12-item self-report measure of the WA. Each subscale (Goals, Tasks, and Bond) is made up of four individual items (see Table 23). There are two versions available: a client and a therapist version. For the client version, the tool requires respondents to imagine inserting the name of their *therapist* into items and *describe which category best describes [their] own experience*, for instance *I feel _____ cares about me even when I do things that he/she does not approve of*. For the therapist version, the word *therapist* is replaced with *client*. Application specific forms are not available for the WAI-SR, but modifications can and have been made to the word *therapist* (i.e., *physician/nurse*) (Bar-Sela et al., 2016). Items are scored on a 5-point Likert scale ranging from 1 (*seldom*) to 5 (*always)*. Subscale scores can range from 5 to 20 and can be combined to create a total score, ranging from 8 to 60. Higher scores are indicative of more positive WA ratings. See Appendix N for full WAI-SR and scoring key.

Table 23

Subscales and Items of the WAI-SR[9]

Subscale	**Item**	
Goals	4	
	6	____ and I are working towards mutually agreed upon goals.
	8	____ and I agree on what is important for me to work on.
	11	____ and I have established a good understanding of the kind of changes that would be good for me.
Tasks	1	As a result of these sessions I am clearer as to how I might be able to change.
	2	What I am doing in therapy gives me new ways of looking at my problem.
	10	I feel that the things I do in therapy will help me to accomplish the changes that I want.
	12	I believe the way we are working with my problem is correct.
Bond	3	I believe ___ likes me.
	5	____ and I respect each other.
	7	I feel that ____ appreciates me.
	9	I feel ____ cares about me even when I do things that he/she does not approve of.

---

[9] Reprinted by permission of the Society for Psychotherapy Research © 2016 (see Appendix P).

WAI-SR in the Literature

A review of the literature conducted in 2019[10] revealed a total of 47 published studies on the WAI-SR (see Appendix O). Forty-one studies collected data from community samples (which included psychological, occupational, and physical health treatment); four studies from general inpatient settings; and two studies from offenders receiving court-ordered rehabilitative treatment in the community. As mentioned earlier in this critique, one study (Otte et al., 2018) applied the WAI-SR within a secure inpatient setting in Germany (*n* = 55). Eleven of the 47 studies utilised the therapist version of the WAI-SR.

The search above was replicated in early 2022 and found at least 300 additional studies published within the last three years. This indicates that the WAI-SR is still one of the most popular and widely researched tools within the alliance literature (Horvath, 2018). It is beyond the scope of this critique to provide a detailed overview of these studies. However, it is pertinent to note the landscape of more recent literature is in-keeping with earlier searches. A handful of studies collected data from general inpatient facilitates (i.e., O'Callaghan et al., 2022; Peters et al., 2022) and offending populations (i.e., Mahajan & Howard, 2022; Muijsson, 2022). No additional studies were found to have been conducted within secure inpatient services, or to have primarily explored the psychometric properties of the WAI-SR.

Psychometric Properties of the WAI-SR

A total of seven studies were found to examine the psychometric properties of the WAI-SR (including its development by Hatcher and Gillaspy [2006]). Two of these studies examined the psychometric properties of the therapist version only (Hatcher et al., 2019). Although the alliance is a dyadic construct, the purpose of this review is to examine the psychometric properties of the WAI-SR client version only (owing to the aims of this thesis). Thus, a total of six studies were utilised for this critique. A summary of samples used can be found in Table 24. For all reported demographic information and general characteristics of each study, see Appendix Q.

---

[10] Electronic search (Ovid Databases: EMBASE, Medline and PsycINFO) and manual search of reference lists.

Table 24

Summary of Samples used to Explore the Psychometric Properties of the WAI-SR

Study	*n*	Description	Location
Hatcher and Gillaspy (2006)	231	Psychotherapy located at a university	US
	235	Various counselling and outpatient settings	
Perdrix et al. (2010)	188	Counselling service for careers	US
	95	Counselling located at a university	
Munder et al. (2010)	88	Psychotherapy located at a university	Germany
	243	Inpatients from two clinics	
Tatman and Love (2010)	182	Adult male offenders on parole or probation who had committed sexual offenses or domestic abuse	US
Falkenström et al. (2015)	235	Sample 2 from Hatcher and Gillaspy (2006)	US
	634	Primary care counselling	Sweden
	234	Therapy delivered in inpatient care	
Mallinckrodt and Tekie (2016)	1,786	Archival data from counselling center and community clients.	US
(*N*) = 3,916			

Level of Measurement

Ideally, a good psychometric test "…should aim to produce ratio scales. Failing that, interval scales are desirable if the results are to be subjected to any form of statistical analysis" (Kline, 1986, p. 2). The WAI-SR uses a Likert-type scale from 1 through to 5. Although not a true interval scale, a prerequisite for Likert rating scales is an identical space between each response point; which, in turn, is a prerequisite for both ratio and interval level data. It is therefore arguable that the WAI-SR satisfies the minimum level of measurement.

Reliability

Reliability refers to whether an instrument is able to measure an attribute in a consistent manner (DeVon et al., 2007). Two primary types of reliability exist: internal reliability and test-retest reliability (Howitt & Cramer, 2005).

Internal Reliability

Internal reliability evaluates the extent to which all items within a test measure the same underlying construct that they are intended to measure (Kline, 1998). The often-quoted rule of thumb denoting a reliable test is a Cronbach's (α) coefficient of 0.7 or above (Coaley, 2010). Many argue that the internal reliability of a test should be as high as possible (Cronbach, 1984; Nunnally & Bernstein, 1994 as cited in Kline 1998); low alphas indicate that the items may be too heterogenous which, in turn, suggests that the items are measuring more than one underlying construct. However, Cattel (1957, as cited in Kline, 1998) argues that a test can be too internally consistent. High alphas indicate that the items within a test may be too similar and therefore redundant; with each item adding little to the overall correlation (i.e., bloated specifics) (Cattell & Kline, 1977). The more items within a scale, the higher coefficients are likely to be (Samuels, 2017). Recommended minimum sample sizes for internal reliability range from 200 to 300 (Kline, 1986).

Table 25 displays the Cronbach alpha coefficients of WAI-SR total and subscale item scores according to each of the seven studies. At first glance, the WAI-SR appears to demonstrate "very good internal consistency" (Munder et al., 2010, p. 236). Overall, Cronbach alpha coefficients are high: total scores are equal to or above .90 and subscale items are equal to or above .80. However, taking into account concerns regarding bloated specifics (Cattell & Kline, 1977), these scores also indicate that internal consistency may be *too* high; especially when considering that the WAI-SR contains only 12 items. This implies that the Bond, Task and Goal subscale items are too similar; that they are all measuring one underlying construct (i.e., a global alliance factor) as opposed to the three discreet sub-constructs that they are intended to measure. This mirrors findings from the development of the WAI and WAI-S. That said, some of the studies did not include a sample size that met the minimum requirement for reliability analysis (Kline, 1986). It is therefore difficult to make definitive conclusions regarding the internal reliability of the WAI-SR subscale items. Evidence for the WAI-SR's ability to reliably measure a global alliance factor is arguably much stronger.

Table 25

Cronbach's Alpha (α) Coefficients to Determine the Internal Consistency of WAI-SR Scores

Study	Sample size (n)	Cronbach's alpha (α) coefficients			
		Bond	Task	Goal	Total
Hatcher and Gillaspy (2006)	231	.90	.85	.87	.91
	235	.85	.87	.85	.92
Perdrix et al. (2010)	188*	.52	.71	.58	.76
	95*	.80	.86	.88	.92
Munder et al. (2010)	88*	.82	.85	.81	.90
	243	.83	.86	.91	.93
Tatman and Love (2010)	182	.93	.90	.93	-
Falkenström et al. (2015)	-	-	-	-	-
Hukkelberg and Ogden (2016)	259	.84	.79	.59	-
		.80	.82	.52	
Mallinckrodt and Tekie (2016)	-	-	-	-	-

Note: Hyphens indicate where coefficients were not investigated or reported.

*Samples that did not meet the minimum requirement for reliability analysis.

Test-Retest Reliability

Test-retest reliability involves the administration of a tool to the same group of participants on two separate occasions that are separated by time (Kline, 1998). If the two sets of scores are correlated highly with each other (i.e., the same or similar), then given that each subjects status on the variable has not changed, a tool is regarded as having good test re-test reliability; random error due to temporal factors is said to be minimal (Kline, 2010). Correlation coefficients for a good test should be .80 and, typically, the interval between the administration of the two tests should be no less than three months (Kline, 2000).

Tatman and Love (2010) was the only study to assess the test-retest reliability of the WAI-SR. A significant correlation of .70 ($p < .001$) was found between test and re-test total scores of the WAI-SR after a two-week period. The authors concluded that this indicates strong test-retest reliability. However, no evidence was provided for any of the three subscales scores, the sample size was relatively small ($n = 174$), and the interval between tests was much less than three months; making it possible that participants simply remembered their original responses. Evidence for the test re-test reliability of the WAI-SR is therefore weak.

It is important to note however, that examining test re-test reliability of the WAI-SR may be inappropriate, as the alliance is not intended to be stable construct. Indeed, there is some evidence that the developmental profile of the alliance develops over time, usually in a linear and/or U-shaped fashion throughout treatment (Horvath & Luborsky, 1993; Hukkelberg & Ogden, 2016; Kivlighan & Shaughnessy, 2000; Stiles et al., 2004). This may explain why Tatman and Love (2010) chose to re-administer the WAI-SR after only two weeks, and why no other studies have investigated this component. Exploring the longitudinal measurement invariance of the WAI-SR may provide more clarity on the matter. No studies have done this, although a few have highlighted its importance (Falkenström et al., 2015; Hukkelberg & Odgen, 2016).

Validity

According to Kline (1986), “a test is valid if it appears to measure what it claims to measure” (p. 4). The following concepts must be met: face validity; criterion validity (including concurrent and predictive); content validity; and construct validity.

Face Validity

Face validity refers to the appearance of a test; whether it looks like it measures what it claims to (Howitt & Cramer, 2005). No literature could be found to have explored the face validity of the WAI-SR. Whether this has been avoided or simply overlooked, this means that - beyond the seven experts in the field of the alliance and 21 registered psychologists[11] that were involved in the development of the original WAI over four decades ago - no additional professionals, patients and/or researchers have commented on the extent to which the WAI-SR makes logical sense. At first glance, this may not seem to be a significant issue. Face validity is regarded as the least sophisticated measure of validity (Kline, 1998); and, from inspection of the WAI-SR, all 12 items certainly appear to measure aspects of the WA. However, it is important to bear in mind that the WAI and its derivatives were specifically designed with a community psychotherapeutic treatment context in mind. As aforementioned,

---

[11] Alliance experts were found from a review of the published alliance literature, and registered Psychologists were randomly selected from a “local psychological association” (Horvath & Greenberg, 1989, p. 225).

the WAI-SR has been used across a diverse range of additional helping professions (including secure inpatient); many of which differ markedly from this exemplar. Whilst it is positive that modifications can easily be made to the term *therapist* (i.e., *physician/nurse*) (Bar-Sela et al., 2016), some items and/or wording may not be appropriate or make logical sense when applied to other contexts. For instance, inclusion of the phrase “my problem” is arguably limited for use within secure inpatient services; a setting that is designed to provide multidisciplinary treatment and care for those with complex difficulties, distress, and risk presentations. In addition, inclusion of the word “therapy” is specific to an individual therapeutic context (i.e., psychological sessions). To capture individual relationships outside of this context (i.e., psychiatrist, key nurse), as well as multiple relationships with staff on the ward (i.e., multi-disciplinary team, nurses, health care assistants, all staff on the ward), this would need amending to “treatment” or “care”. An awareness of such contextual discrepancies is important when considering use of the WAI-SR across and within different helping professions.

It must also be noted that if a respondent is clear on the purpose of the tool and has motivation to complete it, they may respond in a socially desirable manner. Response bias or false reporting in this way is a known problem for self-report measures (Kline, 1998). Again, this is particularly relevant when considering use of the WAI-SR across different helping professions; particularly those where care and/or treatment providers hold an element of power or control over progression (i.e., secure inpatient). In such cases, patients may anticipate possible benefits and/or consequences in how they rate the alliance with those they are working with. There may be a tendency for individuals to present the alliance in a particularly positive, even negative, light. This may interfere with the WAI-SR’s ability to capture accurate alliance scores. To explore this, Tatman and Love (2010) compared anonymous and identifiable administrations of the WAI-SR within a sample of offenders on parole or probation (N = 202) who were completing group treatment for sexual offenses or domestic abuse in a supervised community-based setting. They hypothesised that it “would be intuitively obvious that anonymous endorsements” (i.e., the offenders name was not included on the form) “will likely capture the most honest and accurate opinions about the working alliance” between participants (offenders) and their parole or probation officers (p. 174). In fact, the authors found no significant differences between total anonymous and identifiable WAI-SR scores, with mean scores of 70.81 and 70.82 respectively (administered two weeks apart). They concluded that both the anonymous and identifiable responses were valid representations of the alliance; participants rated their alliance honestly and accurately, even when their responses were identifiable by their parole or probation officers. Whilst this is encouraging to see, it is idealistic to assume that these results would hold across different populations and helping professions. As such, an awareness of the impact of socially desirable responses is important to hold in mind when considering use of the WAI-SR across different helping professions.

Concurrent Validity (Criterion)

Concurrent validity is demonstrated when a test correlates with another test - recognised as a sound measure of the same construct (i.e., the criterion) - when completed at the same time (Kline, 2000). Using Pearson's product-moment correlation, "if a test correlates more than 0.7 with the criterion test, this is regarded as good evidence for concurrent validity" (Kline, 1998, p.36). Kline (1998) also states that a test should not have correlations with tests that are measuring different variables (Kline, 1998).

Hatcher and Gillaspy (2006) conducted a study with 231 participants which aimed to compare and explore correlations between the WAI-SR with the CALPAS (Gaston, 1991) and the HAQ (Alexander & Luborsky, 1986). They found total scores of the WAI-SR to correlate .80 and .74, respectively. Munder et al. (2010) conducted a study with 243 participants and also found correlations of the WAI-SR and HAQ to be .71. These findings provide some evidence in support of the concurrent validity of the WAI-SR. However, as Kline (1998) notes, a correlation of 0.7 is not powerful evidence; it indicates that more than half the variance is not shared between the two measures. It should also be noted that neither the CALPAS nor the HAQ are gold standard measures of the alliance, and they each measure different subscales based on different theories of the alliance. Arguably, evidence for concurrent validity of the WAI-SR is modest at best.

Predictive Validity (criterion)

Predictive validity looks to assess how well a test is able predict something about a respondent in the future (Kline, 2000). For true predictive validity, "correlations are obtained between the test given on one occasion and some later criterion" (Kline, 1986, p. 5). There is some tentative evidence that the WAI-SR may be able to predict offender risk and estimates of improvement in therapy. In a study looking at scores of 174 participants, Tatman and Love

(2010) investigated the relationship between total WAI-SR scores and offender risk. Risk of future offending was measured with the Level of Service Inventory-Revised (LSI-R) (Andrews & Bonta, 1995). They found correlations were small but significant ($r = .187$, $p = .021$). These findings would suggest that "as offender risk increases, working alliance or relationship between probation officer and offender, weakens" (p. 173). However, it is important to consider that much of the variance in predicting risk of reoffending is left unexplained (Kline, 1998). Moreover, for true predictive validity, evidence would need to be taken from recidivism rates; an admittedly challenging task due to the difficulties inherent in following up individuals over several years. Whilst no studies have investigated the relationship between WAI-SR scores and recidivism rates, a handful of studies have done so using alternative alliance tools (i.e., DeSorcy et al., 2020; Sturm et al., 2020)[12]. Such evidence would have proved valuable in determining the predictive validity of the WAI-SR.

Another study, conducted by Hatcher and Gillaspy (2006), found significant relationships between estimates of improvement in therapy (as evidenced by change in behaviour and social life, feelings in relation to self and perceived benefit of therapy) and WAI-SR total scores. Although client rated estimates of improvement were large ($r =.56$, $p < .001$), therapist rated estimates of improvement were small ($r = .17$, $p = .05$). It could be that there were simply discrepancies between the level of subjective and observed improvement in therapy. However, the authors do not state if clients were blind to the nature of the research; if not, it is possible that they responded in a socially desirable manner (i.e., anticipated possible benefits and/or consequences from their responses). This would mean the results are not strong evidence of predictive validity.

Content Validity

Content validity is interested in how well a test has been constructed (Coaley, 2010). To claim that a tool has content validity, Boateng et al. (2018) states that it must have been assessed by both expert (i.e., professional) and target population judges (i.e., tool respondents). As previously mentioned, the original WAI was created using evaluations of prospective items using alliance experts and 21 registered psychologists[13]. On the one hand,

---

[12] Sturm et al. (2020), for example, found that subscale scores of the WAMC predicted serious recidivism from a four-year follow-up period.

[13] Alliance experts were found from a review of the published alliance literature, and registered Psychologists were randomly selected from a "local psychological association" (Horvath & Greenberg, 1989, p. 225).

this is a large number of professional experts that far exceeds the expected range of five to seven for content validation (Boateng et al. 2018). It is also positive to see that the registered psychologists were recruited randomly from a "local psychological association" (Horvath & Greenberg, 1989, p. 225), as this will have removed selection bias. That said, it is unclear how exactly the experts in the field of the alliance were recruited, and it is unclear as to the level of expertise that both group of experts held. Furthermore, the authors did not consult target population judges. Respondents (i.e., patients) were not consulted at all. The WAI-SR itself was created using statistical techniques only. Whilst this will have evaded bias in the selection and/or removal of items, the alliance is, by its very nature, a subjective phenomenon. The absence of content expert evaluation from both professionals and respondents is therefore a significant limitation. For these reasons, it is difficult to conclude with confidence that the WAI-SR includes all necessary items to represent the concept being measured (i.e., the WA).

According to Boateng et al. (2018), an additional criterion for content validity is that the domain being measured should have a generally accepted definition that is "unambiguously defined" (p. 6). No consensual definition exists for the alliance as a conceptual term; it is a complex, subjective and dynamic phenomenon (Horavth, 2018). The WAI-SR is specifically based on Bordin's (1979) pantheoretical conceptualisation of the WA. Despite the WA being one of the most influential and widely theories amongst the alliance literature (Ross et al., 2008), Bordin himself only intended it to be a "source of guidance and inspiration" (Bordin, 1979, p. 259). The theory itself is merely descriptive. It includes no detail "about the mechanisms underlying goals, tasks, bonds and how they develop, how they work together, nor how they engender change" (Ross et al., 2008, p. 464). The WA is also largely assumptive. There is no evidence that it was created using any systematic methods beyond Bordin's own knowledge of the psychotherapy literature (Ross et al., 2008; Tatman & Love, 2010). That said, some would argue that a strength of the WA lies in its simplicity and its resultant flexibility in being "applicable to any change situation" (Ross et al., 2008, p. 463). Indeed, as noted earlier in this critique, the WA has been used as the core foundation for a number of more recent theoretical developments within the alliance literature; both within and outside traditional psychotherapeutic roots. For instance, the Common Factors model (Wampold, 2015), the RRTA (Ross et al., 2008), and the ITA (Pulido, 2011).

Despite this, from an empirical point of view at least, the theoretical underpinning of the WAI-SR are relatively weak and yet to be substantiated. With this and the above paragraph in mind, it can be concluded that the WAI-SR does not demonstrate sufficient evidence to meet the criteria for content validity.

Construct Validity

Construct validity judges a measures ability to assess an actual construct; one that is explained clearly and makes sense within a grounded theoretical framework (Howitt & Cramer, 2005). In order to demonstrate construct validity, “a whole pattern and mosaic of test results” should be presented (Kline, 1998, p. 37). Evidence for the construct validity of the WAI-SR can be taken from analyses of factor structure and response scale performance.

The factor structure of the WAI-SR has received the most attention amongst the six studies that were found to examine the tools psychometric properties. One study explored the factor structure of the WAI-SR using EFA (Perdrix et al., 2010). This analysis extracted three factors, which were able to explain 59.81% of the total variance of the correlation matrix (n = 283). The total alliance score correlated highly with all three subscales ($.75 \leq r \leq .84$). In theory, this seems to confirm a global alliance factor that can be divided into three related subscales. However, whilst it is positive that the total variance explained is above 50%, it is still well below the expected minimum of 70% (Kline, 1998); almost half of the variance (40.19%) is unaccounted for. This could mean that the WAI-SR measures additional or alternative variables beyond the Goals, Tasks and Bonds subscales that it is intended to measure.

A total of four studies have explored the factor structure of the WAI-SR using CFA. These studies tested: three-factor, two-factor (Bond and Task-Goal combined) and one-factor (general alliance) models. Hatcher and Gillaspy (2006), Munder et al. (2010) and Perdrix et al. (2010) found the data only fit a three-factor model; each using a range of independent sample sizes, respectively: n = 231, n = 235; n = 243, n = 88; n = 188, n = 95 (N = 1,080). Tatman and Love (2010), using a single sample (n = 182), concluded that the “one factor model represents the most statistically sound model to measure the working alliance” (p. 171). In theory, this seems to confirm that the WAI-SR is able to measure a global alliance factor as well as all three subscales. However, most of these models were reported to be of adequate fit at best. When comparing these results with more recent and stringent fit indices criteria (e.g., Cangur & Ercan, 2015)[14], some of these models would, in fact, be considered weak. It is therefore debatable as to whether one can rely on CFA data to provide support for the factor structure of the WAI-SR.

In addition to the above, most of the models generated significant chi-square results which indicates ill fit. This seems to have been ignored by the authors of all four studies in favour of alternate fit indices; without mention or justification as to why. Chi-square testing can, admittedly, be "unnecessarily strict" and does often lead to the rejection of models in CFA (Muthén & Asparouhov, 2012, p. 3). Falkenström et al. (2015) recognised this and, in addition to using traditional CFA analyses, also used Bayesian Structural Equation Modelling (SEM) to further trial the factor structure of the WAI-SR. SEM as a whole is a relatively new, powerful and complex statistical tool (Barrett, 2007). It recognises that models may be too easily rejected due to "substantially-driven small-variance priors" (i.e., significant chi-square results; Muthén & Asparouhov, 2012, p. 3). SEM makes allowances for such small deviations so that they do not ruin the model (Falkenström et al., 2015). Falkenström et al. (2015) used three larger independent samples (*n* = 235, *n* = 634, *n* = 243) to a test one, two, and three-factor model. As expected, all models did not pass the chi-square ratio test of exact fit using CFA. Yet, when the models were run with Bayesian SEM, all three showed excellent fit. These results seem to provide support for the WAI-SR's factor structure; they suggest that the tool is able to measure a single global alliance factor in addition to the three distinct components of the WA. However, these results also suggest that the WAI-SR is able to measure a two-factor model. This is not ideal as it contrasts with the intended factor structure of the WAI-SR.

Whilst it must be said that these results are a slight improvement from previous CFA's of the WAI-SR, they should be interpreted with caution. Desired sample sizes for Bayesian SEM are set much higher than traditional CFA. Kline (1998) recommends sizes of at least 200, whereas Yung and Bentler (1994) recommend sizes of at least 2000 to obtain satisfactory results (as cited in Nachtigall et al., 2003); none of the independent samples used by Falkenström et al. (2015) were close to this amount. In addition, Bayesian SEM is a relatively new approach; there are no accepted criteria as to the interpretations of model fit, or

---

[14] For instance, Tatman and Love (2010) report Tucker Lewis Indices (TLI) of 0.93 (one-factor model), 0.94 (two-factor model) and 0.94 (three-factor model). They state this indicates adequate model fit. However, Cangur and Ercan (2015) report that a TLI should be at least 0.95 to be considered adequate.

the amount and size of priors used. It is therefore debatable as to whether one can rely on Falkenström et al.'s (2015) Bayesian SEM results to provide support for the factor structure of the WAI-SR.

Two studies have analysed the response scale performance of the WAI-SR (Hatcher & Gillaspy, 2006; Mallinckrodt & Tekie, 2016). Response scale performance can be analysed using Item Response Theory (IRT). Whereas traditional methods (such as Classical Test Theory) attempt to measure an individual's *average* response to items, IRT estimates the *probability* that an individual's response to an item will fall within a particular category (Embretson & Reise, 2013). Various forms of IRT exist, each with varying complexity (Coaley, 2010). The Rasch Model, for example, "enables a test designer to determine the probability of any individual passing any item based upon knowledge of the person's ability and item difficulty" (Coaley, 2010, p. 432). In terms of sample size for IRT, no gold standard exists (Thorpe & Favia, 2012). Desired sample sizes range from 100 to 500 (Bond et al., 2007; Morizot et al., 2007). When creating modified versions of scales, IRT can be used to exclude and/or discriminate between items. This is an advantage over factor analyses methods, which often simply pick the factors with the highest loadings to maximise the internal reliability of shortened scales. Mallinckrodt and Tekie (2016) noted that both the WAI-S and the WAI-SR had been developed using factor analyses, which would suggest that both measures may not preserve the total 36-item scale information from the original WAI.

Although, in developing the WAI-SR, Hatcher and Gillaspy (2006) did perform Rasch IRT, this was done *after* item content had been finalised, and the author's only conclusions concerned the response format of the scale (i.e., reducing the format to a 5-point scale). Thus, Mallinckrodt and Tekie (2016) used Rasch IRT on a large sample (n = 1,786) to compare both the WAI-S and the WAI-SR in terms of the information each retains from the original WAI. The results showed that neither the WAI-S nor the WAI-SR captured the full range of the original WAI. The WAI-SR, however, was the more sensitive of the two; being able to detect "differences between clients with moderate to strong alliances" on the Goal and Task subscales (p. 20). As a result of these findings, the authors concluded that it is necessary to find an alternative to the WAI-SR.

Standardisation and Norms

It is said that "for every psychometric test norms have to be established; that is, the test has to be standardised" (Kline, 1998, p. 40). Norms are established by computing sets of raw scores into percentile ranks or *Z*-scores. Ideally, these raw scores should be taken from clearly defined, representative and large samples (i.e., $\geq$ 500; Kline, 1998). Without norms, meaningful comparisons between respondents and across samples cannot be made (Kline, 2000). As with the WAI and the WAI-S, the WAI-SR is not a standardised measure; norms have not been established for any population. The WAI-SR was developed using a total sample of 466 clients and therapists. A large majority of clients were young, white, middle-class females undertaking psychotherapy. Given that the WAI-SR was designed to be used across a variety of helping relationships, this sample is neither representative nor large. In order to compare alliance scores across other contexts beyond this sample, one must simply rely on means scores from those samples available in the literature. Although the WAI-SR has been administered to a variety of samples (see Appendix O), this method is fraught with risks (Kline, 2000); on their own, these scores have no meaning and are "impossible to interpret" (Kline, 1998, p. 40). This greatly undermines the overall validity of the WAI-SR.

Utility

Feasibility. Completing the WAI-SR takes about five minutes (Paap & Dijkstra, 2017). This is a relatively short amount of time and is unlikely to unnecessarily burden respondents. It seems feasible that the WAI-SR could be easily completed at various stages of a helping relationship and/or as part of large-scale administrations for patient feedback or service evaluation purposes.

Invariance Across Samples

Measurement invariance is an issue that is frequently disregarded in psychometric validation (Falkenström et al., 2015). It refers to the constancy of factor structure across specific groups or time (Putnick & Bornstein, 2016). For example, if a tool demonstrates measurement invariance across two different populations, this suggests that the construct being measured has the same structure or meaning – and can be appropriately used – across both groups. If measurement invariance does not hold, it may not be appropriate to use the tool in either one or both of the different groups; dependent upon the circumstances. Three of the six studies utilised for this critique examined the measurement invariance the WAI-SR.

Measurement invariance held across: two American community samples (Hatcher & Gillaspy, 2006); community and psychiatric inpatients (undergoing voluntary treatment) in Germany (Munder et al., 2010); and community and psychiatric inpatients in Sweden[15] (Falkenström et al., 2015). Falkenström et al. (2015) found that measurement invariance did not hold across the American community and Swedish psychiatric inpatient samples, and the different treatment modalities of psychodynamic and behavioural therapy in a Swedish community setting. Thus, there is mixed evidence for the measurement invariance of the WAI-SR across different clinical settings, treatment modalities and countries.

Conclusions

Summary of the WAI-SR

This chapter has examined the psychometric properties of the WAI-SR using Kline's (2015) recommendations for a "good" psychometric measure. The evidence presented suggests that the WAI-SR does not meet all of the criteria for a good psychometric test. Although the WAI-SR satisfies the minimum level of measurement, it does not appear to meet the criteria for being reliable, valid, or discriminating. From an empirical standpoint, the WAI-SR is perhaps most greatly limited by its theoretical underpinnings. It has been built upon a descriptive theory of the alliance that was developed from Bordin's own knowledge of the psychotherapy literature over forty years ago. A theory that was only intended as a "source of guidance and inspiration" (Bordin, 1979, p. 259). Although, it may also be noted that a potential strength of the WA lies in its simplicity and resultant flexibility in being "applicable to any change situation" (Ross et al., 2008, p. 463). Indeed, as noted earlier in this critique, the WA has been used as a foundational springboard for a number of initial, albeit still important, theoretical developments; particularly within the involuntary alliance literature domain (Pulido, 2011; Ross et al., 2008).

Critically, the WAI-SR has not been subject to any content expert evaluation (i.e., professionals, patients). It is therefore difficult to conclude that the tool contains all the necessary and important items to represent the concept it has been designed to measure. The WAI-SR also does not appear able to discriminate between its three distinct subscales (Goals, Tasks, Bond). It appears, instead, to capture an elusive single "global alliance factor".

---

[15] Falkenström et al. (2015) did not specify if treatment was voluntary or involuntary.

Implications for Practice

Practically, for now, using the WAI-SR as a stand-alone measure and in its current form within secure inpatient settings does not appear be appropriate. This is the case for measuring both individual (i.e., therapist, psychiatrist, key nurse) and collective (i.e., multi-disciplinary team, nurses, health care assistants, all staff on the ward) relationships. In addition to limited evidence for its psychometric properties, the WAI-SR has been tailored towards community counselling settings (i.e., voluntary) - despite it having been designed for use across a variety of helping relationships. This is an expected finding given that the WAI, the WAI-S, and the WAI-SR were all developed using samples of this kind. This means that some items and/or wording may not be appropriate or make logical sense when applied to secure inpatient services (i.e., involuntary).

However, given the entirety of this thesis so far has highlighted the importance of relational aspects of care, alternative recommendations are proposed. At first glance, it may seem logical to suggest that services simply make extra efforts to obtain verbal and/or written qualitative feedback from patients on the quality of their relationships with staff, whether this be individual or multiple staff members involved in their care. But this poses practical difficulties. Verbal feedback directly to staff removes the option for patient anonymity. Patients may feel uncomfortable doing this face-to-face or obliged to respond in a particular way if they perceive there to be possible benefits and/or consequences to their care. Requesting for written feedback in the absence of any specific prompts or questions may be too vague and arduous a task for patients to complete and staff to interpret.

A more pragmatic approach could be to employ the WAI-SR alongside a full awareness of its limitations, clinical judgement, and supplementary resources. Amendments to the wording of individual items would need to be made. For instance, changing “my problem” to “my difficulties”, and changing “therapy” to “treatment” or “care”. As the WAI-SR instructs, patients could be asked to imagine inserting either individual (i.e., therapist, psychiatrist, key nurse) or multiple staff members (i.e., multi-disciplinary team, nurses, health care assistants, all staff on the ward) into individual items. The inclusion of additional prompts and free-text boxes to encourage participation reflection and identification of specific examples would be beneficial, as this would enable both quantitative and qualitative data to be combined. A second option could be for services to use the WAI-SR as a guide to develop their own patient feedback forms. This should be done in collaboration with patients themselves (i.e., by identifying specifics aspects of relationships that are important). Individual questions within the WAI-SR could be adapted/expanded and used to generate prompts, such as “do you feel that your therapist/the multi-disciplinary team/the staff on the ward respect you? Could you provide an example?”. It is interesting to note that the original WAI included negatively worded items, attempting to capture aspects of the alliance that are confusing, frustrating, or worrisome. Whilst they were removed due to ill-model fit following factor analyses in development of the WAI-S (Hatcher & Gillaspy, 2006), both Chapters Two and Three of this thesis suggest that the inclusion of similarly themed items (i.e., “I am frustrated by the things I am doing in therapy”) would be important for patients within secure inpatient services. It may help them to feel more comfortable in evaluating the more negative, arguably harmful aspects of their relationships with staff. This, in turn, may offer services a deeper and more accurate understanding of how patients experience relational aspects of care. A third option that may be less time and/or resource intensive is for services to utilise measures that capture the alliance “indirectly” and have been specifically designed for and validated within secure inpatient settings. One such tool being the EssenCES (Schalast et al., 2008), which has been designed to assess the social and therapeutic atmosphere within secure inpatient settings[16].

All three of these approaches would ensure that services are able to measure, or at least pay closer attention to, the quality of *all* staff-patient relationships on the ward; the “backbone” of patient experiences and arguably the “single most important factor” in bringing about change (Osborn & Stein, 2019, p. 115). They could be embedded as part of a service evaluation project or as regular patient feedback tools. The latter could be an option for patients to complete “as and when” or become part of a formal outcome measurement process every three to six months prior to individual Care Programme Approach (CPA) meetings. Either way, patients should be offered the opportunity to provide feedback anonymously, or within the context of individual therapeutic work (i.e., psychological therapy or key nurse sessions).

---

[16] A psychometric critique of this tool is already in existence (Robinson, 2018)

Research Recommendations

With regards to research, a recommendation in support of the alliance literature could be a "back to basics" approach. Perhaps the field needs to develop a better understanding of the uniqueness of the alliance within secure inpatient settings; one that captures the delicate balance between the provision of therapeutic care and management of risk (Kurtz and Jeffcote, 2011); as well as the complexities and multidisciplinary nature of the inpatient environment. The RRTA proposed by Ross et al. (2008) and explored in more detail towards the beginning of this critique, could be a useful starting point here. It is a provisional theory specific to offending populations in the context of community (e.g., probation), prison, and other specialist environments (e.g., therapeutic communities). However, it does offer a uniquely rich framework by which to try and better understand the development and maintenance of alliances within involuntary settings (Ross et al., 2008); particularly with regards to the consideration it gives to external factors (e.g., setting and contextual factors, system factors, immediate therapy context, role conflict and confusion, programme factors, and group treatment settings). In fact, the RRTA's provisional status could be said to present an ideal opportunity for further "testing and refinement" (Ross et al., 2008, p. 476) specific to secure inpatient populations. Alternatively, a mixed methods approach combining both existing alliance tools and qualitative data could be useful. This could also be achieved via the Delphi method (Fink-Hafner et al., 2019), combining lived experience and clinical expertise to pin down the most important components of therapeutic relationships. Armed with this knowledge, the field could produce a tool designed specifically to measure the alliance within secure inpatient services. A final suggestion in support of the alliance literature could be to examine the psychometric properties of the IWAI (Pulido et al., 2008) - a tool that has been specifically designed for inpatient treatment settings to measure patient relationships with an individual staff member and all staff on the ward. As the tool is still in the early stages of development, it would be ideal, and most efficient in terms of catalysing progress in the field, to apply it to a secure inpatient setting by replicating the author's original study. That is, involving a large sample and a longitudinal design (e.g., upon admission, after one week, prior to discharge).

However, it does seem that the limitations raised by this critique are not exclusive to the WAI-SR, but rather a consistent theme within the alliance literature more generally (as explored earlier in this critique). Attempts to clarify and re-define the concept of the alliance and develop new alliance measures have been ongoing for several decades. As critics of the alliance literature suggest, it may be more appropriate to focus research efforts “more broadly on understanding the role that relational factors play in the change process” (Safran & Muran, 2006, p. 288). It seems then, that a similar recommendation can be made to Chapter Two. That is, future qualitative research may wish to focus on exploring the specific intricacies of ward-based relationships from the perspectives of patients themselves. A particular focus could be gathering examples as to the *how* and *why* certain interactions with staff contribute to change, whether this is positive or negative. The findings of Chapter Two, combined with the existing - albiet limited - research (Bennett & Hanna, 2021), offer examples of how this could be done.

Chapter Five

Discussion

The aims of this thesis were twofold. Firstly, to take in-depth look at the literature relating to the views and experiences of patients; and secondly, to establish the state of the literature relating to TiC within secure inpatient services. The insights and knowledge gained were used to consider areas of the empirical base which may be lacking or would benefit from being enhanced. The key findings in relation to each chapter will now be discussed.

Chapter Two

Chapter Two presented a systematic literature review and meta-synthesis of the lived experiences of secure inpatient services within the UK. Initial scoping searches were encouraging. They revealed the literature base capturing patient views and experiences has expanded quite significantly over recent years. The review considered if the existing literature base may be limited or biased towards researcher interests. A unique approach was taken whereby studies were only included if they appeared to have provided participants with the flexibility to narrate the complexity of their experiences within secure inpatient services more freely.

Results were made up of 65 participant interviews, taken from six published peer-reviewed articles, and one Doctoral thesis. Central to the narratives of all participant interviewees were ten key, interconnected themes: *Relationships on the Ward*; *Re-Enactment of Adverse Early Life Experiences and Survival Strategies*; *Personal recovery*; *Physical and Psychological Safety*; *Disempowerment and Dehumanisation*; *A Future in the Community*; *Entering and Leaving the Ward*; *Psychological Interventions*; *Occupational Activities*; and *Medical Treatment and Diagnoses*. The narratives presented offered insight into the many different ingredients that make up secure inpatient services. Some experiences were credited as inciting positive change and progress, whereas others were more negative, arguably harmful. Overall, findings were generally in-keeping with a newly developed tool designed in collaboration with patients to capture priorities for outcome measurement: the FORensic oUtcome Measure (FORUM) (Ryland et al., 2021). Notable similarities included the domains of relationships with staff, peers, friends and family in the community, the need for safety, personal identity, quality of life, and future pathways. Participants narratives from the review lent an additional level of qualitative detail as to *why* these aspects of care may be significant to those within secure inpatient services. Yet, some of these domains were not represented within initial scoping exercises, indicating the academic literature may be slightly biased towards researcher interests.

This was explored further via the reviews three most prominent themes, which were interpreted as the aspects of care that are most important to patients themselves. The first theme (*Relationships on the Ward*) formed the back bone of patient experiences. A particular focus was on the quality of day-to-day interactions with staff, but it also included peers and contact with family and friends in the community. It was interesting to compare these findings with service specifications for secure inpatient services (NHS, 2021a; 2021b; 2021c), which make no explicit reference to the importance of relationships other than within a subsection of the appendices. This brought into question the relative value that patients, policy makers, and commissioners place on different aspects of care. There was a little more consistency with the wider academic literature. For instance, a focus on relationships was found to be a running theme throughout existing reviews identified via initial scoping searches. There does, however, appear to be a shortage of individual qualitative studies focusing specifically on patient experiences of relationships on the ward. Only one study was found (Bennett & Hanna, 2021). The findings of which, when combined with those of this review, enhance the wider relational security literature (Markham, 2022); increasing understandings into *how* interactions with staff are experienced by patients and *why* they relate to risk.

The second theme (*Re-enactment of Adverse Early Life Experiences*) detailed how some aspects of secure inpatient services can resonate with past trauma and reinforce the necessity of survival strategies (i.e., self-harm, aggression, violence). The choice of words and sense-making within this theme resonated strongly with TiC. In particular, the PTMF (i.e., “what happened to you?” and “what did you have to do to survive?”) (Johnstone & Boyle, 2018). The potential benefits of the PTMF for forensic mental health service has already been recognised (Ramsden, 2019). However, participants’ narratives seemed unusually progressive in contrast to the wider TiC literature, which – at first glance – appeared sparse and requires further investigation. The work of the Women’s Mental Health Force (Department of Health and Social Care, 2018) was particularly pertinent to this theme. They described “alarming cases of women who had experienced trauma” (p. 13), with further experiences of both general and secure inpatient services that were “disempowering and, in some circumstances, *re*-traumatising” [emphasis added] (p. 19). A “worrying number” (p. 20) spoke of disturbing practices (p. 20) that were “profoundly distressing, triggering and humiliating” (p. 24). Altogether, this theme provided very clear evidence that TiC is not just important, but is in fact essential for secure inpatient services.

The third theme (*Personal Recovery*) detailed various factors that promoted and hindered personal recovery. This was strongly supported by the wider “secure recovery” literature. The CHIME-Secure (CHIME-S) framework (Senneseth et al., 2022), for example, was found to be highly accurate in capturing participant experiences, hopes, expectations, worries and fears of recovery within this review. The idea of personal recovery was touched upon again in the theme *A Future in the Community.* Participants expressed their concerns about the discharge process and a life in the community (e.g., possible restrictions, lack of support, societal stigma of being both “mad and bad”). These narratives were strongly supported again by the work of the Women’s Mental Health Taskforce (Department of Health and Social Care, 2018). This reinforced concerns that discharges from secure inpatient services are not always being planned and/or implemented in a way that gives patients the best chance of building, and sustaining, a life in the community. Consistent with the first two themes of this review, wider literature focusing explicitly on discharge into the community from a patient perspective appeared sparse. Only one study was found (Stuart et al., 2017). The results of which offered further confirmation that this is an important area for consideration, as all participants experienced “ongoing elements of struggle and difficulty” in relation to the discharge process (p. 22).

In conclusion, the results of Chapter Two did indicate that the academic literature relating to the experiences of secure inpatient services within the UK is slightly limited and, in some cases, potentially biased towards researcher interests. The review highlighted several aspects of care that are particularly important to the patients themselves, and therefore require further consideration in both academic and practical domains.

Chapter Three

Chapter Three presented a review of the literature review in order to establish and improve understanding of what the literature base tells us about trauma-informed care within secure inpatient services. More specifically, the aims were to: (i) to determine how TiC has been defined within the literature base; (ii) to identify the specific components of TiC that have been operationalised and/or implemented; (iii) to identify any evaluations of TiC including both the potential and/or actual impact of implementation; (iv) to identify future recommendations regarding TiC for both practice and research; and (v) to identify any additional and relevant key findings or discussion points that provide deeper insights into the discourse surrounding use of the term TiC. The review started by setting the scene with an overview of TiC guided by the Substance Abuse and Mental Health Services Administration's (SAMHSA) (2014) key assumptions and principles, clarified definitions of trauma, and addressed common misunderstandings of the term trauma-informed.

Initial scoping searches of the wider TiC literature landscape revealed it to be a rapidly growing yet formative and highly complex field of academic study. A large majority of existing reviews sought to identify operational or field- specific definitions; citing concerns regarding the aforementioned misunderstandings and noting the lack of quality and quantity of information relating to actual implementation and evaluation. Only two existing reviews were found to have been conducted within the domain of forensic mental health (Maguire & Taylor, 2019; Stamatopoulou, 2019). Neither had managed to find studies specific to secure inpatient services. The review in Chapter Three therefore conducted a more comprehensive and up-to-date search of the literature. Studies were included if terms used synonymously or interchangeably with "trauma-informed" were found within the study aims, findings and/or discussion (i.e., recommendations), and if the focus of the study was relevant to TiC. This identified eleven references for inclusion.

The aim/s and phenomenon of interest of the included studies varied considerably. Three qualitative studies focused explicitly on TiC (Cartwright, 2020; Owens, 2021; Stamatopoulou, 2019). The others were mostly quantitative cross-sectional. Of these, one alleged to contribute to improving TiC by investigating the frequency of diagnosed post-traumatic stress disorder (PTSD) (Alexander et al. 2016). The remainder explored links between histories and: (i) psychiatric diagnoses or symptoms; (ii) and various psychiatric and criminal outcomes. All eleven studies generated recommendations for TiC based on their findings. With the latter point in mind, data were extracted from both the results and discussion sections if it made direct reference to TiC (as determined by the authors of the studies themselves), or indirect reference to TiC (i.e., what the author/s found and/or discussed that led them to conclude that TiC is important). Ostensibly, the results of the search strategy looked promising in that it indicated the literature has started to expand.

However, after extracting data and presenting the key themes with reference to the five specific aims of the review, the picture presented revealed itself to be complex and contradictory in parts. Some findings offered valuable contributions that were in-keeping with a *true* trauma-informed approach. It was disappointing to discover that most findings were, in-fact, not compatible with a trauma-informed approach.

Findings that made explicit reference to TiC (as determined by the authors of the included studies) - those that met the first four specific aims of the review[1] - were represented within the key themes: *Definitions of trauma-informed care*; *What does TiC look like in practice?*; *What does TiC* not *look like in practice*?*; Positive impact of implementing TiC; Challenges of implementing TiC*; *Future recommendations for what TiC should look like in practice*; and *Future recommendations for TiC research*. The definitions of TiC provided by the eleven studies differed in quantity and quality, indicating a lack of clarity, and understanding. It was also difficult to decipher how TiC may translate differently into the secure inpatient environment. Only two studies provided examples of what TiC looks like in practice (Owens, 2021; Stamatopoulou, 2019). Whilst these were generally in-line with a true trauma-informed approach (e.g., patients feeling physically and emotionally safe through relationships with staff and a sense of belonging via peer relationships), details were left slightly vague. That said, one study (Owens, 2011) did offer a handful of more concrete and practical suggestions regarding what TiC does *not* look like in practice. These were accompanied by explanations as to *why* certain practices can be unhelpful or harmful. For instance, staff making assumptions about patients' best interests, which led to patients feeling invalidated and infantilised. A single study (Stamatopoulou, 2019) offered an evaluation of TiC from the perspective of staff. This was presented as the challenges and potential benefits of transitioning to a TiC pilot scheme. Although these findings formed a minority of the review, they made a refreshing and valued contribution. The challenges were framed with reference to systemic barriers, such as conflict and tension with the medical model, lack of resources, and concerns around sustainability. Potential benefits included staff unpicking and unlearning negative, unhelpful, and arguably harmful attitudes, and ways of working. Again,

---

[1] (i) to determine how TiC has been defined within the literature base; (ii) to identify the specific components of TiC that have been operationalised and/or implemented; (iii) to identify any evaluations of TiC, including both the potential and/or actual impact of implementation; and (iv) to identify future recommendations regarding TiC for both practice and research.

this referred to dominance of the medical model (i.e., looking beyond the lens of diagnostic criteria), as well as over-reliance on restrictive practice, and normalisation of staff burnout.

A large proportion of the findings that made explicit reference to TiC related to future recommendations for TiC practice. The first and most prominent three sub-themes here (*Impact of Trauma*, *Importance of staff-Patient Relationships*, *and Staff Training*) were the most relevant and compatible with a trauma-informed approach. For instance, better recognition and understanding of the long-term impact of trauma; the importance of staff-patient relationships; and staff training to increase knowledge regarding trauma responses that extend beyond the diagnostic criteria for Post-Traumatic Stress Disorder (PTSD). At the same time, some of the sub-themes were largely incompatible with a trauma-informed approach (*Trauma History Assessments*, *Trauma-Based Diagnoses*, *Psychological Treatment*). For instance, there were recommendations for specific types of psychological treatment (i.e., TF-CBT, EMDR, CFT, DBT, schema therapy), which fall under the domain of being trauma-*specific*. By comparison, future recommendations relating to research were more demonstrative of TiC, albeit slightly brief. A small number of studies produced particularly apt recommendations, such as operationalising what it means for a service to be "trauma-informed" and exploring staff attitudes as potential barriers to the implementation of TiC. Some endorsed longitudinal evaluations of TiC. This seemed like an ambitious recommendation, considering the results of this review found that the academic field is in its infancy and still needs to reach a consensus on what TiC could, should, or does look like within secure inpatient services. However, the work of the Women's Mental Health Taskforce[2] (Department of Health and Social Care, 2018) – which was referenced throughout the Discussion section of Chapter Three - painted a different, and potentially more encouraging picture. They profess to have "secured commitments" from a number of "important organisations" (p. 43) (e.g., NHS England, Public Health England, Care Quality Commission, NHS Improvement, Health Education England) to push for trauma-informed change across all mental health, criminal justice, and social care services; some of which are specific to the provision of women's secure inpatient services. This would suggest that there are, in fact, opportunities for future research to explore the implementation and longer-term evaluation of TiC. Thus, an additional finding of this review was that there may be some

---

[2] Explored further within Implications for Practice and Research (p. 171).

discrepancy between the state of the academic literature and the practical field of TiC within secure inpatient services.

Findings that made implicit reference to TiC - those that met the fifth specific aim of this review[3] - were represented within the key themes: *Trauma Histories*, *Beyond Trauma "Symptoms"*, *Protective Factors*, *Psychiatric Diagnoses*, *Trauma and Other Variables*, and *Limitations of Trauma Research*. In other words, these were key concepts that the author/s of the studies found and/or discussed that led them to conclude that TiC is important. Some of these findings were representative of a true trauma-informed approach. For instance, a small section looked beyond psychiatric diagnoses and symptoms; instead, detailing and emphasising the individualised nature of trauma responses and coping strategies, alongside the various functions that they may serve. However, a large majority of these findings focused on proving the high prevalence of trauma histories, generating "ACE scores", and linking these to psychiatric diagnoses (i.e., personality disorders, schizophrenia-spectrum disorders). The picture presented insinuated that the "answer" to being more trauma-informed lies in diagnosing more of the secure inpatient population with PTSD. It has been suggested that this represents linearity or simplicity of thought (Willmot & Jones, 2022); arguably very much still in-keeping with the medical model (i.e., what's *wrong* with you?). Similarly, there was little acknowledgement or further discussion of gender and race-related differences in how people experience and respond to trauma. This suggests that the academic discourse surrounding use of the term TiC within secure inpatient services could benefit from a higher level of curiosity and critical thinking.

Taken together, the results of Chapter Three indicated that the literature relating to TiC is perhaps underdeveloped and has been misrepresented by some in the academic field. This is in stark contrast to participants' progressive narratives presented in Chapter Two. On this basis, it is somewhat ironic - and disappointing - that only one study within the review (Cartwright, 2022) referred to the importance of patient involvement.

---

[3] (v) to identify any additional and relevant key findings or discussion points that provide deeper insights into the discourse surrounding use of the term TiC.

Chapter Four

Chapter Four presented a critique of the Working Alliance Inventory – Short Revised (WAI-SR; Hatcher & Gillasby, 2006). The chapter provided discussion regarding the ability of the inventory to measure the quality of patient-staff relationships within secure inpatient services. Taking into consideration that care is provided by multiple professionals, thought was given to measurement of the alliance at both the individual (i.e., therapist, psychiatrist, key nurse) and collective (i.e., multi-disciplinary team, nurses, health care assistants, all staff on the ward) level. It seemed apt to continue the focus on relational aspects of care, as this had been a running theme throughout both reviews documented within preceding chapters.

A historical overview of the alliance was provided, which revealed a large and complex literature base. Its definition has been attempted by several different theorists, with over 70 different tools in existence. The Working Alliance (Bordin, 1979) was found to be the most popular and influential theory, and the WAI-SR was found to be the most widely researched and up to date tool (Horvath, 2018). A closer look was then taken into the so-called "involuntary treatment" literature; the domain under which secure inpatient services reside. It was disappointing to discover that the theoretical application and measurement of the alliance has, generally speaking, been neglected here (Sturm et al., 2022). Having said that, two notable, albiet provisional, theoretical developments were found to have occurred. These have attempted to capture the unique and complex challenges that involuntary settings pose to the development and maintenance of alliances, beyond those that may be encountered within more conventional or voluntary settings (Ross et al., 2008). The first was the Revised Theory of the Therapeutic Alliance (RTTA) (Ross et al., 2008), which is specific to working with people who have offended in criminal justice settings. The second was the Institutional Therapeutic Alliance (ITA) (Pulido, 2011), which is specific to inpatient settings. The former offered a detailed and "sketched out" visual framework centred upon the alliance, that placed emphasis on the inclusion of additional factors exclusive to involuntary contexts (e.g., setting and contextual factors, system factors, immediate therapy context, role conflict and confusion; programme factors, and group treatment settings) (Ross et al., 2008, p. 476). The latter was merely a descriptive extension of the alliance that encompassed two interactive relational levels: the alliance between patient and individual staff members; and the alliance between patient and the institution, with the multidisciplinary team as a collective whole. Both the RRTTA and the ITA borrowed Bordin's (1979) Working Alliance theory as their foundational framework. Although these theories offered an innovative and much needed advancement to the involuntary alliance literature, they remain unsubstantiated and, unfortunately, have not acted as the intended catalyst for sufficient progress with regards to the measurement of alliance within involuntary settings. The critique also managed to locate six involuntary alliance tools. One these was the Institutional Working Alliance Inventory (IWAI) (Pulido, 2011), designed for inpatient settings with multi-disciplinary teams. The other five were designed for probation or parole contexts. Unfortunately, all of these tools were either in the very early stages of development or have been subject to limited psychometric evaluation.

On this basis, it was unsurprising to find that no tool has been designed or validated for use within secure inpatient services (MacInnes et al., 2014). Nevertheless, nine studies were found to have employed alliance tools within these services. Six of these measured relationships between patients and individual staff members (i.e., therapist, psychiatrist, key nurse). The other three measured relationships between patients and multiple staff members (i.e., all staff on the ward, nurses). The findings of all nine studies were notable in that the quality of the alliance was found to have a strong and/or significant relationship with increased treatment motivation and engagement, and decreased distress and level of risk (i.e., number of aggressive and violent incidents). This offered an additional layer of quantitative support to participants' narratives in Chapter Two - confirming the critical role of relationships on the ward.

The critique investigated the level of measurement, reliability, validity, standardisation, and utility of the WAI-SR. Based on the evidence presented, it was concluded that the WAI-SR does not meet all of the required criteria for a *good* psychometric test (Kline, 2015). Notably, the items of the tool were created using statistical techniques only and have not been subject to content expert evaluation by prospective respondents. The critique could not, therefore, conclude that the WAI-SR contains all the necessary items to represent the concept it has been designed to measure; those that professionals and/or patients would deem to be important. From an empirical viewpoint, the WAI-SR was found to be somewhat limited by its theoretical underpinnings. To date, there is no concrete evidence that it is able to discriminate between its three distinct subscales (Goals, Tasks, Bond); instead capturing an elusive, single "global alliance" factor. The WAI-SR was not created using systematic methods. Rather, it was built upon a descriptive theory of the alliance that Bordin

(1979) created using his expert knowledge of the psychotherapy literature. Interestingly, Bordin noted that the WAI-SR was only intended to be a "source of guidance and inspiration" (p. 259). Paradoxically, looking beyond the empirical evidence and taking the entirety of the critique into account, the WAI-SR's theoretical "simplicity" also appeared to be a strength. Bordin's model was intentionally designed to be applied to *all* kinds of helping relationships. Its malleability to "any change situation" (Ross et al., 2008, p. 463) – both within and outside the context of traditional psychotherapy - is perhaps a key reason as to why it has been so influential within the field. Indeed, as noted in the paragraph above, the Working Alliance (1979) has been used as the foundation for two important, albeit provisional, developments within the involuntary alliance literature base (Pulido, 2011; Ross et al., 2008).

Overall, it was unfortunate to conclude that the WAI-SR, in its current form and as a stand-alone measure, would not be appropriate for use within secure inpatient settings. This applied to both individual (i.e., therapist, psychiatrist, key nurse) and collective (i.e., multi-disciplinary team, nurses, health care assistants, all staff on the ward) relationships. In consideration of the long-standing complexities and limitations of the alliance literature, a number of alternative recommendations were made. These were to ensure that services are able to measure, or at least pay closer attention to, the quality of all staff-patient relationships on the ward.

Implications for Practice and Research

The implications of this thesis are twofold. Firstly, it has highlighted the need to actively seek out, genuinely listen to, and meaningfully engage with the patient voice; to ensure that greater attention and evaluation is paid to the aspects of care that are important to the patients themselves. Secondly, it has evidenced the need for trauma-informed, relational- and recovery-focused research and practiceThese shall now be discussed in turn[4].

All professionals working within secure inpatient services would benefit from reading participant narratives presented in Chapter Two. This includes staff working closely with patients, as well senior service, policy, and commissioning decision makers. As well as

---

[4] Further details of recommendations specific to the main pieces of work have already been documented in Chapter's Two, Three and Four.

gaining a better understanding of what *does* and what *doesn't* work, the "simple" act of recognising and holding on to the humanity of patient experiences can, on its own, be a powerful tool in creating a ripple effect of systemic shifts towards the provision of more trauma-informed, relational- and recovery-focused care. Patients themselves could also benefit from this knowledge; after all, it is "about them". Learning of the experiences of other patients' is likely to normalise and validate their own. This can be a very powerful tool in fostering feelings of inclusion and a sense of togetherness. That said, communication of detailed qualitative findings poses various practical barriers. An alternative approach could be to present key findings, in terms of the aspects of care that are important to patients themselves, via staff training or groups on the ward co-designed and delivered with current or former patients. Providing aspects of importance may differ according to patient mix and service type, it is important that this is delivered in an interactive format to facilitate discussion and necessary amendments.

Moving forwards, services must – if not already doing so - make efforts to seek out, listen to and engage with the voices of patients on their own wards. Examples include patient-led service development forums (i.e., once a month). There should be opportunities for patients to fill in anonymous feedback forms as patients may feel uncomfortable, worried, or frightened of providing direct feedback to the people that make decisions about their care. A dedicated staff member or team of individuals should be tasked with overseeing and evaluating the implementation of such projects. Opportunity for a patient representative role would also be ideal. Indeed, both the Quality Network for Forensic Mental Health Services (QNFMHS) and NHS service specifications for low, medium, and high secure settings already recommend having a patient involvement strategy (NHS, 2021a; NHS, 2021b; NHS, 2021c; QNFMHS, 2021). Although no practical examples are offered, the guidance does state that patients must be represented and involved in "provider governance structures, policy-making and service development processes" (NHS, 2021a, p. 20). This is an important point, as the recommendations highlighted so far will require additional time and resources; a luxury that many professionals and services will not always have. Without the commitment and support of these entities, it is unlikely that any patient involvement strategies will reach full potential for meaningful and sustainable change.

It is, however, naïve to assume that some, if not many, services are not already implementing the above. The extra time and resources required to publicise this work is, as mentioned above, a luxury that many professionals and services will not always have. Perhaps then, an additional recommendation is for Research and Development (R&D) teams to adopt organisational responsibility for supporting, facilitating, and publicising research dedicated to patient involvement. Or, if not available, services could utilise links with local Universities. It would also be beneficial for the field to develop research policy or guidance specific to incorporating secure inpatient views or experience into the evidence-base. This, as mentioned within Chapter One of this thesis, does not currently exist (Völlm et al., 2017). With time, these changes could drive key stakeholders (i.e., NHS, QNFHMS) to consider wider recognition and publication of successful patient involvement strategies. Ultimately, ensuring that the aspects of care that are important to patients themselves are afforded greater attention and evaluation in both practice and the academic sphere.

On a similar note, considering the links found between participants narratives in Chapter Two and the newly developed patient-focused FORensic oUtcome Measure (FORUM) (Ryland et al., 2021), a logical recommendation is for future research to evaluate its meaningfulness to patients from other secure inpatient services, and its utility for integration into practice (i.e., every three to six months prior to Care Plan Approach [CPA] meetings). The FORUM holds great potential as an additional and complimentary outcomes measure alongside those with a clinical and risk focus. It is also a tool that could easily be incorporated into service specifications, policy and/or guidance documents.

Each of the main chapters demonstrated the importance of relational aspects of care. All services should measure, or at least pay closer attention to, the quality of all staff-patient relationships on the ward. As well as being important to patients, the insights and knowledge gained would be beneficial to staff in helping to manage and reduce levels of distress and risk on the ward. The WAI-SR could be used, but with caution and clinical judgement. For instance, including prompts and free-text boxes to encourage patient reflection or identification of specific examples. Amendments may need to be made to the wording of specific items. For instance, changing “my problem” to “my difficulties”, and “therapy” to “treatment” or “care”. Patients could also be asked to consider each item with respect to individual (i.e., therapist, psychiatrist, key nurse) and/or multiple staff members (i.e., multi-disciplinary team, nurses, health care assistants, all staff on the ward). Contents of the WAI-SR could also be used as a guide for services to develop their own patient feedback forms. Both approaches could be employed via therapeutic work, or as part of a formal outcome measurement process (i.e., prior to CPA meetings). Alternatively, services could utilise tools that indirectly measure the alliance, such as the Essen Climate Evaluation Schema (EssenCES) (Schalast et al., 2008), which has been validated for use within secure inpatient services (Robinson, 2018).

Regarding research, a recommendation in support of the alliance literature could be a "back to basics" approach. The early developments within the involuntary alliance domain present an ideal opportunity here. Both the RRTA (Ross et al., 2008) and the IWAI (Pulido et al., 2008) could be applied to a secure inpatient population for further testing and refinement. This could be combined with qualitative lived experience expertise and clinical expertise. Ultimately, the purpose of this work would be for the academic field to establish a deeper, more nuanced, and accurate understanding and measurement of the alliance within secure inpatient services. Although, considering long-standing complexities and limitations of the alliance literature, efforts may be best placed towards purely qualitative research focusing on patient views and experiences. Perhaps, capturing specific examples of helpful, unhelpful, and potentially harmful interactions with staff. This could address challenges of the wider relational security literature regarding definition and measurement.

A key recommendation from Chapter Three is for the academic field to develop a better understanding of TiC. A nuanced operational definition or framework acknowledging how it may translate differently into the secure inpatient environment would be instrumental in moving the field forwards. It would also help to highlight and address any discrepancies between academic and practical domains; to make sure any progress that *is* taking place in practice is in-line with a genuine trauma-informed approach. Ideally, this work would combine both lived and clinical experience using the Delphi method (Fink-Hafner et al., 2019), guided by SAMHSA (2014) and other influential authors in the field (i.e., Johnstone & Boyle, 2018; Triesman, 2021). Practical, concrete, and applicable examples of what is and what is *not* trauma-informed would be ideal; similar to those offered by Covington (2022) and the Women's Mental Health Taskforce (Department of Health and Social Care, 2018), referenced throughout the Discussion section of Chapter Three. This work could be developed into a practice guidance document to be used at an individual practitioner or whole service level. Wider implementation of TiC would open-up more opportunities for future research and service evaluation, in addition to the commitments that the Women's Mental Health Taskforce (Department of Health and Social Care, 2018) have already secured from the NHS to pilot a new trauma-informed model of secure inpatient services for women. It is hoped that evidence of its efficacy in improving the lives of those receiving and delivering secure inpatient services would set an expectation for TiC to become best practice. Additional support from commissioning services across *all* secure inpatient services (not just those specific to women) would catalyse progress. Although, this is perhaps an idealistic recommendation under the current economic and political climate. For now, the best chance of change is by taking a "bottom-up" approach.

In the meantime, there are more efficient ways for services to start the transition towards becoming more trauma-informed. Both Chapter's Two and Three made recommendations for service development and/or training programmes that focus on some of the more concrete and practical components of TiC. These included: restrictive practice; patient empowerment and co-production; staff wellbeing; and physical, procedural, and relational security. Naturally, this should, where possible, be planned, designed, and/or implemented in collaboration with patients. Patient examples or testimonies would add a stark but necessary "human" element that would undoubtedly aid the learning process for staff. Services may also wish to identify additional areas of focus based on, and therefore unique to, patients on their own wards.

Whilst essential starting points, the work outlined above is not, on its own, enough to create and sustain a cultural shift in thinking from "what is *wrong* with this person?" to "what has *happened* (or is *happening*) to this person?" (Butler et al., 2011). This shift requires staff to develop a deeper understanding as to *why* the potential changes they are being asked to make to their day-to-day practice are important. One of the ways in which this could be achieved is via a comprehensive TiC training programme. The Introduction section of Chapter Three offers an example of the types of content that could be included (i.e., *Key Assumptions and Principles of TiC*, *Definitions of "Trauma*", and *Misunderstandings of TiC*). The format of the training would need to be sufficient in length to allow for in-depth coverage and create space for interactive discussions; perhaps similar to the TiC pilot scheme implemented by one of the studies included in the review of Chapter Three (i.e., "a two-day development and training programme") (Stamatopoulou, 2019, p. 64). It also goes without saying that the training should be planned, designed, and delivered by practitioners with a genuine understanding of a true trauma-informed approach; as well as with the involvement of patients. The beginnings of systemic shifts could also be instigated in more indirect ways, via integration of the PTMF (Johnstone & Boyle, 2018). Examples for services to consider include PTMF informed therapeutic interventions (i.e., psychoeducational groups and individual collaborative psychological formulations), team formulations, and group reflective practice sessions.

It is already best practice for all patients to have an individualised care plan with a focus on personal recovery (NHS, 2021a). The findings of Chapter Two recommend the CHIME-Secure framework (CHIME-S) (Senneseth et al., 2022) as an additional source of guidance and inspiration for both patients and staff. The framework itself could be disseminated via psychoeducational material or interactive groups on the ward. It is envisaged this shared knowledge would offer patients confirmation and validation regarding their own personal recovery challenges. But also, fostering realistic hope for change and the future. Increased insights for staff could help them to work with and hold on to such hope, during times it may not be easy for patients to do so themselves. Evaluation of the CHIME-S could be a focus of future research. Chapter Two also found evidence to suggest that discharges from secure inpatient services are not always being planned and/or implemented according to best practice guidance and standards (NHS, 2021a; 2021b; 2021c; QNFMHS, 2021). Or, at the very least, that they are not meeting the needs of patients themselves. It therefore seems necessary to recommend that this is given more focused consideration. Services could facilitate quality improvement projects, and researchers could conduct qualitative research that focuses explicitly on patient views and experiences of the discharge process and life in the community. The insights and knowledge gained from this work would help to determine if discharges from secure inpatient services are being planned and/or implemented in a way that gives patients the best chance of building, and sustaining, a life in the community.

As mentioned in Chapter Three, systems are “strongly resistant to change” (DeCandia & Guarino, 2015, p. 19). Many of the proposed recommendations outlined above are built upon foundations of “empowerment, autonomy, identity and connectedness” (Tomlin & Jordan, 2021, p. 1). These are at odds with the deep-rooted dominance of the medical model, over-reliance on restrictive practice, and normalisation of staff burnout. Critics may say it is too “sympathetic” or “soft”; at odds with the toughness or punitiveness of risk management and public protection (Markham 2021b; Willmot & Jones, 2022).

However, as has hopefully been made clear throughout this thesis, the benefits – to patients, staff, and the wider public - far outweigh the risks. Impediments to progress are likely to include staff attitudes, feelings, and biases towards the sharing of power with patients. The double stigma of the forensic mental health patient (i.e., both “mad and bad”), alongside the diagnoses with which they are identified, is likely to intensify the salience of power differentials here (Happell et al., 2018; Markham, 2021a). This may also be particularly heightened if patients are perceived as likely to challenge existing clinical practices or dominant ideologies (Happell et al., 2018). Feelings of confusion, tension, and resistance are, to some extent, normal and expected. Staff should be provided with the space to identify and explore these feelings; to understand where they come from and the protective function that they are likely to serve. Ideally, within the containment of individual supervision or group reflective practise sessions.

Strengths and Limitations

This thesis has contributed to the literature by identifying and synthesising existing research that had captured the patient voice. Findings and further interpretations offered insights into the aspects of care that may be of most significance to patients themselves: relationships on the ward, trauma-informed care, and personal recovery. When the first two themes were compared with the wider, professionally led literature base, noticeable inconsistencies and gaps were revealed. These directed the focus of subsequent chapters and generated several recommendations to improve both research and practice. The third theme complimented the wider literature, confirming potential value of the CHIME-Secure (CHIME-S) framework (Senneseth et al., 2022). Thus, a key strength of this review is the way in which it has substantiated the value of patient voice.

The method of data extraction used within Chapter Two posed a great advantage in attempting to seek out as much of the authentic patient voice as possible. Findings were extracted using meta-aggregation, which sought to protect against any re-reinterpretation by the researcher. All individual findings were included within the Appendix, which increased transparency. It was reassuring to find that almost half (45%) of these were supported by direct participant quotes, which served to increase the credibility of interpretations made by other researchers from the included studies. The second review detailed in Chapter Three was significant in being the first to have captured studies focusing on TiC within secure inpatient services; achieved via an in-depth and comprehensive search strategy. Whilst results were generally disappointing, they established important foundations. The recommendations that start on page 151 have the potential to provoke transformative change; a paradigm shift towards more trauma-informed research and practice. Similar can be said for the psychometric critique in Chapter Four. The beginnings of this chapter provided a comprehensive overview of the alliance, including its measurement within secure inpatient setting. The latter has not been done before. Whilst the reliability and validity of WAI-SR is limited and does not seem appropriate for use as a stand-alone measure in secure inpatient settings, various avenues for future research and practise were proposed. Regardless of the direction taken, this would ensure more focused attention is paid to evaluating the quality and potential impact of relationships on the ward.

This thesis is not without its limitations, the most evident being the absence of the planned research project (see Covid-19 Impact Statement on page 2). This had been designed with patients and had planned to explore their experiences of the admission process to secure inpatient services. Without first-hand patient involvement, the researcher is aware that the impact of this thesis in promoting the value of the patient voice becomes somewhat diluted. It is acknowledged that the approach taken can be critiqued as a tokenistic "'box-ticking' exercise" (Beresford, 2007, p. 333) towards patient involvement. The researcher also recognises that they are in a position of privilege and power – being both a researcher and professional in the field - which will have impacted on how the data was interpreted and presented to the reader.

Overall Conclusions

Under the framework of traditional medically focused research hierarchies, the evidence-base for secure inpatient services has "predominantly been conducted from a clinical perspective, where evaluation methods and markers of what constitutes success are determined by care providers" (Tapp et al., 2013, p.1). The field has, historically, assigned little prominence to the patient voice. This approach has, paradoxically, proved to have limited or suboptimal efficacy when it comes to achieving what it set out to do: reduce risk (Markham 2021a; Markham, 2021b; Willmot & Jones, 2022).

The question posed at the beginning of this thesis was: “do patients within secure inpatient services have a voice?” (p. 24). The answer, in short, is both yes and no. The field has progressed in recent years, but there is still much more work to do. As Willmot and Jones (2022) put, “forensic psychology is currently due a paradigm shift” (p. 4). This thesis has highlighted the need to actively seek out, genuinely listen to, and meaningfully engage with the patient voice. It has also evidenced the need for trauma-informed, relational- and recovery-focused research and practice. It has made suggestions for the many ways in which this can be achieved, alongside recognition of the deep-rooted systemic and interpersonal barriers that must be addressed for the field to move forwards.

References

Asterisks mark references included for review within Chapter's Two (*) and Three (**) of this thesis.

Aboaja, A., Forsyth, B., Bates, H., & Wood, R. (2020). Involving service users to identify research priorities in a UK forensic mental health service. *BJPsych Bulletin*, 1–6. https://doi.org/10.1192/bjb.2020.131

Agnew-Davies, R., Stiles, W. B., Hardy, G. E., Barkham, M., & Shapiro, D. A. (1998). Alliance structure assessed by the Agnew Relationship Measure (ARM). *British Journal of Clinical Psychology*, *37*(2), 155-172. https://doi.org/10.1111/j.2044-8260.1998.tb01291.x

**Alexander, A. A., Welsh, E., & Glassmire, D. M. (2016). Underdiagnosing Posttraumatic Stress Disorder in a State Hospital. *Journal of Forensic Psychology Practice*, *16*(5), 448–459. https://doi.org/10.1080/15228932.2016.1234142

Alexander, L. B., & Luborsky, L. (1986). *The Penn Helping Alliance Scales.* In L. S. Greenberg & W. M. Pinsof (Eds.), Guilford clinical psychology and psychotherapy series. The psychotherapeutic process: A research handbook (pp. 325–366). Guilford Press.

Allen, J. G., Newsom, G. E., Gabbard, G. O., & Coyne, L. (1984). Scales to assess the therapeutic alliance from a psychoanalytic perspective. *Bulletin of the Menninger Clinic*, *48*(5), 383.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders Third Edition* (DSM-III).

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders Third Edition Revised* (DSM-III-R).

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders Fourth Edition* (DSM-IV).

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders Fourth Edition Text Revision* (DSM-IV-TR).

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders Fifth Edition* (DSM-V).

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders Fifth Edition Text Revision* (DSM-V-TR).

Andrews, D. A., & Bonta, J. (1995). *LSI-R: The Level of Service Inventory-Revised*. Multi-Health Systems.

Anthea Sutton. (2016). *Systematic Approaches to a Successful Literature Review.* Sage Publications.

Arrigo, B. A. (2001). Transcarceration: A Constitutive Ethnography of Mentally Ill "Offenders." *The Prison Journal*, *81*(2), 162–186. https://doi.org/10.1177/0032885501081002003

Atkins, S., Launiala, A., Kagaha, A., & Smith, H. (2012). Including mixed methods research in systematic reviews: Examples from qualitative syntheses in TB and malaria control. *BMC Medical Research Methodology*, *12*(1). https://doi.org/10.1186/1471-2288-12-62

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology*, *8*(1). https://doi.org/10.1186/1471-2288-8-21

Askew, L., Fisher, P., & Beazley, P. (2019). What are adult psychiatric inpatients' experience of seclusion: A systematic review of qualitative studies. *Journal of psychiatric and mental health nursing*, *26*(7-8), 274-285. https://doi.org/10.1111/jpm.12537

Bachelor, A. (1987). The Counseling Evaluation Inventory and the Counselor Rating Form: Their relationship to perceived improvement and to each other. *Psychological Reports*, *61*(2), 567-575. https://doi.org/10.2466/pr0.1987.61.2.567

*Baker, S. (2017). *Staff and service user experiences of forensic mental health services* [Doctoral Thesis, The University of Warwick]. http://wrap.warwick.ac.uk/90135/1/WRAP_Theses_Baker_2017.pdf

Banongo, E., Davies, J. & Godin, P. (2006). Engaging service users in the evaluation and development of forensic mental health care services: a peer reviewed report to the funders. *City University London.* https://core.ac.uk/download/pdf/76980191.pdf

Bar-Sela, G., Mitnik, I., & Lulav-Grinwald, D. (2015). Perceptions of the working alliance among medical staff and cancer patients. *Palliative and Supportive Care*, *14*(3), 199–203. https://doi.org/10.1017/s1478951515000759

Bar-Sela, G., Yochpaz, S., Gruber, R., Lulav-Grinwald, D., Mitnik, I., & Koren, D. (2016). The association between the strength of the working alliance and sharing concerns by advanced cancer patients: a pilot study. *Supportive Care in Cancer*, *24*(1), 319-325. https://doi.org/10.1007/s00520-015-2794-6

Barkham, M. (2004). Patterns of alliance development and the rupture-repair hypothesis: Are productive relationships U-shaped or V-shaped?. *Journal of Counseling Psychology*, *51*(1), 81. https://doi.org/10.1037/0022-0167.51.1.81

Barrett-Lennard, G. T. (1986). The Relationship Inventory now: Issues and advances in theory, method, and use. In L. S. Greenberg & W. M. Pinsof (Eds.), *The Psychotherapeutic process: A research handbook* (pp. 439-476). Guildford Press.

Barrett, P. (2007). Structural equation modelling: Adjudging model fit. *Personality and Individual differences*, *42*(5), 815-824. https://doi.org/10.1016/j.paid.2006.09.018

*Barsky, J. S., & West, A. G. (2007). Secure settings and the scope for recovery: service users' perspectives on a new tier of care. *Journal of Forensic Practice*, *9*(4), 5. https://doi.org/10.1108/14636646200700020

Becker-Blease, K. A. (2017). As the world becomes trauma–informed, work to do. *Journal of Trauma & Dissociation*, *18*(2), 131-138. https://doi.org/10.1080/15299732.2017.1253401

Behera, P., & Dash, M. (2021). Life after lower limb amputation: a meta-aggregative systemic review of the effect of amputation on amputees. *Journal of Disability Studies*, *7*(2), 90-96. http://pubs.iscience.in/journal/index.php/jds/article/viewFile/1203/782

Bellis, M. A., Lowey, H., Leckenby, N., Hughes, K., & Harrison, D. (2013). Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population. *Journal of Public Health*, *36*(1), 81–91. https://doi.org/10.1093/pubmed/fdt038

Bendall, S., Eastwood, O., Cox, G., Farrelly-Rosch, A., Nicoll, H., Peters, W., Bailey, A. P., McGorry, P. D., & Scanlan, F. (2020). A Systematic Review and Synthesis of Trauma-Informed Care Within Outpatient and Counseling Health Settings for Young People. *Child Maltreatment*, *26*(3), 107755952092746. https://doi.org/10.1177/1077559520927468

Bennett, A., & Hanna, P. (2021). Exploring the Experiences of Male Forensic Inpatients' Relationships with Staff within Low, Medium and High Security Mental Health Settings. *Issues in Mental Health Nursing*, 1–47. https://doi.org/10.1080/01612840.2021.1913683

Beresford, P., Nettle, M., & Perring, R. (2010). *Towards a social model of madness and distress: Exploring what service users say.* https://www.jrf.org.uk/sites/default/files/jrf/migrated/files/mental-health-service-models-full.pdf

Bergdahl, E. (2019). Is meta-synthesis turning rich descriptions into thin reductions? A criticism of meta-aggregation as a form of qualitative synthesis. *Nursing inquiry*, *26*(1), e12273. https://doi.org/10.1111/nin.12273

Bernstein, D. P., Fink, L., Handelsman, L., Foote, J., Lovejoy, M., Wenzel, K., Sapareto, E., & Ruggiero, J. (1995). "Initial reliability and validity of a new retrospective measure of child abuse and neglect': Reply." *The American Journal of Psychiatry*, *152*(10).

Bialystok, E., Kroll, J. F., Green, D. W., MacWhinney, B., & Craik, F. I. (2015). Publication bias and the validity of evidence: What's the connection?. *Psychological science, 26*(6), 944-946. https://doi.org/10.1177/0956797615573759

Boateng, G. O., Neilands, T. B., Frongillo, E. A., Melgar-Quiñonez, H. R., & Young, S. L. (2018). Best practices for developing and validating scales for health, social, and behavioral research: a primer. *Frontiers in public health*, *6*, 149. https://doi.org/10.3389/fpubh.2018.00149

**Bohle, A., & de Vogel, V. (2017). Gender Differences in Victimization and the Relation to Personality Disorders in Forensic Psychiatry. *Journal of Aggression, Maltreatment & Trauma*, *26*(4), 411–429. https://doi.org/10.1080/10926771.2017.1284170

Bond, T. G., Fox, C. M., & Lacey, H. (2007). *Applying the Rasch model: Fundamental measurement in the Human Sciences*. Routledge.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research & practice*, *16*(3), 252. http://clinica.ispa.pt/ficheiros/areas utilizador/user11/63._the_generalizability_of_the_psychoanalytic_concept_of_the_working_alliance.pdf

Bouman, Y. H., de Ruiter, C., & Schene, A. H. (2008). Quality of life of violent and sexual offenders in community-based forensic psychiatric treatment. *The Journal of Forensic Psychiatry & Psychology*, *19*(4), 484-501. https://doi.org/10.1080/14789940701877669

Brackenridge, I., & Morrissey, C. (2009). *Trauma and post traumatic stress disorder (ptsd) in a high secure forensic learning disability population: scoping of incidence, and assessment and treatment needs*. Unpublished report.

**Brackenridge, I., & Morrissey, C. (2010). Trauma and post-traumatic stress disorder (PTSD) in a high secure forensic learning disability population: future directions for practice. *Advances in Mental Health and Intellectual Disabilities*, *4*(3), 49–56. https://doi.org/10.5042/amhid.2010.0544

Braun, V., & Clarke, V. (2006). Using Thematic Analysis in Psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: A Practical Guide for Beginners*. Sage. https://www.sagepub.com/sites/default/files/upm-binaries/54402_Braun_&_Clarke_ch1.pdf

Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. *Qualitative Research in Sport, Exercise and Health*, *11*(4), 589–597. https://doi.org/10.1080/2159676x.2019.1628806

Braun, V., & Clarke, V. (2022). Toward Good Practice in Thematic analysis: Avoiding Common Problems and be(com)ing a *knowing* Researcher. *International Journal of Transgender Health*, *24*(1), 1–6. https://doi.org/10.1080/26895269.2022.2129597

Bressington, D., Stewart, B., Beer, D., & MacInnes, D. (2011). Levels of service user satisfaction in secure settings–A survey of the association between perceived social climate, perceived therapeutic relationship and satisfaction with forensic services. *International journal of nursing studies*, *48*(11), 1349-1356. https://doi.org/10.1016/j.ijnurstu.2011.05.011

Brodey, B. B., Claypoole, K. H., Motto, J., Arias, R. G., & Goss, R. (2000). Satisfaction of Forensic Psychiatric Patients With Remote Telepsychiatric Evaluation. *Psychiatric Services*, *51*(10), 1305–1307. https://doi.org/10.1176/appi.ps.51.10.1305

Brown, D., Igoumenou, A., Mortlock, A., Gupta, N., & Das, M. (2017). Work-related stress in forensic mental health professionals: a systematic review. *The Journal of Forensic Practice*, *19*(3), 227–238. https://doi.org/10.1108/jfp-05-2016-0024

Butler, L. D., Critelli, F. M., & Rinfrette, E. S. (2011). Trauma-informed care and mental health. *Directions in Psychiatry, 31*(3), 197-212. https://www.researchgate.net/profile/Lisa-Butler-5/publication/234155324_Trauma-Informed_Care_and_Mental_Health/links/02bfe50f9b4cbb8051000000/Trauma-Informed-Care-and-Mental-Health.pdf

Byrt, R., & Reece, J. (1999). Patients' perspectives of self-harm in a medium secure unit. *Mental Health Practice*, *3*(3).

Callard, F., & Rose, D. (2012). The mental health strategy for Europe: Why service user leadership in research is indispensable. *Journal of Mental Health, 21*(3), 219-226. https://doi.org/10.3109/09638237.2011.651661

Campbell, P. (2005). From little acorns. The mental health service user movement. In *Beyond the Water Towers: The Unfinished Revolution in Mental Health Services* 1985-2005 (pp. 73-83). Sainsbury Centre for Mental Health.

Cangur, S., & Ercan, I. (2015). Comparison of model fit indices used in structural equation modeling under multivariate normality. *Journal of Modern Applied Statistical Methods*, *14*(1), 14. https://doi.org/10.22237/jmasm/1430453580

Carlin, P., Gudjonsson, G., & Yates, M. (2005). Patient satisfaction with services in medium secure units. *Journal of Forensic Psychiatry & Psychology, 16*(4), 714-728. https://doi.org/10.1080/14789940500328245

**Cartwright, J. (2020). *Forensic service users' experiences of adversity and psychological interventions in secure care* [Doctoral Thesis, Cardiff University]. https://orca.cardiff.ac.uk/id/eprint/134530/1/2020CartwrightDClinPsy.pdf

Cartwright, J., Lawrence, D., & Hartwright, C. (2022). Improving psychological interventions from the perspective of forensic mental health service users: a Meta-synthesis. *Journal of Forensic Psychology Research and Practice, 22*(2), 113-141. https://doi.org/10.1080/24732850.2021.1945838

Casey, S., Day, A., Howells, K., & Ward, T. (2007). Assessing suitability for offender rehabilitation: Development and validation of the Treatment Readiness Questionnaire. *Criminal justice and behavior*, *34*(11), 1427-1440. https://doi.org/10.1177/0093854807305827

Cattell, R. B. (1957). *Personality and Motivation Structure and Measurement*. World Book Company.

Cattell, R. B., & Kline, P. E. (1977). *The scientific analysis of personality and motivation*. Academic Press.

Centre for Mental Health. (2011). *Pathways to Unlocking Secure Mental Health Care.* https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/Pathways_to_unlocking_secure_mental_health_care.pdf

Centre for Mental Health. (2021). *Secure mental health services.* https://www.centreformentalhealth.org.uk/secure-mental-health-services

Chester, V., & Morgan, W. (2012). Relational security within secure services: summary of findings from a literature review. *Quality Network for Forensic Mental Health Services Newsletter*, 10-4.

Chester, V., Alexander, R. T., & Morgan, W. (2017). Measuring relational security in forensic mental health services. *BJPsych Bulletin*, *41*(6), 358–363. https://doi.org/10.1192/pb.bp.116.055509

Clark, L. A. (1993). *SNAP (schedule for nonadaptive and adaptive personality). Manual for administration, scoring and interpretation*. University of Minnesota Press.

Clarke, C., Lumbard, D., Sambrook, S., & Kerr, K. (2016). What does recovery mean to a forensic mental health patient? A systematic review and narrative synthesis of the qualitative literature. *The Journal of Forensic Psychiatry & Psychology, 27*(1), 38-54. https://doi.org/10.1080/14789949.2015.1102311

Clercx, M., de Vogel, V., Lancel, M. and Keulen-de Vos, M. (2021). The influence of therapy alliance and treatment motivation in patients with Cluster B personality disorders on incidents in forensic hospitals. *The Journal of Forensic Practice*, 23(3), pp.272–284. https://doi.org/10.1108/jfp-05-2021-0022.

Coaley, K. (2010). *An introduction to psychological assessment and psychometrics*. Sage.

Coffey, M. (2006). Researching service user views in forensic mental health: A literature review. *The Journal of Forensic Psychiatry & Psychology*, *17*(1), 73-107. https://doi.org/10.1080/14789940500431544

Collins, P., & Crowe, S. (2016). Research, recovery and mental health: Challenges and opportunities. *Mental Health and Social Inclusion, 20*(3), 174-179. https://doi.org/10.1108/MHSI-02-2

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: the SPIDER tool for qualitative evidence synthesis. *Qualitative health research*, *22*(10), 1435-1443. https://doi.org/10.1177/1049732312452938

Corden, A. (2007). *Using verbatim quotations in reporting qualitative social research: A review of selected publications.* University of York. https://www.york.ac.uk/inst/spru/pubs/pdf/verbpubs.pdf

Covington, S. (2022). Creating a Trauma-Informed Justice System for Women. In *The Wiley Handbook on What Works with Girls and Women in Conflict with the Law: A Critical Review of Theory, Practice, and Policy*. John Wiley & Sons. https://doi.org/10.1002/9781119874898.ch12

Crandall, A., Miller, J. R., Cheung, A., Novilla, L. K., Glade, R., Novilla, M. L. B., Magnusson, B. M., Leavitt, B. L., Barnes, M. D., & Hanson, C. L. (2019). ACEs and counter-ACEs: How positive and negative childhood experiences influence adult health. *Child Abuse & Neglect*, *96*(96), 104089. https://doi.org/10.1016/j.chiabu.2019.104089

Critical Appraisal Skills Programme. (2020). *The CASP Qualitative Checklist.* https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Cronbach, L. J. (1984). A research worker's treasure chest. *Multivariate behavioral research*, *19*(2-3), 223-240. https://doi.org/10.1080/00273171.1984.9676925

Crossley, M. L., & Crossley, N. (2001). Patient voices, social movements and the habitus; how psychiatric survivors speak out. *Social Science & Medicine, 52*(10), 1477-1489. https://doi.org/10.1016/S0277-9536(00)00257-4

Dawes, M., Summerskill, W., Glasziou, P., Cartabellotta, A., Martin, J., Hopayian, K., Porzsolt, F., Burls, A., & Osborne, J. (2005). Sicily statement on evidence-based practice. *BMC medical education, 5*(1), 1. https://doi.org/10.1186/1472-6920-5-1

De Pau, M., Nicaise, P., Bourmorck, D., Vanderplasschen, W., & Vander Laenen, F. (2021). Organizing Forensic Mental Health Care Delivery: Putting the Trinitarian Model of Therapeutic Security to the Test. *International Journal of Forensic Mental Health*, *20*(3), 291–302. https://doi.org/10.1080/14999013.2021.1876795

de Vogel, V., Stam, J., Bouman, Y. H. A., Ter Horst, P., & Lancel, M. (2015). Violent women: a multicentre study into gender differences in forensic psychiatric patients. *The Journal of Forensic Psychiatry & Psychology*, *27*(2), 145–168. https://doi.org/10.1080/14789949.2015.1102312

DeCandia, C., & Guarino, K. (2020). Trauma-Informed Care: An Ecological Response. *Journal of Child and Youth Care Work*, *25*, 7–32. https://doi.org/10.5195/jcycw.2015.69

Dell, S., & Grounds, A. (1998). *The Discharge and Supervision of Restricted Patients: Report to the Home Office*. University of Cambridge, Institute of Criminology.

Department of Health (2005). *Research Governance Framework for Health and Social Care.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/139565/dh_4122427.pdf

Department of Health and Social Care. (2018). *The Women's Mental Health Taskforce: Final report*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/765821/The_Womens_Mental_Health_Taskforce_-_final_report1.pdf

DeSorcy, D. R., Olver, M. E., & Wormith, J. S. (2020). Working alliance and psychopathy: Linkages to treatment outcome in a sample of treated sexual offenders. *Journal of interpersonal violence*, *35*(7-8), 1739-1760. https://doi.org/10.1177/0886260517698822

DeVon, H. A., Block, M. E., Moyle-Wright, P., Ernst, D. M., Hayden, S. J., Lazzara, D. J., Savoy, S. M., & Kostas-Polston, E. (2007). A psychometric toolbox for testing validity and reliability. *Journal of Nursing scholarship*, *39*(2), 155-164. https://doi.org/10.1111/j.1547-5069.2007.00161.x

DiGiuseppe, R., Linscott, J., & Jilton, R. (1996). Developing the therapeutic alliance in child—adolescent psychotherapy. *Applied and Preventive Psychology*, *5*(2), 85-100. https://doi.org/10.1016/S0962-1849(96)80002-3

Dixon-Woods, M., Agarwal, S., Jones, D., Young, B., & Sutton, A. (2005). Synthesising qualitative and quantitative evidence: a review of possible methods. *Journal of health services research & policy*, *10*(1), 45-53. https://doi.org/10.1177/135581960501000110

Dixon, J. (2012). Mentally disordered offenders' views of 'their' risk assessment and management plans: Perceptions of health risks. *Health, risk & society*, *14*(7-8), 667-680. https://doi.org/10.1080/13698575.2012.720965

Donnelly, V., Lynch, A., Devlin, C., Naughten, L., Gibbons, O., Mohan, D., & Kennedy, H. G. (2011). Therapeutic alliance in forensic mental health: coercion, consent and recovery. *Irish Journal of Psychological Medicine*, *28*(1), 21-28. https://doi.org/10.1017/S0790966700011861

Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). *HCR-20V3: Assessing risk of violence – User guide*. Burnaby, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University.

Downes, M. J., Brennan, M. L., Williams, H. C., & Dean, R. S. (2016). Development of a critical appraisal tool to assess the quality of cross-sectional studies (AXIS). *BMJ Open*, *6*(12), e011458. https://doi.org/10.1136/bmjopen-2016-011458

Doyle, P., Quayle, E., & Newman, E. (2017). Social climate in forensic mental health settings: A systematic review of qualitative studies. *Aggression and violent behavior*, *36*, 118-136. https://doi.org/10.1016/j.avb.2017.06.008

Drennan, G., & Alred, D. (2012). *Secure recovery : approaches to recovery in forensic mental health settings*. Routledge.

Drieschner, K.H. and Boomsma, A. (2008). The Treatment Motivation Scales for Forensic Outpatient Treatment (TMS-F). *Assessment*, 15(2), pp.224–241. https://doi.org/10.1177/1073191107311650.

Driessen, E., Hollon, S., Bockting, C., Cuijpers, P., & Turner, E. (2015). Does Publication Bias Inflate the Apparent Efficacy of Psychological Treatment for Major Depressive Disorder? A Systematic Review and Meta-Analysis of US National Institutes of Health-Funded Trials. *PloS One, 10*(9). https://doi.org/https://doi.org/10.1371/journal.pone.0137864

Drisko, J. (2013). The Common Factors Model: Its Place in Clinical Practice and Research. *Smith College Studies in Social Work*, *83*(4), 398–413. https://doi.org/10.1080/00377317.2013.833435

Dundar, Y., & Fleeman, N. (2014). Developing my search strategy and applying inclusion criteria. In A. Boland, G. Cherry, & R. Dickson (Eds.), *Doing a systematic review: a student's guide*. SAGE.

Edworthy, R., Sampson, S., & Völlm, B. (2016). Inpatient forensic-psychiatric care: legal frameworks and service provision in three European countries. *International journal of law and psychiatry, 47*, 18-27. https://doi.org/10.1016/j.ijlp.2016.02.027

Elkins, D.N. (2019). Common Factors: What Are They and What Do They Mean for Humanistic Psychology? Journal of Humanistic Psychology, 62(1). https://doi.org/10.1177/0022167819858533

Elliott, D. E., Bjelajac, P., Fallot, R. D., Markoff, L. S., & Reed, B. G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of community psychology*, *33*(4), 461-477. https://doi.org/10.1002/jcop.20063

Elvins, R., & Green, J. (2008). The conceptualization and measurement of therapeutic alliance: An empirical review. *Clinical psychology review*, *28*(7), 1167-1187. https://doi.org/10.1016/j.cpr.2008.04.002

Elwyn, L. J., Esaki, N., & Smith, C. A. (2015). Safety at a girls secure juvenile justice facility. *Therapeutic Communities: The International Journal of Therapeutic Communities*, *36*(4), 209–218. https://doi.org/10.1108/tc-11-2014-0038

Elwyn, L. J., Esaki, N., & Smith, C. A. (2016). Importance of Leadership and Employee Engagement in Trauma-Informed Organizational Change at a Girls' Juvenile Justice Facility. *Human Service Organizations: Management, Leadership & Governance*, *41*(2), 106–118. https://doi.org/10.1080/23303131.2016.1200506

Embretson, S. E., & Reise, S. P. (2013). *Item Response Theory for Psychologists*. Taylor and Francis.

Engel, G. L. (1977). The need for a new medical model: a challenge for biomedicine. *Science*, *196*(4286), 129-136. https://doi.org/10.1126/science.84746

Estrada, A., & Russell, R. (1999). The development of the child psychotherapy process scales (CPPS). *Psychotherapy research*, *9*(2), 154-166. https://doi.org/10.1080/10503309912331332661

Falkenström, F., Hatcher, R. L., & Holmqvist, R. (2015). Confirmatory factor analysis of the patient version of the Working Alliance Inventory–Short Form Revised. *Assessment*, *22*(5), 581-593. https://doi.org/10.1177/1073191114552472

Fallot, R., & Harris, M. (2009). Creating cultures of trauma-informed care (CCTIC): A self-assessment and planning protocol. *Community Connections*. https://doi.org/10.13140/2.1.4843.6002

Faulkner, A. (2017). Survivor research and Mad Studies: the role and value of experiential knowledge in mental health research. *Disability & Society, 32*(4), 500-520. https://doi.org/10.1080/09687599.2017.1302320

Fazel, S., Fimińska, Z., Cocks, C., & Coid, J. (2016). Patient outcomes following discharge from secure psychiatric hospitals: systematic review and meta-analysis. *The British Journal of Psychiatry, 208*(1), 17-25. https://doi.org/10.1192/bjp.bp.114.149997

Felitti, V. J., Anda, R. F., Nordenberg, D., & Williamson, D. F. (1998). Adverse childhood experiences and health outcomes in adults: The Ace study. *Journal of Family and Consumer Sciences*, *90*(3), 31.

Filson, B. (2011). Is anyone really listening?. *National Council Magazine,* Special Issue: Breaking the Silence: Trauma-informed Behavioral Healthcare, p.5. https://www.pacesconnection.com/fileSendAction/fcType/0/fcOid/421123326088380637/filePointer/421264063590218713/fodoid/421264063590218709/NC-Mag-Trauma-Web-Email.pdf

Fink-Hafner, D., Dagen, T., Doušak, M., Novak, M., & Hafner-Fink, M. (2019). Delphi method. *Advances in Methodology and Statistics*, *16*(2). https://doi.org/10.51936/fcfm6982

Fletcher R, Loschen E, Stravrakaki C & First M (2007) *Diagnostic Manual: Intellectual disability (DM-ID). A textbook of diagnosis of mental disorders in persons with intellectual disability*. NADD Press.

Florsheim, P., Shotorbani, S., Guest-Warnick, G., Barratt, T., & Hwang, W. C. (2000). Role of the working alliance in the treatment of delinquent boys in community-based programs. *Journal of clinical child psychology*, *29*(1), 94-107. https://doi.org/10.1207/S15374424jccp2901_10

Flückiger, C., Del Re, A. C., Wampold, B. E., & Horvath, A. O. (2018). The alliance in adult psychotherapy: A meta-analytic synthesis. *Psychotherapy*, 55(4), 316-340. http://dx.doi.org/10.1037/pst0000172

Foa, E. B., Cashman, L., Jaycox, L., & Perry, K. (1997). The validation of a self-report measure of posttraumatic stress disorder: The Posttraumatic Diagnostic Scale. *Psychological Assessment*, *9*(4), 445–451. https://doi.org/10.1037/1040-3590.9.4.445

Ford, K., Sweeney, J., & Farrington, A. (1999). User views of a regional secure unit--findings from a patient satisfaction survey. *The International Journal of Psychiatric Nursing Research*, *5*(1), 526-541.

**Fosse, R., Eidhammer, G., Selmer, L. E., Knutzen, M., & Bjørkly, S. (2021). Strong Associations Between Childhood Victimization and Community Violence in Male Forensic Mental Health Patients. *Frontiers in Psychiatry*, *11*. https://doi.org/10.3389/fpsyt.2020.628734

Fosse, R., Skjelstad, D. V., Schalinski, I., Thekkumthala, D., Elbert, T., Aanondsen, C. M., Greger, H. K., & Jozefiak, T. (2020). Measuring childhood maltreatment: Psychometric properties of the Norwegian version of the Maltreatment and Abuse Chronology of Exposure (MACE) scale. *PLOS ONE*, *15*(2), e0229661. https://doi.org/10.1371/journal.pone.0229661

Frank, A. F., & Gunderson, J. G. (1990). The role of the therapeutic alliance in the treatment of schizophrenia: Relationship to course and outcome. *Archives of general psychiatry*, *47*(3), 228-236. https://doi.org/10.1001/archpsyc.1990.01810150028006

Frank, J. D., & Frank, J. (1991). *Persuasion and healing: a comparative study of psychotherapy*. Johns Hopkins University Press.

Frese III, F. J., Stanley, J., Kress, K., & Vogel-Scibilia, S. (2001). Integrating evidence-based practices and the recovery model. *Psychiatric services, 52*(11), 1462-1468. https://doi.org/10.1176/appi.ps.52.11.1462

Freud, S. (1912). The dynamics of transference. In *Complete Psychological Works*, Volume 12 (pp. 97-108). Hogarth Press.

Friedlander, M. L., Escudero, V., Horvath, A. O., Heatherington, L., Cabero, A., & Martens, M. P. (2006). System for observing family therapy alliances: A tool for research and practice. *Journal of Counseling Psychology*, *53*(2), 214. https://doi.org/10.1037/0022-0167.53.2.214

Gaab, S., Brazil, I. A., de Vries, M. G., & Bulten, B. H. (2020). The relationship between treatment alliance, social climate, and treatment readiness in long-term forensic psychiatric care: an explorative study. *International journal of offender therapy and comparative criminology*, *64*(9), 1013-1026. https://doi.org/10.1177/0306624X19899609

Gaston, L. (1991). Reliability and criterion-related validity of the California Psychotherapy Alliance Scales—patient version. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, *3*(1), 68. https://doi.org/10.1037/1040-3590.3.1.68

Gaston, L., & Marmar, C. (1994). The California psychotherapy alliance scales. In A. O.

Gerber, G. J., Prince, P. N., Duffy, S., McDougall, L., Cooper, J., & Dowler, S. (2003). Adjustment, Integration, and Quality of Life Among Forensic Patients Receiving Community Outreach Services. *International Journal of Forensic Mental Health*, *2*(2), 129–136. https://doi.org/10.1080/14999013.2003.10471184

Gillaspy, J. A. (1997). *The factor structure of the working alliance inventory: Confirmatory and exploratory factor analyses* [Doctoral Dissertation, Texas A & M University].

Glasby, J., & Beresford, P. (2006). Commentary and issues: Who knows best? Evidence-based practice and the service user contribution. *Critical Social Policy, 26*(1), 268-284. https://doi.org/10.1177/0261018306059775

Glorney, E., Raymont, S., Lawson, A., & Allen, J. (2019). Religion, spirituality and personal recovery among forensic patients. *Journal of Forensic Practice*, *21*(3), 190–200. https://doi.org/10.1108/jfp-05-2019-0021

Gochyyev, P. and Skeem, J.L. (2019). Efficiently assessing firm, fair, and caring relationships: Short form of the Dual Role Relationship Inventory. *Psychological Assessment*, 31(3), pp.352–364. https://doi.org/10.1037/pas0000672.

Gomes-Schwartz, B. (1978). Effective ingredients in psychotherapy: Prediction of outcome from process variables. *Journal of Consulting and Clinical Psychology*, *46*(5), 1023. https://doi.org/10.1037/0022-006X.46.5.1023

Gomory, T. (2013). The limits of evidence-based medicine and its application to mental health evidence-based practice: Part one. *Ethical Human Psychology and Psychiatry, 15*(1), 18-34. https://doi.org/10.1891/1559-4343.15.1.18

Goodwin, S. (1994). Getting the patient's perspective: self-assessment in a special setting. *Psychiatric Care*, *1*, 56-60.

Gorin, S. S. (1993). The prediction of child psychotherapy outcome: Factors specific to treatment. *Psychotherapy: Theory, Research, Practice, Training*, *30*(1), 152. https://doi.org/10.1037/0033-3204.30.1.152

Green, B. L. (1996). Trauma History Questionnaire. In *Measurement of stress, trauma, and adaptation* (pp. 366–369). Sidran Press.

Green, J., Kroll, L., Imre, D., Frances, F. M., Begum, K., Gannon, L., & Anson, R. (2001). Health gain and predictors of outcome in inpatient and day patient child psychiatry treatment. *Journal of the American Academy of Child and Adolescent Psychiatry*, *40*(3), 325-332. https://doi.org/10.1097/00004583-200103000-00012

Green, T., Batson, A., & Gudjonsson, G. (2011). The development and initial validation of a service-user led measure for recovery of mentally disordered offenders. *Journal of Forensic Psychiatry & Psychology*, *22*(2), 252-265. https://doi.org/10.1080/14789949.2010.541271

Greenacre, K., & Palmer, E. (2018). Exploring forensic environments: how do environmental factors influence individual outcomes for residents and staff? A systematic review. *Mental Health and Social Inclusion, 22*(4), 203-217. https://doi.org/10.1108/MHSI-06-2018-0020

Greenhalgh, T., & Heath, I. (2010). Measuring quality in the therapeutic relationship. https://www.kingsfund.org.uk/sites/default/files/Therapeutic_Practice.pdf

Greenson, R. R. (1965). The working alliance and the transference neurosis. *The Psychoanalytic Quarterly*, *34*(2), 155-181. https://doi.org/10.1002/j.2167-4086.2008.tb00334.x

Groot, B., Haveman, A., & Abma, T. (2020). Relational, ethically sound co-production in mental health care research: epistemic injustice and the need for an ethics of care. *Critical Public Health*, 1–11. https://doi.org/10.1080/09581596.2020.1770694

Gudjonsson, G. H., Young, S., & Yates, M. (2007). Motivating mentally disordered offenders to change: instruments for measuring patients' perception and motivation. *The Journal of Forensic Psychiatry & Psychology*, *18*(1), 74-89. https://doi.org/10.1080/14789940601063261

Hall, M. A., Zheng, B., Dugan, E., Camacho, F., Kidd, K. E., Mishra, A., & Balkrishnan, R. (2002). Measuring patients' trust in their primary care providers. *Medical care research and review*, *59*(3), 293-318. https://doi.org/10.1177/1077558702059003004

Hamilton, J. R. (1980). The development of Broadmoor 1863–1980. *Bulletin of the Royal College of Psychiatrists, 4*(9), 130-133. https://doi.org/10.1192/S0140078900014127

Hannes, K., & Lockwood, C. (2011). *Synthesizing qualitative research: choosing the right approach.* John Wiley & Sons.

Hannes, K., Petry, K., & Heyvaert, M. (2017). The meta-aggregative approach to qualitative evidence synthesis: a worked example on experiences of pupils with special educational needs in inclusive education. *International Journal of Research & Method in Education*, *41*(3), 291–305. https://doi.org/10.1080/1743727x.2017.1299124

Hannes, K., & Pearson, A. (2011). Obstacles to the implementation of evidence based practice in Belgium: a worked example of meta-aggregation. In *Synthesizing qualitative research: choosing the right approach* (pp. 21–41). Wiley Blackwell. https://doi.org/10.1002/9781119959847.ch2

Happell, B., Scholz, B., Gordon, S., Bocking, J., Ellis, P., Roper, C., Liggins, J., & Platania-Phung, C. (2018). "I don't think we've quite got there yet": The experience of allyship for mental health consumer researchers. *Journal of psychiatric and mental health nursing, 25*(8), 453-462. https://doi.org/10.1111/jpm.12476

Harding, D. (2004). *Writing the City: Urban Visions and Literary Modernism*. Routledge.

Hare Duke, L., Furtado, V., Guo, B., & Völlm, B. A. (2018). Long-stay in forensic-psychiatric care in the UK. *Social psychiatry and psychiatric epidemiology, 53*(3), 313-321. https://doi.org/10.1007/s00127-017-1473-y

Hare, R. D. (1991). *The Hare psychopathy checklist-revised: manual*. Multi-Health Systems.

Hare, R. D. (2003). *The Hare Psychopathy Checklist—Revised* (2nd Ed.). Multi-Health Systems.

Harris, M., & Fallot, R. D. (2001). Envisioning a trauma-informed service system: A vital paradigm shift. *New Directions for Mental Health Services*, *2001*(89), 3–22. https://doi.org/10.1002/yd.23320018903

Harrison, R., Jones, B., Gardener, P., & Lawton, R. (2021). Quality assessment with diverse studies (QuADS): an appraisal tool for methodological and reporting quality in systematic reviews of mixed- or multi-method studies. *BMC Health Services Research*, *21*(1). https://doi.org/10.1186/s12913-021-06122-y

Hartley, D. E., & Strupp, H. H. (1983). The therapeutic alliance: Its relationship to outcome in brief psychotherapy. *Empirical studies of psychoanalytic theories*, *1*, 1-37.

Hartsock, N. C. M. (1987). The feminist standpoint: Developing the ground for a specifically feminist historical materialism. In S. Harding, *Feminism and methodology* (pp. 157–180). Indiana University Press.

Hatcher, R. L., & Barends, A. W. (1996). Patients' view of the alliance in psychotherapy: Exploratory factor analysis of three alliance measures. *Journal of Consulting and Clinical Psychology*, *64*(6), 1326. https://doi.org/10.1037/0022-006X.64.6.1326

Hatcher, R. L., & Gillaspy, J. A. (2006). Development and validation of a revised short version of the Working Alliance Inventory. *Psychotherapy research, 16*(1), 12-25. https://doi.org/10.1080/10503300500352500

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, *5*(3), 377–391. https://doi.org/10.1002/jts.2490050305

Hinsby, K., & Baker, M. (2004). Patient and nurse accounts of violent incidents in a Medium Secure Unit. *Journal of Psychiatric and Mental Health Nursing*, *11*(3), 341–347. https://doi.org/10.1111/j.1365-2850.2004.00736.x

Holley J., & Weaver T. (2019) The Experience of Long-Stay in Secure Psychiatric Hospitals in the UK: The Patient Perspective. In Völlm B., Braun P. (Eds.) *Long-Term Forensic Psychiatric Care*. Springer. https://doi.org/10.1007/978-3-030-12594-3_14

Hong, Q. N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M.-P., Griffiths, F., Nicolau, B., O'Cathain, A., Rousseau, M.-C., Vedel, I., & Pluye, P. (2018). The Mixed Methods Appraisal Tool (MMAT) version 2018 for information professionals and researchers. *Education for Information*, *34*(4), 285–291. https://doi.org/10.3233/efi-180221

Hörberg, U. (2018). 'The art of understanding in forensic psychiatric care'–From a caring science perspective based on a lifeworld approach. *Issues in mental health nursing, 39*(9), 802-809. https://doi.org/10.1080/01612840.2018.1496499

Horowitz, L. M., Strauß, B., & Kordy, H. (2000). *Inventar zur Erfassung interpersonaler Probleme (IIP-D): deutsche Version*. Beltz.

Horvath, A.O. (2011). Alliance in Common Factor Land: A view through the research lens. Research in Psychotherapy: Psychopathology, Process and Outcome, 14(1), p.121. https://doi.org/10.4081/ripppo.2011.45

Horvath, A. O. (2018). Research on the alliance: Knowledge in search of a theory. *Psychotherapy Research*, *28*(4), 499-516. https://doi.org/10.1080/10503307.2017.1373204

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of counseling psychology*, *36*(2), 223. https://doi.org/10.1037/0022-0167.36.2.223

Horvath, A. O. & L. S. Greenberg (1994). *The working alliance: Theory, research and practice.* John Wiley & Sons.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of consulting and clinical psychology*, *61*(4), 561. https://doi.org/10.1037/0022-006X.61.4.561

Hougaard, E. (1994). The therapeutic alliance–A conceptual analysis. *Scandinavian Journal of Psychology*, *35*(1), 67-85. https://doi.org/10.1111/j.1467-9450.1994.tb00934.x

Howells, K., Tonkin, M., Milburn, C., Lewis, J., Draycot, S., Cordwell, J., Price, M., Davies, S., & Schalast, N. (2009). The EssenCES measure of social climate: A preliminary validation and normative data in UK high secure hospital settings. *Criminal Behaviour and Mental Health*, *19*(5), 308-320. https://doi.org/10.1002/cbm.745

Howitt, D., & Cramer, D. (2005). *Introduction to Research Methods in Psychology* (2nd Ed.). Pearson Education.

Hsieh, H.-F., & Shannon, S.E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277–1288. https://doi.org/10.1177/1049732305276687

Huckle, P. L. (1997). The use of patient satisfaction surveys in forensic psychiatric settings. *Psychiatric Care*, *4*, 230-234.

Humpries, K. (2022). *Experiences of secure patients within forensic settings* [Unpublished Doctoral Thesis, University of Southampton].

Hyland, P., Karatzias, T., Shevlin, M., McElroy, E., Ben-Ezra, M., Cloitre, M., & Brewin, C. R. (2020). Does requiring trauma exposure affect rates of ICD-11 PTSD and complex PTSD? Implications for DSM–5. *Psychological Trauma: Theory, Research, Practice, and Policy, 13*(2), 133. https://doi.org/10.1037/tra0000908

Isobel, S., Wilson, A., Gill, K., & Howe, D. (2020). "What would a trauma-informed mental health service look like?" Perspectives of people who access services. *International Journal of Mental Health Nursing*, *30*(2). https://doi.org/10.1111/inm.12813

J, Gran. (2014). *Peer Relationships Within The Recovery Journey: Perspectives Of Forensic Dual Diagnosis Clients* [Doctoral Thesis, University of East London]. https://repository.uel.ac.uk/item/85887

Jackson-Blott, D. K., Hare, D. D., Morgan, D. S., & Davies, D. B. (2019). Recovery from Psychosis in a Forensic Service: Assessing Staff and Service Users' Perspectives Using Q Methodology. *Journal of Forensic Psychology Research and Practice*, *19*(2), 147–169. https://doi.org/10.1080/24732850.2018.1556516

Johnson, S. (2000). *The therapeutic alliance with early adolescents: Introduction of an instrument* [Unpublished Doctoral dissertation, Temple University].

Johnson, S., Hogue, A., Diamond, G., Leckrone, J., & Liddle, H. A. (1998). *Scoring manual for the Adolescent Therapeutic Alliance Scale (ATAS).* Unpublished manuscript. Temple University, Philadelphia.

Johnstone, L. (2022). *A Straight Talking Introduction to Psychiatric Diagnosis* (2nd Ed.). PCCS Books.

Johnstone, L. & Boyle, M. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis.* https://www.bps.org.uk/sites/bps.org.uk/files/Policy%20-%20Files/PTM%20Main.pdf

Jones, L., & Willmot, P. (2022). The Future of Trauma-Informed Forensic Practice. In P. Willmot & L. Jones, *Trauma-Informed Forensic Practice* (pp. 413-427). Routledge

**Karatzias, T., Shevlin, M., Pitcairn, J., Thomson, L., Mahoney, A., & Hyland, P. (2019). Childhood adversity and psychosis in detained inpatients from medium to high secured units: Results from the Scottish census survey. *Child Abuse & Neglect*, *96*, 104094. https://doi.org/10.1016/j.chiabu.2019.104094

Kay, S. R., Fiszbein, A., & Opler, L. A. (1987). The positive and negative syndrome scale (PANSS) for schizophrenia. *Schizophrenia bulletin*, *13*(2), 261-276. https://doi.org/10.1093/schbul/13.2.261

Kazdin, A. E., Holland, L., Crowley, M., & Breton, S. (1997). Barriers to treatment participation scale: Evaluation and validation in the context of child outpatient treatment. *Journal of Child Psychology and Psychiatry*, *38*(8), 1051-1062. https://doi.org/10.1111/j.1469-7610.1997.tb01621.x

Kennedy, H. G., O'Reilly, K., Davoren, M., O'Flynn, P., & O'Sullivan, O. P. (2019). How to Measure Progress in Forensic Care. In B. Völlm, P. Braun (Eds.), *Long-Term Forensic Psychiatric Care* (pp.103-121). Springer. https://doi.org/10.1007/978-3-030-12594-3_8

Keown, P., Murphy, H., McKenna, D., & McKinnon, I. (2018). Changes in the use of the Mental Health Act 1983 in England 1984/85 to 2015/16. *The British Journal of Psychiatry, 213*(4), 595-599. https://doi.org/10.1192/bjp.2018.123

Keulen-de Vos, M. and de Vogel, V. (2021). Do Changes in Emotional States Predict Therapy Alliance in Dutch Male Offenders in Mandated Clinical Care? *International Journal of Offender Therapy and Comparative Criminology*, 66(5), pp.625–644. https://doi.org/10.1177/0306624x211013733.

Keulen-de-Vos, M., Bernstein, D.P., Clark, L.A., Arntz, A., Lucker, T.P.C. and de Spa, E. (2011). Patient versus informant reports of personality disorders in forensic patients. *Journal of Forensic Psychiatry & Psychology*, 22(1), pp.52–71. https://doi.org/10.1080/14789949.2010.511242.

Kidd, I. J., & Carel, H. (2019). Pathocentric epistemic injustice and conceptions of health. In B.R. Sherman & S. Goguen, *Overcoming epistemic injustice: social and psychological perspectives* (pp. 153-162). Rowman & Littlefield International, Ltd.

Kim, S. C., Boren, D., & Solem, S. L. (2001). The Kim Alliance Scale: development and preliminary testing. *Clinical nursing research*, *10*(3), 314-331. https://doi.org/10.1177/c10n3r7

Kivlighan Jr, D. M., & Shaughnessy, P. (2000). Patterns of working alliance development: A typology of client's working alliance ratings. *Journal of Counseling Psychology*, *47*(3), 362. https://doi.org/10.1037/0022-0167.47.3.362

Kline, P. (1986). *A handbook of test construction: Introduction to psychometric design.* Methuen & Co. Ltd.

Kline, P. (1998). *The new psychometrics: Science, psychology, and measurement*. Routledge.

Kline, P. (2000). *The Handbook of Psychological Testing* (2nd Ed.). Routledge.

Kline, P. (2015). *A Handbook of Test Construction (Psychology Revivals) Introduction to Psychometric Design*. Taylor and Francis.

Kline, R. B. (2010). *Principles and practice of structural equation modelling* (3rd Ed.). Guildford Press.

Kline, R. B. (2015). *Principles and practice of structural equation modelling* (4th Ed.). Guildford Press.

Korsten, D. and Keulen-de Vos, M. (2022). The Impact of Adverse Childhood Events on Therapy Alliance in Male Inpatients with Convictions. *Journal of Forensic Psychology Research and Practice*, 22(4), pp.404–425. https://doi.org/10.1080/24732850.2021.2013349.

Kramer, M. G. (2016). Sanctuary in a residential treatment center: creating a therapeutic community of hope countering violence. *Therapeutic Communities: The International Journal of Therapeutic Communities*, *37*(2), 69–83. https://doi.org/10.1108/tc-01-2015-0005

Kroll, L., & Green, J. (1997). The therapeutic alliance in child inpatient treatment: Development and initial validation of a family engagement questionnaire. *Clinical Child Psychology and Psychiatry*, *2*(3), 431-447. https://doi.org/10.1177/1359104597023009

Kubiak, S., Covington, S. and Hiller, C. (2017). Trauma-informed corrections. In Springer, D. and Roberts, A. (Eds.), *Social work in Juvenile and Criminal justice systems*. Charles C. Thomas.

Kurtz, A., & Jeffcote, N. (2011). "Everything contradicts in your mind": A qualitative study of experiences of forensic mental health staff in two contrasting services. *Criminal Behaviour and Mental Health*, *21*(4), 245–258. https://doi.org/10.1002/cbm.796

Kuzel, A. J. (1992). Sampling in qualitative inquiry. In *Research methods for primary care, Vol. 3. Doing qualitative research* (pp. 31–44). Sage Publications.

Lachal, J., Revah-Levy, A., Orri, M., & Moro, M. R. (2017). Metasynthesis: An Original Method to Synthesize Qualitative Literature in Psychiatry. *Frontiers in Psychiatry*, *8*. https://doi.org/10.3389/fpsyt.2017.00269

*Laithwaite, H., & Gumley, A. (2007). Sense of self, adaptation and recovery in patients with psychosis in a forensic NHS setting. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice, 14*(4), 302-316. https://doi.org/10.1002/cpp.538

Larkin, M., Watts, S., & Clifton, E. (2006). Giving voice and making sense in interpretative phenomenological analysis. Qualitative Research in Psychology, 3(2), 102-120. https://doi.org/10.1191/1478088706qp062oa.

Leamy, M., Bird, V., Boutillier, C. L., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry*, *199*(06), 445–452. https://doi.org/10.1192/bjp.bp.110.083733

Leitch, L. (2017). Action Steps Using ACEs and trauma-informed care: a Resilience Model. *Health & Justice*, *5*(1). https://doi.org/10.1186/s40352-017-0050-5

Lilienfeld, S. O., Widows, M. R., & Staff, P. A. R. (2005). Psychopathic personality inventory™-revised. *Social Influence (SOI)*, *61*(65), 97.

Lim, X. M., Lim, Z. H. T., & Ignacio, J. (2022). Nurses' experiences in the management of delirium among older persons in acute care ward settings: A qualitative systematic review and meta-aggregation. *International Journal of Nursing Studies*, *127*, 104157. https://doi.org/10.1016/j.ijnurstu.2021.104157

Linden, J. D., Stone, S. C., & Shertzer, B. (1965). Development and evaluation of an inventory for rating counseling. *The Personnel and Guidance Journal*, *44*(3), 267-276. https://doi.org/10.1002/j.2164-4918.1965.tb03516.x

Lindqvist, P. E. R., & Skipworth, J. (2000). Evidence-based rehabilitation in forensic psychiatry. *The British Journal of Psychiatry, 176*(4), 320-323. https://doi.org/10.1192/bjp.176.4.320

Lobbestael, J., van Vreeswijk, M., Spinhoven, P., Schouten, E., & Arntz, A. (2010). Reliability and validity of the short Schema Mode Inventory (SMI). *Behavioural and Cognitive Psychotherapy*, *38*(4), 437–458. https://doi.org/10.1017/s1352465810000226

Lockwood, C., Munn, Z., & Porritt, K. (2015). Qualitative research synthesis: methodological guidance for systematic reviewers utilizing meta-aggregation. *International journal of evidence-based healthcare, 13*(3), 179-187. https://doi.org/10.1097/XEB.0000000000000062

Lofland, J. (1971). *Analysing social settings: A guide to qualitative observation and analysis.* Wadsworth.

Long, C. G., Anagnostakis, K., Fox, E., Silaule, P., Somers, J., West, R., & Webster, A. (2011). Social climate along the pathway of care in women's secure mental health service: Variation with level of security, patient motivation, therapeutic alliance and level of disturbance. *Criminal Behaviour and Mental Health*, *21*(3), 202-214. https://doi.org/10.1002/cbm.791

Lolkus, M., Kenney, R., & Maeda, Y. (2022). Developing Formative Assessment Practices in Instruction: Recommendations from a Meta-Aggregation. *Practical Assessment, Research, and Evaluation*, *27*(1), 26. https://scholarworks.umass.edu/cgi/viewcontent.cgi?article=1568&context=pare

Lord, K., Priest, H., & McGowan, A. (2016). Therapeutic engagement in medium-secure care: an interpretative phenomenological analysis of service users' experiences. *The Journal of Forensic Psychiatry & Psychology, 27*(1), 55-76. https://doi.org/10.1080/14789949.2015.1090622

Lovell, T. (2019). *Recovery in forensic mental health services: a review and meta-ethnography of reported accounts of service user experiences* [Doctoral Thesis, Canterbury Christ Church University]. https://repository.canterbury.ac.uk/download/982287bef68176cef40d00101cd63e6a9656722dcfba19e7a086e85d697a4fbe/2469138/Tamsin_Lovell_MRP_2019.pdf

Lowenthal, A. (2020). Trauma-informed care implementation in the child- and youth-serving sectors: A scoping review. *International Journal of Child and Adolescent Resilience*, *7*(1), 178–194. https://doi.org/10.7202/1072597ar

Luborsky, L. (1976). Helping alliance in psychotherapy. In J. L. Cleghhorn, *Successful psychotherapy* (pp. 92-116). Brunner/Mazel.

Luborsky, L., & DeRubeis, R. J. (1984). The use of psychotherapy treatment manuals: A small revolution in psychotherapy research style. *Clinical Psychology Review*, *4*(1), 5-14. https://doi.org/10.1016/0272-7358(84)90034-5

Macinnes, D., Beer, D., Keeble, P., Rees, D., & Reid, L. (2010). The development of a tool to measure service user satisfaction with in-patient forensic services: The Forensic Satisfaction Scale. *Journal of Mental Health*, *19*(3), 272-281. https://doi.org/10.3109/09638231003728133

MacInnes, D., Beer, D., Keeble, P., Rees, D., & Reid, L. (2011). Service-user involvement in forensic mental health care research: Areas to consider when developing a collaborative study. *Journal of Mental Health, 20*(5), 464-472. https://doi.org/10.3109/09638231003728109

MacInnes, D., Courtney, H., Flanagan, T., Bressington, D., & Beer, D. (2014). A cross sectional survey examining the association between therapeutic relationships and service user satisfaction in forensic mental health settings. *BMC research notes*, *7*(1), 657. https://doi.org/10.1186/1756-0500-7-657

Madders, S. A. S., & George, C. A. (2014). "I couldn't have done it on my own." Perspectives of patients preparing for discharge from a UK high secure hospital. *Mental Health Review Journal, 19*(1), 27-36. https://doi.org/10.1108/MHRJ-04-2013-0014

Maguire, D., & Taylor, J. (2019). A Systematic Review on Implementing Education and Training on Trauma-Informed Care to Nurses in Forensic Mental Health Settings. *Journal of forensic nursing*, *15*(4), 242-249. https://doi.org/10.1097/JFN.0000000000000262

Mahajan, Y. and Howard, M. (2022). Quality of the therapeutic alliance and associations with program outcomes for offenders participating in High Intensity Program Units (HIPUs). *Corrections Research Evaluation and Statistics.*

Mallinckrodt, B. (1993). Session impact, working alliance, and treatment outcome in brief counseling. *Journal of Counseling Psychology*, *40*(1), 25. https://doi.org/10.1037/0022-0167.40.1.25

Mallinckrodt, B., & Tekie, Y. T. (2016). Item response theory analysis of Working Alliance Inventory, revised response format, and new Brief Alliance Inventory. *Psychotherapy Research*, *26*(6), 694-718. http://dx.doi.org/10.1080/10503307.2015.1061718

Mallinckrodt, B., Choi, G., & Daly, K. (2015). Pilot test of a measure to assess therapeutic distance and its association with client attachment, and corrective experience in therapy. *Psychotherapy Research*, 25, 505–517. https://doi.org/10.1080/10503307.2014.928755

Mallinckrodt, B., Gantt, D. L., & Coble, H. M. (1995). Attachment patterns in the psychotherapy relationship: Development of the Client Attachment to Therapist Scale. *Journal of Counseling Psychology*, 42, 307–317. https://doi.org/10.1037/0022-0167.42.3.307

Mallinckrodt, B., Porter, M. J., & Kivlighan Jr, D. M. (2005). Client attachment to therapist, depth of in-session exploration, and object relations in brief psychotherapy. *Psychotherapy: Theory, Research, Practice, Training*, *42*(1), 85. https://doi.org/10.1037/0033-3204.42.1.85

Malterud, K. (2001). Qualitative research: standards, challenges, and guidelines. *The lancet*, *358*(9280), 483-488. https://doi.org/10.1016/S0140-6736(01)05627-6

Mann, B., Matias, E., & Allen, J. (2014). Recovery in forensic services: facing the challenge. *Advances in psychiatric treatment*, *20*(2), 125-131. https://doi.org/10.1192/apt.bp.113.011403

Markham, S. (2021a). The omnipresence of risk and associated harms in secure and forensic mental health services in England and Wales. *Social Theory & Health*. https://doi.org/10.1057/s41285-021-00167-z

Markham, S. (2021b). The totalising nature of secure and forensic mental health services in England and Wales. *Frontiers in Psychiatry,* 1989. https://doi.org/10.3389/fpsyt.2021.789089

Markham, S. (2022). See think act: the need to rethink and refocus on relational security. *The Journal of Forensic Psychiatry & Psychology*, *33*(2), 200–230. https://doi.org/10.1080/14789949.2022.2044068

Marmar, C. R., Horowitz, M. J., Weiss, D. S., & Marziali, E. (1986). The development of the Therapeutic Alliance Rating System. In L. S. Greenberg & W.M. Pinsof (Eds.), *The psychotherapeutic process: a research* handbook (pp. 367−390). New York and London: Guilford Press

Marmar, C. R., Weiss, D. S., & Gaston, L. (1989). Toward the validation of the California Therapeutic Alliance Rating System. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, *1*(1), 46. https://doi.org/10.3389/fpsyg.2011.00270

Marshall, L. A., & Adams, E. A. (2018). Building from the ground up: exploring forensic mental health staff's relationships with patients. *The Journal of Forensic Psychiatry & Psychology*, *29*(5), 744–761. https://doi.org/10.1080/14789949.2018.1508486

Marziali, E., Marmar, C., & Krupnick, J. (1981). Therapeutic alliance scales: development and relationship to psychotherapy outcome. *The American Journal of Psychiatry*, *138*(3), 361-364. https://doi.org/10.1176/ajp.138.3.361

McEvedy, S., Maguire, T., Furness, T., & McKenna, B. (2017). Sensory modulation and trauma-informed-care knowledge transfer and translation in mental health services in Victoria: Evaluation of a statewide train-the-trainer intervention. *Nurse Education in Practice*, *25*, 36–42. https://doi.org/10.1016/j.nepr.2017.04.012

McGuire-Snieckus, R., McCabe, R., Catty, J., Hansson, L., & Priebe, S. (2007). A new scale to assess the therapeutic relationship in community mental health care: STAR. *Psychological medicine*, *37*(1), 85-95. https://doi.org/10.1017/S0033291706009299

McGuire, F., Carlisle, J., & Clarke, F. (2022). Trauma-Informed Care in Secure Hospitals. In *Trauma-Informed Forensic Practice* (pp. 348–362). Routledge.

McIntosh, L. G., Janes, S., O'Rourke, S., & Thomson, L. D. (2021). Effectiveness of psychological and psychosocial interventions for forensic mental health inpatients: A meta-analysis. *Aggression and Violent Behavior, 58*, 101551. https://doi.org/10.1016/j.avb.2021.101551

**McKenna, G., Jackson, N., & Browne, C. (2019). Trauma history in a high secure male forensic inpatient population. *International journal of law and psychiatry*, *66*, 101475. https://doi.org/10.1016/j.ijlp.2019.101475

McKenzie-Smith, L. (2019). *Recovery experiences of forensic mental health service users* [Doctoral Thesis, Canterbury Christ Church University]. https://repository.canterbury.ac.uk/download/1a5090256ccc91dc7935d10d12003cf522ea01b633c2c482361c7455a13c87be/1136747/Laura_McKenzie-Smith_MRP_2019.pdf

McKeown, M., Jones, F., Foy, P., Wright, K., Paxton, T., & Blackmon, M. (2016). Looking back, looking forward: Recovery journeys in a high secure hospital. *International journal of mental health nursing, 25*(3), 234-242. https://doi.org/10.1111/inm.12204

McLeod, B. D., & Weisz, J. R. (2005). The therapy process observational coding system-alliance scale: measure characteristics and prediction of outcome in usual clinical practice. *Journal of consulting and clinical psychology*, *73*(2), 323. https://doi.org/10.1037/0022-006X.73.2.323

Mental Health Act (1983, amended 2007). http://www.legislation.gov.uk/ukpga/2007/12/contents

Menzies, R., LeFrançois, B. A., & Reaume, G. (2013). Introducing mad studies. *Mad matters: A critical reader in Canadian Mad Studies*, 1-22.

Merrick, J. S., & Narayan, A. J. (2020). Assessment and screening of positive childhood experiences along with childhood adversity in research, practice, and policy. *Journal of Children and Poverty*, 26(2), 1–13. https://doi.org/10.1080/10796126.2020.1799338

Messina, N., Calhoun, S., & Braithwaite, J. (2013). Trauma-Informed Treatment Decreases Posttraumatic Stress Disorder Among Women Offenders. *Journal of Trauma & Dissociation*, *15*(1), 6–23. https://doi.org/10.1080/15299732.2013.818609

Metzl, J. (2011). *The protest psychosis : how schizophrenia became a black disease*. Beacon.

*Mezey, G. C., Kavuma, M., Turton, P., Demetriou, A., & Wright, C. (2010). Perceptions, experiences and meanings of recovery in forensic psychiatric patients. *The Journal of*

Forensic Psychiatry & Psychology, 21(5), 683-696. https://doi.org/10.1080/14789949.2010.489953

Millar, S. L., Chambers, M., & Giles, M. (2016). Service user involvement in mental health care: an evolutionary concept analysis. *Health Expectations, 19*(2), 209-221. https://doi.org/10.1111/hex.12353

Ministry of Justice. (2021). *Restricted Patients 2020 England and Wales.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/981888/Restricted_Patients_Statistical_Bulletin_2020.pdf

Molinaro (1998). *Development and validation of a new measure of therapist focus on alliance related content* [Unpublished Doctoral dissertation, Temple University].

Morizot, J., Ainsworth, A. T., & Reise, S. P. (2007). Toward modern psychometrics: Application of item response theory models in personality research. In R. W. Robins, R. C. Fraley, & R. F. Krueger (Eds.), *Handbook of Research Methods in Personality Psychology* (pp. 407-423). Guilford.

**Morris, D. J., Shergill, S., & Beber, E. (2019). Developmental trauma in a forensic intellectual disability population. *Journal of Intellectual Disabilities and Offending Behaviour*, *11*(1), 35–48. https://doi.org/10.1108/jidob-06-2019-0011

Morris, K., Cox, D. L., & Ward, K. (2016). Exploring stories of occupational engagement in a regional secure unit. *The journal of forensic psychiatry & psychology, 27*(5), 684-697. https://doi.org/10.1080/14789949.2016.1187759

Morrison, P., Burnard D, P., & Philips, C. (1996). Patient satisfaction in a forensic unit. *Journal of Mental health*, *5*(4), 369-378.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of counseling psychology*, *52*(2), 250. https://doi.org/10.1037/0022-0167.52.2.250

Mottershead, T., Khalifa, N., & Völlm, B. (2020). A mixed-methods examination of patient feedback within forensic and non-forensic mental healthcare services. *The Journal of Forensic Psychiatry & Psychology, 31*(1), 106-122. https://doi.org/10.1080/14789949.2019.1680726

Muijsson, S. (2022). *Predicting professionals' engagement in information provision about victim-offender mediation to offenders with addiction problems and the impact of an educational intervention*. [Masters Thesis, University of Twente]. http://essay.utwente.nl/89371/.

Munder, T., Wilmers, F., Leonhart, R., Linster, H. W., & Barth, J. (2010). Working Alliance Inventory-Short Revised (WAI-SR): psychometric properties in outpatients and inpatients. *Clinical psychology & psychotherapy*, *17*(3), 231-239. https://doi.org/10.1002/cpp.658

Munn, Z., Porritt, K., Lockwood, C., Aromataris, E., & Pearson, A. (2014). Establishing confidence in the output of qualitative research synthesis: the ConQual approach. *BMC medical research methodology, 14*(1), 108. https://doi.org/10.1186/1471-2288-14-108

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*, *23*(1), 51–59. https://doi.org/10.1111/inm.12012

Muthén, B., & Asparouhov, T. (2012). Bayesian structural equation modeling: a more flexible representation of substantive theory. *Psychological methods*, *17*(3), 313. https://doi.org/10.1037/a0026802

Nachtigall, C., Kroehne, U., Funke, F., & Steyer, R. (2003). Pros and cons of structural equation modeling. *Methods Psychological Research Online*, *8*(2), 1-22. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.329.7618&rep=rep1&type=pdf

National Research Consortium of Counseling Centers in Higher Education. (n.d.). *Project 3, psychotherapy process and outcome study* (1997–98). http://cmhc. utexas.edu/rc_project3.html

NHS England. (2018). *Carer support and involvement in secure mental health services: A toolkit*. https://www.england.nhs.uk/wp-content/uploads/2018/05/secure-carers-toolkit-v2.pdf

NHS England. (2021a). *Service specification: low secure mental health services (Adult)*. https://www.england.nhs.uk/wp-content/uploads/2018/03/Adult-Low-Secure-Service-Specification-SCFT-WSBS-addendum-version.pdf

NHS England. (2021b). *Service specification: medium secure mental health services (Adult)*. https://www.england.nhs.uk/wp-content/uploads/2018/03/Adult-Medium-Secure-Service-Specification-SCFT-WSBS-addendum-version.pdf

NHS England. (2021c). *Service specification: High secure mental health services (Adult)*. https://www.england.nhs.uk/wp-content/uploads/2021/02/service-specification-high-secure-mental-health-services-adult.pdf

North, C. S., Surís, A. M., Smith, R. P., & King, R. V. (2016). The evolution of PTSD criteria across editions of DSM. *Annals of Clinical Psychiatry*, *28*(3), 197–208.

Nunnally, J.O., & Bernstein, A. (1994). *Psychometric theory* (3rd Ed.). McGraw-Hill.

O’Callaghan, A.K., Plunkett, R. and Kelly, B.D. (2022). The association between objective necessity for involuntary treatment as measured during admission, legal admission status and clinical factors in an inpatient psychiatry setting. *International Journal of Law and Psychiatry*, 81, p.101777. https://doi.org/10.1016/j.ijlp.2022.101777.

O’Dowd, R., Laithwaite, H., & Quayle, E. (2022). A Qualitative Exploration of Service Users’ Experiences of Violence Risk Assessment and Management in Forensic Mental Health Settings: An Interpretative Phenomenological Analysis. *Journal of Forensic Psychology Research and Practice*, 1–32. https://doi.org/10.1080/24732850.2021.2001195

Olafson, E., Boat, B. W., Putnam, K. T., Thieken, L., Marrow, M. T., & Putnam, F. W. (2016). Implementing Trauma and Grief Component Therapy for Adolescents and Think Trauma for Traumatized Youth in Secure Juvenile Justice Settings. *Journal of Interpersonal Violence*, *33*(16), 2537–2557. https://doi.org/10.1177/0886260516628287

Oliver, M. (2018). *Understanding disability: From theory to practice*. Bloomsbury Publishing.

Onken, S. J., Craig, C. M., Ridgway, P., Ralph, R. O., & Cook, J. A. (2007). An analysis of the definitions and elements of recovery: a review of the literature. *Psychiatric rehabilitation journal*, *31*(1), 9. https://doi.org/10.2975/31.1.2007.9.22

Orf, R. W. (2014). *Factors that promote and inhibit client disclosure of suicidal ideation* [Doctoral dissertation, Antioch University New England]. https://aura.antioch.edu/cgi/viewcontent.cgi?article=1196&context=etds

Orlinsky, D. E., & Howard, K. I. (1966). The experience of psychotherapy: a prospectus on the psychotherapy session project. *Institute for Juvenile Research, Research Report*, *3*(8).

Orlinsky, D. E., & Howard, K. I. (1975). *Varieties of Psychotherapeutic Experience: Multivariate Analysis of Patients' and Therapists Reports*. Teachers College Press

Osborn, L. A., & Stein, C. H. (2019). Recovery-oriented services in an inpatient setting: The role of consumers' views of therapeutic alliance and practitioner directiveness on recovery and well-being. *American Journal of Orthopsychiatry*, *89*(1), 115. https://doi.org/10.1037/ort0000355

Otte, S., Streb, J., Rasche, K., Franke, I., Nigel, S., Segmiller, F., Sosic-Vasic, Z., & Dudeck, M. (2019). The Therapeutic Relationship in Forensic and General Psychiatric Settings. *Fortschritte der Neurologie-Psychiatrie*, *87*(8), 421-428. https://doi.org/10.1055/a-0586-3253

**Owens, E. (2021). *Trauma Informed Care in Forensic Mental Health and Intellectual Disability Services: Conceptualisation, Scale Development and Preliminary Validation* [Doctoral Thesis, University of Portsmouth]. https://pure.port.ac.uk/ws/portalfiles/portal/51339703/UP616383_DForenPsy_Thesis_with_Corrections_1_.pdf

Paap, D., & Dijkstra, P. U. (2017). Working alliance inventory-short form revised. *Journal of physiotherapy*, *63*(2), 118. https://doi.org/10.1016/j.jphys.2017.01.001

Papaioannou, D., Sutton, A., Carroll, C., Booth, A., & Wong, R. (2010). Literature searching for social science systematic reviews: consideration of a range of search techniques. *Health Information & Libraries Journal, 27*(2), 114-122. https://doi.org/10.1111/j.1471-1842.2009.00863.x

Parrott, F. R., MacInnes, D. L., & Parrott, J. (2015). Mental illness and parenthood: being a parent in secure psychiatric care. *Criminal Behaviour and Mental Health, 25*(4), 258-272. https://doi.org/10.1002/cbm.1948

Paterson, B. L. (2001). *Meta-study of qualitative health research : a practical guide to meta-analysis and meta-synthesis*. Sage Publications.

Perdrix, S., de Roten, Y., Kolly, S., & Rossier, J. (2010). The psychometric properties of the WAI in a career counseling setting: Comparison with a personal counselling sample. *Journal of Career Assessment*, *18*(4), 409-419. https://doi.org/10.1177/1069072710374583

Peters, E., Hardy, A., Dudley, R., Varese, F., Greenwood, K., Steel, C., Emsley, R., Keen, N., Bowe, S., Swan, S., Underwood, R., Longden, E., Byford, S., Potts, L., Heslin, M., Grey, N., Turkington, D., Fowler, D., Kuipers, E. and Morrison, A. (2022). Multisite randomised controlled trial of trauma-focused cognitive behaviour therapy for psychosis to reduce post-traumatic stress symptoms in people with co-morbid post-traumatic stress disorder and psychosis, compared to treatment as usual: study protocol for the STAR (Study of Trauma And Recovery) trial. *Trials*, 23(1). https://doi.org/10.1186/s13063-022-06215-x.

Picker Institute Europe. (2011). *Service User Feedback Tools. An evidence review and Delphi consultation for the health professions council*. https://www.hcpc-uk.org/globalassets/resources/reports/service-user-feedback-tools---an-evidence-review-and-delphi-consultation-for-the-health-professions-council.pdf

Pinsof, W.M. (1999). *Family Therapy Alliance Scale-Revised*. Unpublished Manuscript. The Family Institute, Evanston IL.

Pirelli, G., Formon, D. L., & Maloney, K. (2020). Preventing vicarious trauma (VT), compassion fatigue (CF), and burnout (BO) in forensic mental health: Forensic psychology as exemplar. *Professional Psychology: Research and Practice*. https://doi.org/10.1037/pro0000293

Popay, J., Roberts, H., Snowden, A., Petticrew, M., Arai, L., Rogers, M., Britten, N., Roen, K., & Duffy, S. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. *A Product from the ESRC Methods Programme Version*, *1*(1).

Priebe, S., & Gruyters, T. (1993). The role of the helping alliance in psychiatric community care: a prospective study. *Journal of Nervous and Mental Disease,* 181(9), 552–557. https://doi.org/10.1097/00005053-199309000-00004

Procter, N., Ayling, B., Croft, L., Degaris, P., Devine, M., Dimanic, A., Fiore, D. L., Eaton, H., Edwards, M., Lang, S., Rebellato, A., Shaw, K., & Sullivan., R. (2017). *Trauma-informed approaches in mental health: A practical resource for health professionals*. University of South Australia. https://www.unisa.edu.au/siteassets/episerver-6-files/global/health/sansom/documents/mhsa/trauma-informed-approaches-in-forensic-mental-health-resource.pdf

Pulido, R. (2011). Institutional therapeutic alliance in multi-professional treatments with severely disturbed patients. In: *Psychiatric Disorders: Worldwide Advances*. IntechOpen, pp.139–150. https://library.um.edu.mo/ebooks/b28351083.pdf#page=153.

Pulido, R., Monari, M., & Rossi, N. (2008). Institutional therapeutic alliance and its relationship with outcomes in a psychiatric day hospital program. *Archives of Psychiatric Nursing*, *22*(5), 277-287. https://doi.org/10.1016/j.apnu.2007.07.003

Putnick, D. L., & Bornstein, M. H. (2016). Measurement invariance conventions and reporting: The state of the art and future directions for psychological research. *Developmental review*, *41*, 71-90. https://doi.org/10.1016/j.dr.2016.06.004

Quality Network for Forensic Mental Health Services. (2021). *Standards for Forensic Mental Health Services: Low and Medium Secure Care – Fourth Edition.* https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/secure-forensic/forensic-standards-qnfmhs/quality-network-for-forensic-mental-health-services---fourth-edition-standards.pdf?sfvrsn=fdcee87c_2

Quinsey, V. L., Reid, K. S., & Stermac, L. E. (1996). Mentally disordered offenders' accounts of their crimes. *Criminal Justice and Behavior*, *23*(3), 472-489.

Ramsden, J. (2019). Editorial: The power threat meaning framework and forensic mental health settings. *Criminal Behaviour and Mental Health*, *29*(3), 131–133. https://doi.org/10.1002/cbm.2118

Ratcliffe, J. M., & Stenfert Kroese, B. (2021). Female service users' experiences of secure care in the UK: a synthesis of qualitative research. *The Journal of Forensic Psychiatry & Psychology*, 1–30. https://doi.org/10.1080/14789949.2021.1880615

Rattan, A. (2019). How lay theories (or mindsets) shape the confrontation of prejudice. In *Confronting prejudice and discrimination: The science of changing minds and behaviors* (pp. 121–140). Academic Press. https://doi.org/10.1016/C2017-0-01959-6

Read, J., & Harper, David. J. (2020). The Power Threat Meaning Framework: Addressing Adversity, Challenging Prejudice and Stigma, and Transforming Services. *Journal of Constructivist Psychology*, 1–14. https://doi.org/10.1080/10720537.2020.1773356

Read, J., & Harper, David. J. (2020). The Power Threat Meaning Framework: Addressing Adversity, Challenging Prejudice and Stigma, and Transforming Services. *Journal of Constructivist Psychology*, *35*(1), 1–14. https://doi.org/10.1080/10720537.2020.1773356

Rees, G., & Waters, R. (2003). 'Lost and locked in': Patients' perspectives on leave under Section 37/41. *The Mental Health Foundation.*

Riordan, S., & Humphreys, M. (2007). Patient perceptions of medium secure care. *Medicine, science and the law, 47*(1), 20-26. https://doi.org/10.1258/rsmmsl.47.1.20

Riordan, S., Smith, H., & Humphreys, M. (2014). Alternative Perceptions of Statutory Community Aftercare: Patient and Responsible Medical Officer Views. *International Journal of Mental Health and Capacity Law*, *7*, 119. https://doi.org/10.19164/ijmhcl.v0i7.348

Robinson, D. K., & Collins, M. (1995). Working in partnership: Consumer views of the patient council. *Psychiatric Care*, *2*(3), 101-104.

Robinson, J. E. C. (2018). *Perceptions of social climate and their influence on aggression in forensic Intellectual Developmental Disability (IDD) services* (Doctoral dissertation). https://etheses.bham.ac.uk/id/eprint/8576/1/Robinson18ForenPsyD.pdf

Robinson, J., Craig, L. A., & Tonkin, M. (2018). Perceptions of social climate and aggressive behavior in forensic services: A systematic review. *Trauma, Violence, & Abuse, 19*(4), 391-405. https://doi.org/10.1177/1524838016663936

Rogers, C. R. (1965). *Client-centered therapy, its current practice, implications, and theory*. Houghton Mifflin.

Rose, D., Carr, S., & Beresford, P. (2018). 'Widening cross-disciplinary research for mental health': what is missing from the Research Councils UK mental health agenda?. *Disability & Society, 33*(3), 476-481. https://doi.org/10.1080/09687599.2018.1423907

Rose, H. (1994). *Love, power, and knowledge: towards a feminist transformation of the sciences*. Indiana University Press.

Ross, E. C., Polaschek, D. L., & Ward, T. (2008). The therapeutic alliance: A theoretical revision for offender rehabilitation. *Aggression and violent behavior*, *13*(6), 462-480. https://doi.org/10.1016/j.avb.2008.07.003

Rouhi, M., Stirling, C., Ayton, J., & Crisp, E. P. (2019). Women's help-seeking behaviours within the first twelve months after childbirth: A systematic qualitative meta-aggregation review☆. *Midwifery*, *72*, 39-49. https://doi.org/10.1016/j.midw.2019.02.005

Rossiter, K. R. (2012). *Victimization, trauma, and mental health: Women's recovery at the interface of the criminal justice and mental health systems* [Doctoral Dissertation, University of Alberta]. https://core.ac.uk/download/pdf/56376639.pdf

Russell, J. H., & Kettles, A. M. (1996). User views of a forensic service. *Psychiatric Care*, *3*, 98-104.

Rutherford, M., & Duggan, S. (2008). Forensic mental health services: facts and figures on current provision. *Journal of Forensic Practice, 10*(4), 4. https://doi.org/10.1108/14636646200800020

Ryan, S., Moore, E., Taylor, P. J., Wilkinson, E., Lingiah, T., & Christmas, M. (2002). The voice of detainees in a high security setting on services for people with personality disorder. *Criminal Behaviour and Mental Health*, *12*(4), 254–268. https://doi.org/10.1002/cbm.504

Rye, O. (2017). *Perspectives on recovery and recall to hospital in forensic mental health* [Doctoral Thesis, University of Oxford]. https://ora.ox.ac.uk/objects/uuid:3bd28a0b-26e6-42db-b692-d97097910686b

Ryland, H., Davies, L., Kenney-Herbert, J., Kingham, M., & Deshpande, M. (2022). Advancing research in adult secure mental health services in England. *Medicine, Science and the Law, 62*(3), 225-229. https://doi.org/10.1177/00258024211066981

Ryland, H., Davies, L., Kenney-Herbert, J., Kingham, M., & Deshpande, M. (2021). Advancing research in adult secure mental health services in England. *Medicine, Science and the Law*, *62*(3), 225–229. https://doi.org/10.1177/00258024211066981

Safran, J. D., & Muran, J. C. (2006). Has the concept of the therapeutic alliance outlived its usefulness?. *Psychotherapy: Theory, research, practice, training*, *43*(3), 286. https://doi.org/10.1037/0033-3204.43.3.286

Sainsbury Centre for Mental Health. (2014). *Implementing Recovery: A new framework for organisational change.* http://yavee1czwq2ianky1a2ws010-wpengine.netdna-ssl.com/wp-content/uploads/2016/09/implementing_recovery_paper.pdf

*Sainsbury, L., Krishnan, G., & Evans, C. (2004). Motivating factors for male forensic patients with personality disorder. *Criminal Behaviour and Mental Health*, *14*(1), 29–38. https://doi.org/10.1002/cbm.558

Sampson, S., Edworthy, R., Völlm, B., & Bulten, E. (2016). Long-term forensic mental health services: an exploratory comparison of 18 European countries. *International Journal of Forensic Mental Health*, *15*(4), 333-351. https://doi.org/10.1080/14999013.2016.1221484

Samuels, P. (2017). *Advice on Reliability Analysis with Small Samples-Revised Version.*http://www.open-access.bcu.ac.uk/6077/1/__staff_shares_storage%20500mb_Library_ID112668_Stats%20Advisory_New%20Statistics%20Workshops_17ReliabilityAnalysis_ReliabilitySmallSamples3.pdf

Samuels, E., & Moran, N. (2021). Accessing and engaging with primary health care services following discharge from forensic secure services: the perspectives of service users and mental health practitioners. *The Journal of Forensic Practice*, *23*(2), 117-131. https://doi.org/10.1108/JFP-12-2020-0049

Sarlin, N. S. (1992). *Working relationships in the treatment of adolescent inpatients: Early treatment predictors and associations with outcome* [Doctoral Dissertation, University of Denver].

Saunders, S. M., Howard, K. I., & Orlinsky, D. E. (1989). The Therapeutic Bond Scales: Psychometric characteristics and relationship to treatment effectiveness. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, *1*(4), 323. https://doi.org/10.1037/1040-3590.1.4.323

Schafer, P., & Peternelj-Taylor, C. (2003). Therapeutic Relationships and Boundary Maintenance: The Perspective of Forensic Patients Enrolled in a Treatment Program for Violent Offenders. *Issues in Mental Health Nursing*, *24*(6-7), 605–625. https://doi.org/10.1080/01612840305320

Schalast, N., Redies, M., Collins, M., Stacey, J., & Howells, K. (2008). EssenCES, a short questionnaire for assessing the social climate of forensic psychiatric wards. *Criminal Behaviour and Mental Health*, *18*(1), 49-58. https://doi.org/10.1002/cbm.677

Schulz, H., Nübling, R., & Rüddel, H. (1995). Entwicklung einer Kurzform eines Fragebogens zur Psychotherapiemotivation. *Verhaltenstherapie*, *5*(2), 89-95. https://doi.org/10.1159/000258901

Senneseth, M., Pollak, C., Urheim, R., Logan, C., & Palmstierna, T. (2022). Personal recovery and its challenges in forensic mental health: systematic review and thematic synthesis of the qualitative literature. *BJPsych Open*, *8*(1). https://doi.org/10.1192/bjo.2021.1068

Sequeira, H., & Halstead, S. (2002). Control and restraint in the UK: service user perspectives. *The British Journal of Forensic Practice, 4*(1), 9–18. https://doi.org/10.1108/14636646200200003

Shakespeare, T. (2006). The social model of disability. In L. J. Davies (5th Ed.), *The Disability Studies Reader* (pp. 197-204). Bloomsbury Publishing

Shapiro, F. (2001). *Eye movement desensitization and repro- cessing: Basic principles, protocols, and procedures* (2nd Ed.). Guilford Press.

Shaw, C., & Proctor, G. (2005). Women at the Margins: A Critique of the Diagnosis of Borderline Personality Disorder. *Feminism & Psychology*, *15*(4), 483–490. https://doi.org/10.1177/0959-353505057620

Shepherd, A., Doyle, M., Sanders, C., & Shaw, J. (2016). Personal recovery within forensic settings–Systematic review and meta-synthesis of qualitative methods studies. *Criminal Behaviour and Mental Health, 26*(1), 59-75. https://doi.org/10.1002/cbm.1966

Shinkfield, G., & Ogloff, J. (2014). Use and interpretation of routine outcome measures in forensic mental health. *International Journal of Mental Health Nursing*, *24*(1), 11–18. https://doi.org/10.1111/inm.12092

Shinkfield, G., & Ogloff, J. (2015). Use and interpretation of routine outcome measures in forensic mental health. *International Journal of Mental Health Nursing, 24*(1), 11-18. https://doi.org/10.1111/inm.12092

Shirk, S. R., & Saiz, C. C. (1992). Clinical, empirical, and developmental perspectives on the therapeutic relationship in child psychotherapy. *Development and Psychopathology*, *4*(4), 713-728. https://doi.org/10.1017/S0954579400004946

Simpson, R., Simpson, S., Wasilewski, M., Mercer, S., & Lawrence, M. (2022). Mindfulness-based interventions for people with multiple sclerosis: a systematic review and meta-aggregation of qualitative research studies. *Disability and rehabilitation*, *44*(21), 6179-6193. https://doi.org/10.1111/j.1365-2850.1994.tb00041.x

Skeem, J. L., Encandela, J., & Louden, J. E. (2003). Perspectives on probation and mandated mental health treat- ment in specialized and traditional probation departments. Behavioral Sciences & the Law, 21(4), 429–458. https://doi.org/10.1002/bsl.547

Skeem, J.L., Louden, J.E., Polaschek, D. and Camp, J. (2007). Assessing relationship quality in mandated community treatment: Blending care with control. *Psychological Assessment*, *19*(4), pp.397–410. https://doi.org/10.1037/1040-3590.19.4.397.

Skelly, C. (1994a). The experience of special hospital patients in regional secure units. *Journal of Psychiatric and Mental Health Nursing*, *1*(3), 171-177. https://doi.org/10.1111/j.1365-2850.1994.tb00041.x

Skelly, C. (1994b). From special hospital to regional secure unit: A qualitative study of the problems experienced by patients. *Journal of Advanced Nursing*, *20*(6), 1056-1063. https://doi.org/10.1046/j.1365-2648.1994.20061056.x

Slade, M., Amering, M., & Oades, L. (2008). Recovery: an international perspective. *Epidemiology and Psychiatric Sciences, 17*(2), 128-137. https://doi.org/10.1017/S1121189X00002827

Smith-Acuna, S., Durlak, J. A., & Kaspar, C. J. (1991). Development of child psychotherapy process measures. *Journal of Clinical Child and Adolescent Psychology*, *20*(2), 126-131. https://doi.org/10.1207/s15374424jccp2002_3

Spiers, S., Harney, K., & Chilvers, C. (2005). Service user involvement in forensic mental health: Can it work?. *The Journal of Forensic Psychiatry & Psychology, 16*(2), 211-220. https://doi.org/10.1080/14789940500098137

**Stamatopoulou, S. (2019). *Transitioning to a Trauma Informed Forensic Unit: Staff Perceptions of a Shift in Organisational Culture* [Doctoral Thesis, University of Hertfordshire]. https://uhra.herts.ac.uk/bitstream/handle/2299/22758/14191703%20STAMATOPOULOU%20Vasiliki%20Final%20Version%20of%20DClinPsy%20Submission.pdf?sequence=1&isAllowed=y

Stiles, W. B., Glick, M. J., Osatuke, K., Hardy, G. E., Shapiro, D. A., Agnew-Davies, R., &

**Stinson, J. D., Quinn, M. A., Menditto, A. A., & LeMay, C. C. (2021). Adverse Childhood Experiences and the Onset of Aggression and Criminality in a Forensic Inpatient Sample. *International Journal of Forensic Mental Health*, 1–12. https://doi.org/10.1080/14999013.2021.1895375

Stojanovich, L., & Marisavljevich, D. (2008). Stress as a trigger of autoimmune disease. *Autoimmunity Reviews*, *7*(3), 209–213. https://doi.org/10.1016/j.autrev.2007.11.007

Strauss, A., & Corbin, J. (2009). *Basics of qualitative research. Techniques and procedures for developing grounded theory* (2nd Ed.). Sage Publications.

Strong, S. R. (1968). Counseling: An interpersonal influence process. *Journal of Counseling Psychology*, *15*(3), 215.

Stuart, S. R., Tansey, L., & Quayle, E. (2017). What are the barriers to recovery perceived by people discharged from a medium-secure forensic mental health unit? An interpretative phenomenological analysis. *Journal of Theoretical & Philosophical Criminology*, *9*(1), 1. http://www.jtpcrim.org/February17/SS.pdf

Sturgiss, E. A., Sargent, G. M., Haesler, E., Rieger, E., & Douglas, K. (2016). Therapeutic alliance and obesity management in primary care–a cross‐sectional pilot using the Working Alliance Inventory. *Clinical obesity*, *6*(6), 376-379. https://doi.org/10.1111/cob.12167

Sturm, A., de Vogel, V., Menger, A., & Huibers, M. J. (2020). Changes in offender-rated working alliance in probation supervision as predictors of recidivism. *Psychology, Crime & Law*, 1-19. https://doi.org/10.1080/1068316X.2020.1793986

Sturm, A., Donker, A., de Vogel, V. and Menger, A. (2021). On the Two-sided Assessment of the Working Alliance: Development of the Working Alliance of Mandated Clients Inventory. *Journal of Forensic Psychology Research and Practice*, 22(1), pp.91–112. https://doi.org/10.1080/24732850.2021.1954431.

Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's Concept of Trauma and Framework for a Trauma-Informed Approach*. https://ncsacw.acf.hhs.gov/userfiles/files/SAMHSA_Trauma.pdf

Svensson, B., & Hansson, L. (1999). Therapeutic alliance in cognitive therapy for schizophrenic and other long‐term mentally ill patients: development and relationship to outcome in an in‐patient treatment programme. *Acta Psychiatrica Scandinavica*, *99*(4), 281-287. https://doi.org/10.1111/j.1600-0447.1999.tb07226.x

Sweeney, A., & Beresford, P. (2020). Who gets to study whom: survivor research and peer review processes. *Disability & Society, 35*(7), 1189-1194. https://doi.org/10.1080/09687599.2019.1664062

Sweeney, A., & Taggart, D. (2018). (Mis)understanding trauma-informed approaches in mental health. *Journal of Mental Health*, *27*(5), 383–387. https://doi.org/10.1080/09638237.2018.1520973

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal*, *21*(3), 174–192. https://doi.org/10.1108/mhrj-01-2015-0006

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: relationships in trauma-informed mental health services. *BJPsych Advances*, *24*(5), 319–333. https://doi.org/10.1192/bja.2018.29

Sweeney, A., Perôt, C., Callard, F., Adenden, V., Mantovani, N., & Goldsmith, L. (2019). Out of the silence: towards grassroots and trauma-informed support for people who have experienced sexual violence and abuse. *Epidemiology and Psychiatric Sciences*, *28*(6), 598–602. https://doi.org/10.1017/s2045796019000131

Szasz, T. S. (1960). The myth of mental illness. *American psychologist, 15*(2), 113. https://doi.org/10.1037/h0046535

Tait, L., & Lester, H. (2005). Encouraging user involvement in mental health services. *Advances in psychiatric treatment, 11*(3), 168-175. https://doi.org/10.1192/apt.11.3.168

*Tapp, J., Warren, F., Fife-Schaw, C., Perkins, D., & Moore, E. (2013). What do the experts by experience tell us about 'what works' in high secure forensic inpatient hospital services?. *The Journal of Forensic Psychiatry & Psychology*, *24*(2), 160-178. https://doi.org/10.1080/14789949.2012.760642

Tatman, A. W., & Love, K. M. (2010). An offender version of the working alliance inventory-short revised. *Journal of Offender Rehabilitation*, *49*(3), 165-179. https://doi.org/10.1080/10509671003666560

Tew, J., Gould, N., Abankwa, D., Barnes, H., Beresford, P., Carr, S., Copperman, J., Ramon, S., Rose, D., Sweeney, A., & Woodward, L. (2016). *Values and methodologies for social research in mental health*. https://www.birmingham.ac.uk/Documents/college-social-sciences/social-policy/IASS/publications/social-research-mental-health.pdf

The Department of Health. (1997). *The New NHS*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/266003/newnhs.pdf

The Department of Health. (2010). *Your Guide to Relational Security: SEE THINK ACT*. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/320249/See_Think_Act_2010.pdf

The Nuffield Trust. (2022, May 27). *Restricted patients, prison population and general population by ethnic group*. https://www.nuffieldtrust.org.uk/chart/chart-of-the-week-the-over-representation-of-black-people-as-restricted-patients-in-secure-hospitals

Thorpe, G. L., & Favia, A. (2012). Data Analysis Using Item Response Theory Methodology: An Introduction to Selected Programs and Applications. *Psychology Faculty Scholarship, 20.* https://digitalcommons.library.umaine.edu/psy_facpub/20

Tomlin, J., & Jordan, M. (2021). Strength- and recovery-based approaches in forensic mental health in late modernity: Increasingly incorporating a human rights angle? *Social Theory & Health*. https://doi.org/10.1057/s41285-021-00169-x

Tomlin, J., Bartlett, P., & Völlm, B. (2018). Experiences of restrictiveness in forensic psychiatric care: Systematic review and concept analysis. *International journal of law and psychiatry*, *57*, 31-41. https://doi.org/10.1016/j.ijlp.2017.12.006

Tomlin, J., Egan, V., Bartlett, P., & Völlm, B. (2020). What do patients find restrictive about forensic mental health services? A qualitative study. *International Journal of Forensic Mental Health*, *19*(1), 44-56. https://doi.org/10.1080/14999013.2019.1623955

Tomlin, J., Völlm, B., Furtado, V., Egan, V., & Bartlett, P. (2019). The Forensic Restrictiveness Questionnaire: Development, Validation, and Revision. *Frontiers in Psychiatry*, *10*. https://doi.org/10.3389/fpsyt.2019.00805

Tracey, T. J., & Kokotovic, A. M. (1989). Factor structure of the working alliance inventory. *Psychological Assessment: A journal of consulting and clinical psychology*, *1*(3), 207. https://doi.org/10.1037/1040-3590.1.3.207

Treisman, K. (2021). *A treasure box for creating trauma-informed organizations : a ready-to-use resource for trauma, adversity, and culturally informed, infused and responsive systems.* Jessica Kingsley Publishers.

Turner, E. H. (2013). Publication bias, with a focus on psychiatry: causes and solutions. *CNS drugs, 27*(6), 457-468. https://doi.org/10.1007/s40263-013-0067-9

Vaughan, P., & Stevenson, S. (2002). An opinion survey of mentally disordered offender service users. *The British Journal of Forensic Practice*, *4*(3), 11–20. https://doi.org/10.1108/14636646200200017

Visser, R. C., MacInnes, D., Parrott, J., & Houben, F. (2019). Growing older in secure mental health care: the user experience. *Journal of Mental health*, 1-7. https://doi.org/10.1080/09638237.2019.1630722

Wampold, B.E. (2015). How important are the common factors in psychotherapy? An update. World Psychiatry, 14(3), pp.270–277. https://doi.org/10.1002/wps.20238.

Völlm, B., Foster, S., Bates, P., & Huband, N. (2017). How best to engage users of forensic services in research: literature review and recommendations. *International Journal of Forensic Mental Health, 16*(2), 183-195. https://doi.org/10.1080/14999013.2016.1255282

Vorstenbosch, E. C., Bouman, Y. H., Braun, P. C., & Bulten, E. B. (2014). Psychometric properties of the forensic inpatient quality of life questionnaire: quality of life assessment for long-term forensic psychiatric care. *Health Psychology and Behavioral Medicine: an Open Access Journal, 2*(1), 335-348. https://doi.org/10.1080/21642850.2014.894890 [Original source: https://studycrumb.com/alphabetizer]

Wells, M., Hartwright, C., Morgan, S., & Gale, L. (2021). "My Kids Will Always Be around Me, if Not Physically, Spiritually They Will Always Be around Me": Fathers in Forensic Inpatient Care. *Journal of Forensic Psychology Research and Practice*, *22*(2), 142–185. https://doi.org/10.1080/24732850.2021.1945840

Wieland, L., Ayton, J., & Abernethy, G. (2021). Retention of general practitioners in remote areas of Canada and Australia: a meta-aggregation of qualitative research. *Australian Journal of Rural Health*, *29*(5), 656-669. https://doi.org/10.1111/ajr.12762

Wigham S (2007) 'Lancaster and Northgate Trauma Scales (LANTS).' Unpublished Thesis.

Willmot, P., & Jones, L. (2022). *Trauma-Informed Forensic Practice*. Routledge.

*Willmot, P., & McMurran, M. (2013). The views of male forensic inpatients on how treatment for personality disorder works. *The Journal of Forensic Psychiatry & Psychology*, *24*(5), 594-609. https://doi.org/10.1080/14789949.2013.823219

World Health Organisation (2011). *Policy: European mental health strategy*. http://www.euro.who.int/en/what-we-do/health-topics/noncommunicable-diseases/mental-health/policy/european-mental-health-strategy

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th Ed.). https://icd.who.int/

World Health Organisation. (2021). *Guidance on community mental health services: Promoting person-centred and rights-based approaches.* https://www.who.int/publications/i/item/9789240025707?search-result=true&query=Guidance+on+community+mental+health+services:+Promoting+person-centred+and+rights-based+approaches&scope=&rpp=10&sort_by=score&order=desc

Wykes, T. (2003). Blue skies in the Journal of Mental Health? Consumers in research. *Journal of Mental Health*, *12*(1), 1-6. https://doi.org/10.1080/09638230021000058247

Yudofsky, S. C., Silver, J. M., Jackson, W., Endicott, J., & Williams, D. (1986). The Overt Aggression Scale for the objective rating of verbal and physical aggression. *The American journal of psychiatry*. https://doi.org/10.1176/ajp.143.1.35

Yung, Y. F., & Bentler, P. M. (1994). Bootstrap-corrected ADF test statistics in covariance structure analysis. *British Journal of Mathematical and Statistical Psychology*, *47*(1), 63-84. https://doi.org/10.1111/j.2044-8317.1994.tb01025.x

Zetzel, E. R. (1956). An approach to the relation between concept and content in psychoanalytic theory: With special reference to the work of Melanie Klein and her followers. *The Psychoanalytic Study of the Child*, *11*(1), 99-121. https://doi.org/10.1080/00797308.1956.11822784

Zilcha-Mano, S. (2017). Is the alliance really therapeutic? Revisiting this question in light of recent methodological advances. *American Psychologist*, *72*(4), 311. https://doi.org/10.1037/a0040435

Appendices

Appendix A – Outputs from Electronic Database Searches

Limits were applied in relation to publication type, source, location, and population. For instance, PsycINFO and CINAHL Plus databases allowed for the limit of 'inpatient' to be applied. Only English language references were included owing to the aims of this review.

PsycINFO (1967-2020)

1. ((Forensic or secure) adj4 (care* or ward* or unit* or rehab* service* or discharge* or admission* or detention* or hospital* or facilit* or treatment* or provision* or psychiatr* or system* or pathway* or setting*)).af. [29965]
2. limit 1 to (english language and "0110 peer-reviewed journal" and journal article and inpatient) [2000]
3. (View* or perspective* or experience* or input* or involvement* or interview* or satisfaction* or account* or attitude* or perception* or evaluation* or feeling* or thought* or stor* or description* or understand* or comment* or voice*).af. [3285558]
4. 2. limit 1 to (english language and "0110 peer-reviewed journal" and journal article and inpatient) [43597]
5. (service user* or expert* by experience or resident* or patient* or inpatient* or client* or consumer* or mental* ill* offend* or individ* or person*).af. [2718317]
6. limit 1 to (english language and "0110 peer-reviewed journal" and journal article and inpatient) [54698]
7. 2 and 4 and 6 [1752]

Updated search between the years 2020 to 2022 [48]

CINAHL Plus (1937-2020)

1. TX service user* or expert* by experience or resident* or patient* or inpatient* or client* or consumer* or mental* ill* offend* or individ* or person*
   Limiters - Peer Reviewed; English Language; Publication Type: Journal Article; Inpatients; Geographic Subset: UK & Ireland; Language: English
   Expanders - Apply equivalent subjects

Search modes - Boolean/Phrase [10,555]

2. TX View* or perspective* or experience* or input* or involvement* or interview* or satisfaction* or account* or attitude* or perception* or evaluation* or feeling* or thought* or stor* or description* or understand* or comment* or voice*

   Limiters - Peer Reviewed; English Language; Publication Type: Journal Article; Inpatients; Geographic Subset: UK & Ireland; Language: English
   Expanders - Apply equivalent subjects
   Search modes - Boolean/Phrase [5,658]
3. TX Forensic or secure adj4 (care* or ward* or unit* or rehab* service* or discharge* or admission* or detention* or hospital* or facilit* or treatment* or provision* or psychiatr* or system* or pathway* or setting*)
   Limiters - Peer Reviewed; English Language; Publication Type: Journal Article; Inpatients; Geographic Subset: UK & Ireland; Language: English
   Expanders - Apply equivalent subjects
   Search modes - Boolean/Phrase [133]

4. S1 AND S2 AND S3 [76]

Social Services Abstracts (1979-2020)

1. (service user* OR expert* by experience OR resident* OR patient* OR inpatient* OR client* OR consumer* OR mental* ill* offend* OR individ* OR person*) AND at.exact("Report" OR "Article") AND la.exact("English") AND PEER(yes) [13,744,402]
2. (View* OR perspective* OR experience* OR input* OR involvement* OR interview* OR satisfaction* OR account* OR attitude* OR perception* OR evaluation* OR feeling* OR thought* OR stor* OR description* OR understand* OR comment* OR voice*) AND at.exact("Article") AND la.exact("English") AND PEER(yes) [160,821]
3. (Forensic OR secure adj4 (care* OR ward* OR unit* OR rehab* service* OR discharge* OR admission* OR detention* OR hospital* OR facilit* OR treatment* OR provision* OR psychiatr* OR system* OR pathway* OR setting*)) AND at.exact("Article") AND la.exact("English") AND PEER(yes) [1,506]

4. ((Forensic OR secure adj4 (care* OR ward* OR unit* OR rehab* service* OR discharge* OR admission* OR detention* OR hospital* OR facilit* OR treatment* OR provision* OR psychiatr* OR system* OR pathway* OR setting*)) AND at.exact("Article") AND la.exact("English") AND PEER(yes)) AND ((View* OR perspective* OR experience* OR input* OR involvement* OR interview* OR satisfaction* OR account* OR attitude* OR perception* OR evaluation* OR feeling* OR thought* OR stor* OR description* OR understand* OR comment* OR voice*) AND at.exact("Article") AND la.exact("English") AND PEER(yes)) AND ((service user* OR expert* by experience OR resident* OR patient* OR inpatient* OR client* OR consumer* OR mental* ill* offend* OR individ* OR person*) AND at.exact("Report" OR "Article") AND la.exact("English") AND PEER(yes)) [922]

Updated search between the years 2020 to 2022 [58]

Sociological Abstracts (1973 to 2020)

1. (service user* or expert* by experience or resident* or patient* or inpatient* or client* or consumer* or mental* ill* offend* or individ* or person*) AND (View* or perspective* or experience* or input* or involvement* or interview* or satisfaction* or account* or attitude* or perception* or evaluation* or feeling* or thought* or stor* or description* or understand* or comment* or voice*) AND (Forensic or secure adj4 (care* or ward* or unit* or rehab* service* or discharge* or admission* or detention* or hospital* or facilit* or treatment* or provision* or psychiatr* or system* or pathway* or setting*))
   Limits applied: Peer reviewed, English language, Location (UK), Source type (Article) [48]

Updated search between the years 2020 to 2022 [56]

Web of Science (1991-2020)

1. TOPIC: (service user* or expert* by experience or resident* or patient* or inpatient* or client* or consumer* or mental* ill* offend* or individ* or person*) ANDTOPIC: (View* or perspective* or experience* or input* or

involvement* or interview* or satisfaction* or account* or attitude* or perception* or evaluation* or feeling* or thought* or stor* or description* or understand* or comment* or voice*) AND TOPIC: (Forensic or secure adj4 (care* or ward* or unit* or rehab* service* or discharge* or admission* or detention* or hospital* or facilit* or treatment* or provision* or psychiatr* or system* or pathway* or setting*))
Refined by: DOCUMENT TYPES: (ARTICLE) AND COUNTRIES/REGIONS: (ENGLAND) AND LANGUAGES: (ENGLISH)
Timespan: All years. Indexes: SCI-EXPANDED, SSCI, A&HCI, CPCI-S, CPCI-SSH, BKCI-S, BKCI-SSH, ESCI, CCR-EXPANDED, IC. [1,000

Updated search between the years 2020 to 2022 [324]

ProQuest Dissertations and Theses Global (2000-2020)

1. ti(service user* OR expert* by experience OR resident* OR patient* OR inpatient* OR client* OR consumer* OR mental* ill* offend* OR individ* OR person*) AND ti(View* OR perspective* OR experience* OR input* OR involvement* OR interview* OR satisfaction* OR account* OR attitude* OR perception* OR evaluation* OR feeling* OR thought* OR stor* OR description* OR understand* OR comment* OR voice*) AND ti(Forensic OR secure adj4 (care* OR ward* OR unit* OR rehab* service* OR discharge* OR admission* OR detention* OR hospital* OR facilit* OR treatment* OR provision* OR psychiatr* OR system* OR pathway* OR setting*))
   Limits applied: English language, full text only, Location (England), Masters and Doctoral theses [8]

Updated search between the years 2020 to 2022 [58]

Appendix B – Selection and Screening Tool

Reference:		
	Inclusion	**Exclusion**
Sample	Setting ☐ Low, medium, or high secure/forensic inpatient services within the UK Population ☐ Currently a secure/forensic inpatient or experience of being a secure/forensic inpatient ☐ Male and/or female ☐ Adults (over 18 years of age)	Setting ☐ Services outside of the UK ☐ Prison or community services Population ☐ Not currently a secure/forensic inpatient or no previous experience of being a secure/forensic inpatient ☐ Mixed samples (i.e., general psychiatric patients/clinical staff) ☐ Children or adolescents (under 18 years of age)
Phenomenon of interest	☐ A multidimensional and/or holistic focus on being the recipient of care within secure inpatient services Thus, having allowed participants to speak during interviews more freely about their experiences of care, without being directed, limited, or restricted by researchers' interests.	☐ Focused on specific aspect/s of care within secure inpatient services (i.e., psychological, occupational, or medical interventions/treatment, relationships with staff, psychiatric diagnoses, risk assessments, restraint, etc.). Thus, participants' responses during interviews were more directed, limited, or restricted by researchers' interests.
Design	☐ Loosely structured interviews (i.e., un/semi-structured interviews and/or interviews utilising open-ended questions only)	☐ Survey ☐ Questionnaire ☐ Focus group ☐ Other
Evaluation	☐ Patient input	☐ No patient input ☐ Staff input
Research type	☐ Qualitative	☐ Quantitative ☐ Mixed methods ☐ Systematic review ☐ Commentary
Publication type	☐ Published peer-reviewed article ☐ Unpublished research paper ☐ Doctoral thesis	☐ Conference abstracts ☐ Below Doctorate level dissertations or theses ☐ Organisational or government reports
Decision	☐ Accept for quality assessment	☐ Reject

Appendix C – Full Text References Excluded References and Reason/s for Exclusion (*N* = 162)

Results from Searches Conducted on 13th January 2020 (n = 135)

Full title of reference, author/s and date		How the citation was identified	Reason/s for exclusion					
			Sample		Phenomenon of Interest (i.e., views, experiences of…)	Design	Evaluation	Research type
			Setting	Location				
1	Impact of a peer-review network on the quality of inpatient low secure mental health services: cluster randomised control trial (Aimola et al., 2018)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Quality of the physical environment	✗ Randomised control trial	✗ Reported incidents and questionnaires	✗ Quantitative
2	Impact of peer-led quality improvement networks on quality of inpatient mental health care: study protocol for a cluster randomized controlled trial (Aimola et al., 2016)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Quality of the physical environment	✗ Randomised control trial	✗ Reported incidents and questionnaires	✗ Quantitative
3	'This is the pain I feel!' Projection and emotional pain in the nurse–patient relationship with people diagnosed with personality disorders in forensic and specialist personality disorder services: findings from a mixed methods study (Aiyegbusi et al., 2015)	Search of electronic databases	✓ Secure forensic inpatient services ✗ Community services	✓ UK	✗ The nurse-patient relationship	✗ Delphi method	✗ Staff input ✓ Patient input	✗ Mixed methods
4	An Evaluation of a Fire-setting group intervention for mentally disordered offenders in a High Security Hospital (Unpublished manuscript, n.d.)	Contact with expert	✓ Secure forensic inpatient services	✓ UK	✗ Fire-setting group intervention	✓ Semi-structured interviews ✗ Psychometrics	✓ Patient input	✗ Mixed methods
5	An Evaluation of Groupwork Interventions with Violent Offending patients in a High Security Hospital: From the patients' perspective (Unpublished manuscript, n.d.)	Contact with expert	✓ Secure forensic inpatient services	✓ UK	✗ Groupwork interventions	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
6	Being in a Seclusion Room: The Forensic Psychiatric Inpatients' Perspective (Askew et al., 2019)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Seclusion	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative

7	Forensic psychiatric patients' perspectives on their care: a narrative view (Askola et al., 2018)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Finland	✓ Care ✗ Offending behaviour	✓ Interviews	✓ Patient input	✓ Qualitative
8	Looking beyond the illness: Forensic service users' perceptions of rehabilitation (Barnao et al., 2015)	Search of electronic databases	✓ Secure forensic inpatient services	✗ New Zealand	✓ Rehabilitation	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
9	Trauma for all: a pilot study of the subjective experience of physical restraint for mental health inpatients and staff in the UK (Bonner et al., 2002)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Physical restraint	✓ Semi-structured interviews	✓ Patient input ✗ Staff input	✓ Qualitative
10	Levels of service user satisfaction in secure settings–A survey of the association between perceived social climate, perceived therapeutic relationship and satisfaction with forensic services (Bressington et al., 2011)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Level of service user satisfaction ✗ Therapeutic relationships and social climate	✗ Cross-sectional survey	✓ Patient input	✗ Quantitative
11	The traumatic effect of homicide in mentally disordered offenders and implications for treatment (Bromley, 2016)	Contact with expert	✓ Secure forensic inpatient services	✓ UK	✗ Group homicide treatment	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
12	Coping with stress: the experiences of service-users with intellectual disabilities in forensic services (Burns & Lampraki, 2016)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Stress and the use of coping strategies	✗ Focus group discussions	✓ Patient input	✓ Qualitative
13	"You Can Talk About Things Forever, But Acting It Out Is Different" An Evaluation of the Benefit of Role-Play in Substance Misuse Treatment for High Security Patients (Burt, 2011)	Contact with expert	✓ Secure forensic inpatient services	✓ UK	✗ Role-play in substance misuse treatment	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
14	Satisfaction guaranteed? Forensic consumer satisfaction survey (Cannon et al., 2018)	Search of electronic databases	✓ Secure forensic inpatient services	✗ New Zealand	✓ Consumer satisfaction	✗ Survey	✓ Patient input	✗ Mixed methods
15	Patient satisfaction with services in medium secure units (Carlin et al., 2005)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✓ Patient satisfaction	✗ Structured questionnaire	✓ Patient input	✗ Quantitative
16	Insight and hopelessness in forensic patients with schizophrenia (Carroll, et al., 2004)	Search of electronic databases	✗ Inpatient rehabilitation ward and outpatient service	✗ Australia	✗ Insight and hopelessness	✗ Cross-sectional (structured questionnaires and interviews)	✓ Patient input	✗ Quantitative

17	Recovery in a low secure service (Clarke et al., 2017)	Manual search	✓ Secure forensic inpatient services	✓ UK	✗ Recovery (including My Shared Pathway)	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
18	What characteristics do service users with intellectual disability value in direct support staff within residential forensic services? (Clarkson et al., 2009)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Experiences of direct support staff	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
19	Restorative practice in a forensic mental health service: three case studies (Cook, 2019)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Restorative practice	✗ Case studies	✓ Patient input ✗ Staff input	✓ Qualitative
20	A qualitative exploration of the experience of restorative approaches in a forensic mental health setting (Cook et al., 2015)	Search of electronic databases	✓ Secure forensic inpatient services ✗ Community services	✓ UK	✗ Restorative justice	✓ Semi-structured interviews	✓ Patient input ✗ Staff input	✓ Qualitative
21	A qualitative study of service user experiences of occupation in forensic mental health (Craik et al., 2010)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Occupational engagement	✗ Focus groups	✓ Patient input	✓ Qualitative
22	The problems of offenders with mental disorders: A plurality of perspectives within a single mental health care organisation (Davies et al., 2006)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Risk management and rehabilitation	✓ Interviews	✓ Patient input ✗ Staff input	✓ Qualitative
23	Ward climate within a high secure forensic psychiatric hospital: Perceptions of patients and nursing staff and the role of patient characteristics (de Vries et al., 2016)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Netherlands	✗ Ward climate ✗ Perceptions of nursing staff ✗ Patient characteristics	✗ Questionnaire and psychometrics	✓ Patient input ✗ Staff input	✗ Quantitative
24	Labelling people who are resident in a secure forensic mental health service: user views (Dickens et al., 2011)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Preference for terminology used to refer to users of secure psychiatric services	✗ Survey	✓ Patient input	✗ Quantitative
25	Smoking in a forensic psychiatric service: a survey of inpatients' views (Dickens et al., 2005)	Search of electronic databases	✗ Psychiatric hospital	✓ UK	✗ Smoking in hospital	✗ Cross-sectional survey	✓ Patient input	✗ Mixed methods
26	Mentally disordered offenders' views of 'their' risk assessment and management plans: Perceptions of health risks (Dixon, 2012)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Risk assessment and management plans	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative

27	Treatment, deterrence or labelling: mentally disordered offenders' perspectives on social control (Dixon, 2015)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Offending risk, risk assessments and restriction orders	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
28	Narratives of illness and offending: mentally disordered offenders' views on their offending (Dixon, 2018)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Narratives of offending behaviour	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
29	When the safe place does not protect: reports of victimisation and adverse experiences in psychiatric institutions (dos Santos Mesquita, 2016)	Search of electronic databases	✗ Psychiatric hospital	✗ Portugal	✗ Occurrence of psychiatric victimization (i.e., physical assaults, threats, verbal abuse)	✗ Survey	✓ Patient input	✗ Quantitative
30	Perspectives of treatment providers and clients with serious mental illness regarding effective therapeutic relationships (Easter, 2016)	Search of electronic databases	✗ Inpatient and outpatient mental health services	✗ US	✗ Therapeutic relationships	✓ Semi-structured interviews	✓ Patient input ✗ Staff input	✓ Qualitative
31	Comparing Staff and Client Perceptions of Needs in a British Single-Sex Medium Secure Unit (Emmanuel & Campbell, 2009)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Met and unmet needs	✗ Survey	✓ Patient input ✗ Staff input	✓ Quantitative
32	Long-term psychiatric inpatients' perspectives on weight gain, body satisfaction, diet and physical activity: a mixed methods study (Every-Palmer et al., 2018)	Search of electronic databases	✗ Forensic and rehabilitation services	✗ New Zealand	✗ Weight gain, body satisfaction, diet and physical activity	✗ Structured and semi-structured interviews	✓ Patient input	✗ Mixed methods
33	Being in a secure forensic psychiatric unit: every day is the same, killing time or making the most of it (Farnworth et al., 2004)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Australia	✗ Occupational activities	✗ Semi-structured interview and observations	✓ Patient input	✗ Mixed methods
34	Inpatient views and experiences before and after implementing a totally smoke-free policy in the acute psychiatry hospital setting (Filia et al., 2015)	Search of electronic databases	✗ Inpatient psychiatric unit	✗ Australia	✗ Smoke-free policy	✗ Questionnaire	✓ Patient input	✗ Quantitative
35	'Behind this wall'–Experiences of seclusion on locked wards for women (Fish, 2018)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Seclusion	✗ Observation and interviews	✓ Patient input ✗ Staff input	✓ Qualitative
36	Gendered experiences of physical restraint on locked wards for women (Fish & Hatton, 2017)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Physical restraint	✗ Observation and interviews	✓ Patient input ✗ Staff input	✓ Qualitative
37	An evaluation of new services for personality-disordered offenders: Staff and	Manual search	✓ Secure forensic inpatient services	✓ UK	✗ Receiving and delivering treatment	✓ Interviews	✓ Patient input ✗ Staff input	✓ Qualitative

	service user perspectives (Fortune et al., 2010)							
38	Treatment environments in secure psychiatric units: A case study (Fuller, 1985)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Social climate	✗ Questionnaire	✓ Patient input ✗ Staff input	✗ Quantitative
39	Who cares? The views of sexual offenders about the group treatment they receive (Garrett et al., 2003)	Search of electronic databases	✓ Secure forensic inpatient forensic services ✗ Community services	✓ UK	✗ Group treatment for sexual offences	✗ Questionnaire	✓ Patient input	✗ Quantitative
40	Religion, spirituality and personal recovery among forensic patients (Glorey et al., 2019)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗Religion/spirituality	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
41	The criminal narrative experience of psychopathic and personality disordered offenders (Goodlad et al., 2019)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Offending behaviour	✗ Questionnaires	✓ Patient input	✗ Quantitative
42	Peer Relationships Within The Recovery Journey: Perspectives Of Forensic Dual Diagnosis Clients (Gran, 2014)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Peer support	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
43	Care planning for aggression management in a specialist secure mental health service: an audit of user involvement (Hallett et al., 2016)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Aggression and/or violence	✗ Clinical audit	✗ Clinical audit	✗ Mixed methods
44	Coercive treatments in forensic psychiatry: a study of patients' experiences and preferences (Haw et al., 2011)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Physical restraint, seclusion and emergency intra-muscular medication	✗ Semi-structured interviews and medical records	✓ Patient input	✗ Mixed methods
45	Evaluation of a smoke-free forensic hospital: Patients' perspectives on issues and benefits (Hehir et al., 2012)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Australia	✗ Smoke-free hospital	✗ Focus group and surveys	✓ Patient input	✗ Mixed methods
46	Perceptions of meaningful activity amongst male patients in a high secure forensic addictive behaviours unit (Helbig, 2003)	Search of electronic databases	N/A	N/A	✗ Meaningful activity	N/A	N/A	N/A
47	The journey effect: how travel affects the experiences of mental health in-patient	Search of electronic databases	✗ Psychiatric hospital	✓ UK	✗ Impact of travel	✓ Semi-structured interviews	✓ Patient input ✗ Staff input	✓ Qualitative

	service-users and their families (Heyman et al., 2015)							
48	Memory at the sharp end: the costs of remembering with others in forensic contexts (Hope & Gabbert, 2019)	Search of electronic databases	✗ Criminal justice	✓ UK	✗ Witness accounts	N/A	N/A	N/A
49	To be strategically struggling against resignation: The lived experience of being cared for in forensic psychiatric care (Hörberg et al., 2012)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Sweden	✓ Care	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
50	A comparative study of forensic and general community psychiatric patients with integrated and parallel models of care in the UK (Humber et al., 2011)	Search of electronic databases	✗ Community forensic and psychiatric services	✓ UK	✗ Clinical characteristics, risk and need profiles	✗ Interviews, psychometrics and case notes	✗ No patient input ✗ Staff input	✗ Quantitative
51	Impacting on factors promoting intra-group aggression in secure psychiatric settings (Ireland et al., 2019)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Intra-group aggression	✗ Questionnaires and psychometrics	✓ Patient input ✗ Staff input	✗ Quantitative
52	A qualitative analysis of the ‘management of schizophrenia’within a medium-secure service for men with learning disabilities (Isherwood et al., 2006)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Psycho-social interventions	✗ Questionnaire	✗ No patient input ✗ Staff input	✓ Qualitative
53	Exploring recovery in women diagnosed with personality disorder in a secure setting (Jenkinson, 2011)	Manual search	✓ Secure forensic inpatient services	✓ UK	✗ Recovery (with a focus on diagnosis of borderline personality disorder)	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
54	How distress is understood and communicated by women patients detained in high secure forensic healthcare, and how nurses interpret that distress: An exploration using a multi-perspective interpretative phenomenological analysis (Jones, 2017)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Distress	✓ Semi-structured interviews	✓ Patient input ✗ Staff input	✓ Qualitative
55	The atmosphere of the ward: Attunements and attachments of everyday life for patients on a medium-secure forensic psychiatric unit (Kanyeredzi et al., 2019)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Ward atmosphere	✗ Interviews based on ‘photo-production’	✓ Patient input	✓ Qualitative
56	Perspective On Excellence in Forensic Mental Health Services: What we can learn from oncology and other medical services (Kennedy et al., 2019)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Recommendations for excellence	N/A	✗ No patient input	N/A

57	Forensic and general psychiatric patients' view of seclusion: a comparison study (Keski-Valkama et al., 2010)	Search of electronic databases	✗ General psychiatric setting	✗ Finland	✗ Seclusion	✗ Structured interview	✓ Patient input	✗ Quantitative
58	Patients' attitudes towards and acceptance of coercion in psychiatry (Krieger et al., 2018)	Search of electronic databases	✗ Inpatient psychiatric services	✗ Germany	✗ Coercion	✗ Questionnaire and psychometrics	✓ Patient input	✗ Quantitative
59	Satisfaction with psychiatric in-patient care as rated by patients at discharge from hospitals in 11 countries (Krupchanka et al., 2017)	Search of electronic databases	✗ Inpatient psychiatric services	✗ 11 different countries	✓ Satisfaction with care	✗ Questionnaires	✓ Patient input	✗ Quantitative
60	Social climate within secure inpatient services for people with intellectual disabilities (Langdon et al., 2006)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Social climate	✗ Questionnaires	✓ Patient input	✗ Quantitative
61	What does success look like in the forensic mental health system? Perspectives of service users and service providers (Livingston, 2018)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Canada	✓ 'Success'	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
62	A tale of two cultures: Examining patient-centered care in a forensic mental health hospital (Livingston et al., 2012)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Canada	✓ Patient-centered care	✗ Semi-structured interviews and surveys	✓ Patient input ✗ Staff input	✗ Quantitative
63	Supporting recovery by improving patient engagement in a forensic mental health hospital: Results from a demonstration project (Livingston et al., 2013)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Canada	✗ Patient engagement intervention	✗ Interviews and surveys	✓ Patient input	✗ Mixed methods
64	Factors associated with quality of life in a cohort of forensic psychiatric in-patients (Long et al., 2008)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Quality of life	✗ Questionnaires	✓ Patient input	✗ Quantitative
65	Effective therapeutic milieus in secure services for women: the service user perspective (Long et al., 2012)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Therapeutic milieus	✗ Focus group	✓ Patient input	✓ Qualitative
66	Therapeutic engagement in medium-secure care: an interpretative phenomenological analysis of service users' experiences (Lord et al., 2016)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Therapeutic engagement	✓ Interviews	✓ Patient input	✓ Qualitative
67	An exploration into the lived experience of having a diagnosis of Borderline Personality Disorder in a forensic setting (Lovell, 2011)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Having a diagnosis of borderline personality disorder	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative

68	Examining attitudes about and influences on research participation among forensic psychiatric inpatients (Magyar et al., 2012)	Search of electronic databases	✓ Secure forensic inpatient services	✗ US	✗ Research participation	✗ Questionnaires	✓ Patient input	✗ Quantitative
69	"I couldn't have done it on my own." Perspectives of patients preparing for discharge from a UK high secure hospital (Madders & George, 2014)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Discharge preparation	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
70	Peaks and troughs—an exploration of patient perspectives of dangerous and severe personality disorder assessment (Peaks Unit, Rampton Hospital) (Maltman et al., 2008)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Admission and assessment	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
71	Offender patients' opinions on placement in a forensic hospital (Margetić et al., 2012)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Croatia	✗ Whether placement in hospital should be punitive, therapeutic, or a mixture of both	✗ Case vignettes	✓ Patient input	✗ Quantitative
72	Exploring service users' experience of community meetings in a high secure service (Mayes et al., 2016)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Community meetings	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
73	Managing madness, murderers and paedophiles: understanding change in the field of English forensic psychiatry (McDonald et al., 2016)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Change in the field of forensic psychiatry	✓ Interviews ✗ Focus groups	✓ Patient input ✗ Staff input	✓ Qualitative
74	Recovery-oriented care in a secure mental health setting: "striving for a good life" (McKenna et al., 2014)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Australia	✗ Service delivery	✓ Interviews ✗ Focus groups	✓ Patient input ✗ Staff input	✓ Qualitative
75	Evaluation of the Secure Care Recovery and Outcomes Network (McKeown, n.d.)	Contact with expert	✓ Secure forensic inpatient services	✓ UK	✗ Secure Care and Recovery Outcomes Network	✗ Questionnaires, observations, interviews	✓ Patient input ✗ Staff input	✗ Mixed methods
76	Finding a voice–the feasibility and impact of setting up a community choir in a forensic secure setting (Mezey et al., 2015)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Setting up a community choir	✗ Participant observation and focus groups	✓ Patient input ✗ Staff input	✓ Qualitative
77	Safety of women in mixed-sex and single-sex medium secure units: staff and patient perceptions (Mezey et al., 2005)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Impact of gender segregation on the safety of women	✓ Interviews	✓ Patient input ✗ Staff input	✓ Qualitative
78	Stigma and discrimination in mentally disordered offender patients–a comparison	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Stigma and discrimination	✗ Questionnaire	✓ Patient input	✗ Quantitative

	with a non-forensic population (Mezey et al., 2016)		✗ Community forensic services ✗ General psychiatric inpatient services					
79	Looking back, looking forward: Recovery journeys in a high secure hospital (McKeown et al., 2016)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✓ Recovery	✓ Semi-structured interviews	✓ Patient input ✗ Staff input	✓ Qualitative
80	Blame attribution regarding index offence on admission to secure hospital services (Moore & Gudjonsson, 2002)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Blame attribution	✗ Survey	✓ Patient input	✗ Quantitative
81	Exploring stories of occupational engagement in a regional secure unit (Morris & Ward, 2016)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Occupational engagement	✓ Semi-structured interview	✓ Patient input	✓ Qualitative
82	A mixed-methods examination of patient feedback within forensic and non-forensic mental healthcare services (Mottershead et al., 2019)	Search of electronic databases	✓ Secure forensic inpatient services ✗ Acute and community general psychiatric services	✓ UK	✗ Patient feedback	✗ Questionnaire	✓ Patient input	✗ Mixed methods
83	Examining the experiences and quality of life of patients with an autism spectrum disorder detained in high secure psychiatric care (Murphy & Mullens, 2017)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Experiences and quality of life of patients with an autism spectrum disorder	✓ Semi-structured interview ✗ Questionnaire	✓ Patient input	✓ Qualitative
84	Lived experiences of recalled mentally disordered offenders with dual diagnosis: a qualitative phenomenological study (O'Sullivan et al., 2013)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Recall	✓ Semi-structured interview	✓ Patient input	✓ Qualitative
85	Reducing or increasing violence in forensic care: a qualitative study of inpatient experiences (Olsson et al., 2015)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Sweden	✗ Decreased or increased risk of violence	✓ Semi-structured interview	✓ Patient input	✓ Qualitative
86	Recovery-oriented services in an inpatient setting: The role of consumers' views of therapeutic alliance and practitioner directiveness on recovery and well-being (Osborn & Stein, 2019)	Search of electronic databases	✗ Inpatient psychiatric hospital	✗ US	✗ Professional relationships and recovery	✗ Questionnaire	✓ Patient input	✗ Quantitative

87	Getting to know you: reflections on a specialist independent mental health advocacy service for Bexley and Bromley residents in forensic settings (Palmer et al., 2012)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Specialist independent mental health advocacy service	✓ Semi-structured interview	✓ Patient input	✓ Qualitative
88	The journey from despair to hope: an exploration of the phenomenon of psychological distress in women residing in British secure mental health services (Parkes & Freshwater, 2012)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Psychological distress	✓ Semi-structured interview	✓ Patient input	✓ Qualitative
89	'Going into the unknown': Experiences of male patients in secure settings during environmental transition (Parkes et al., 2015)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Environmental transition	✓ Semi-structured interview	✓ Patient input	✓ Qualitative
90	'It's Not Forever' The Material Culture of Hope (Parrott, 2005)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Decoration of bedrooms and self-decoration through clothing and accessories	✗ Interviews and participant observation	✓ Patient input	✓ Qualitative
91	Mental illness and parenthood: being a parent in secure psychiatric care (Parrott et al., 2015)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Being a parent in secure psychiatric care	✓ Semi-structured interview	✓ Patient input	✓ Qualitative
92	Loneliness in a maximum-security forensic hospital: An experience sampling analysis (Phelps et al., 1998)	Search of electronic databases	✓ Secure forensic inpatient services	✗ US	✗ Loneliness	✗ Questionnaires	✓ Patient input	✗ Quantitative
93	Assessing the needs of patients in secure settings: a multi-disciplinary approach (Pierzchniak et al., 1999)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Mental health service needs	✗ Questionnaires	✓ Patient input ✗ Staff input	✗ Quantitative
94	"It Had Only Been a Matter of Time Before I Had Relapsed Into Crime": Aspects of Care and Personal Recovery in Forensic Mental Health (Pollak et al., 2018)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Sweden	✗ Aspects of care and personal recovery important for reducing risk	✓ Semi-structured interview	✓ Patient input	✓ Qualitative
95	Aggression in a high secure hospital: staff and patient attitudes (Pulsford et al., 2013)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Aggression	✗ Questionnaire	✓ Patient input	✓ Qualitative
96	Exploring sexual risks in a forensic mental health hospital: Perspectives from patients and nurses (Quinn & Happell, 2015)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Australia	✗ Sexual risks	✓ Semi-structured interview	✓ Patient input ✗ Staff input	✓ Qualitative

97	Sex on show. Issues of privacy and dignity in a Forensic mental health hospital: Nurse and patient views (Quinn & Happell, 2015)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Australia	✗ Issues of privacy and dignity	✓ Semi-structured interview	✓ Patient input ✗ Staff input	✓ Qualitative
98	Explanations for violent behaviour—An interview study among forensic in-patients (Radovic & Höglund, 2014)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Sweden	✗ Explanations for violent behaviour	✓ Semi-structured interview	✓ Patient input	✓ Qualitative
99	Patients' satisfaction with hospital health care: Identifying indicators for people with severe mental disorder (Ratner et al., 2018)	Search of electronic databases	✗ Psychiatric inpatient services	✗ Israel	✓ Satisfaction with care	✗ Questionnaire	✓ Patient input	✗ Quantitative
100	Agents and spectres: Life-space on a medium secure forensic psychiatric unit (Reavey et al., 2019)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Forensic psychiatric environments and recovery (i.e., social interactions and agency)	✗ Interviews using photo-production methodology	✓ Patient input	✓ Qualitative
101	Playing the game: service users' management of risk status in a UK medium secure forensic mental health service (Reynolds et al., 2014)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Management of risk status	✗ Interviews and observation	✓ Patient input ✗ Staff input	✓ Qualitative
102	The 'honeymoon effect'and 'gate fever'in a secure forensic adolescent psychiatric hospital: Do they exist? (Riordan-Eva et al., 2018)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ The 'honeymoon effect' and 'gate fever'	✗ Incident rates	✗ No patient input	✗ Quantitative
103	Patient perceptions of medium secure care (Riordan & Humpheys, 2007)	Manual search	✓ Secure forensic inpatient services	✓ UK	✓ Perceptions of care	✗ 'Qualitative survey'	✓ Patient input	✓ Qualitative
104	Assessment of health needs, satisfaction with care, and quality of life in compulsorily admitted patients with severe mental disorders (Ritsner et al., 2018)	Search of electronic databases	✗ Psychiatric inpatient services	✗ Israel	✗ Level of needs, care satisfaction, quality of life and social support	✗ Questionnaires	✓ Patient input	✗ Quantitative
105	The voice of detainees in a high security setting on services for people with personality disorder (Ryan et al., 2002)	Manual search	✓ Secure forensic inpatient services	✓ UK	✗ Service development for people with 'dangerous and severe personality disorder' (DSPD)	✓ Semi-structured interview	✓ Patient input	✓ Qualitative

106	Quality of life in long-term forensic psychiatric care: comparison of self-report and proxy assessments (Schel et al., 2015)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Quality of life	✗ Questionnaires	✓ Patient input ✗ Staff input	✗ Quantitative
107	Seeking to understand lived experiences of personal recovery in personality disorder in community and forensic settings–a qualitative methods investigation (Shepherd et al., 2017)	Search of electronic databases	✓ Secure forensic inpatient services ✗ Community settings	✓ UK	✓ Recovery	✓ Semi-structured interview	✓ Patient input	✓ Qualitative
108	The experience of a smoke-free policy in a medium secure hospital (Shetty et al., 2010)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Smoke free hospital	✗ Recorded changes in behaviour, incidents and prescribing	✗ No patient input	✗ Quantitative
109	Risk assessment interviews: exploring the perspectives of psychologists and indeterminate sentenced prisoners in the United Kingdom (Shingler et al., 2018)	Search of electronic databases	✗ Prison	✓ UK	✗ Risk assessment	✓ Semi-structured interview	✓ Patient input ✗ Staff input	✓ Qualitative
110	“The opposite of treatment”: A qualitative study of how patients diagnosed with psychosis experience music therapy (Solli & Rolvsjord, 2015)	Search of electronic databases	✗ Psychiatric inpatient service	✗ Norway	✗ Music therapy	✓ Semi-structured interview	✓ Patient input	✓ Qualitative
111	What are the barriers to recovery perceived by people discharged from a medium-secure forensic mental health unit? An interpretative phenomenological analysis (Stuart et al., 2017)	Manual search	✓ Secure forensic inpatient services	✓ UK	✗ Barriers to recovery upon discharge	✓ Semi-structured interview	✓ Patient input	✓ Qualitative
112	Measuring quality of life in secure care: comparison of mentally ill and personality disordered patients (Swinton et al., 1999)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Quality of life	✗ Questionnaires	✓ Patient input	✗ Quantitative
113	Essential elements of treatment and care in high secure forensic inpatient services: an expert consensus study (Tapp et al., 2016)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✓ Essential elements of treatment and care	✗ Delphi survey	✗ No patient input	✗ Quantitative
114	The personal social networks of personality disordered forensic psychiatric patients (Ter Haar-Pomp et al., 2015)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Netherlands	✗ Personal social networks	✗ Forensic Social Network Analysis	✓ Patient input	✗ Quantitative
115	Religious conversion among high security hospital patients: a qualitative analysis of patients’ accounts and experiences on changing faith (Thomas et al., 2016)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Religious conversion	✓ Interview	✓ Patient input	✓ Qualitative

116	The individual needs of patients in high secure psychiatric hospitals in England (Thomas et al., 2004)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Individual needs	✗ Case note review and interviews	✓ Patient input ✗ Staff input	✗ Quantitative
117	What Do Patients Find Restrictive About Forensic Mental Health Services? A Qualitative Study (Tomlin et al., 2019)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Restrictiveness	✓ Semi-structured interview	✓ Patient input	✓ Qualitative
118	Living 'in between' outside and inside: The forensic psychiatric unit as an impermanent assemblage (Tucker et al., 2019)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Restrictiveness	✗ Interview and photo-production project	✓ Patient input ✗ Staff input	✓ Qualitative
119	One size fits all: or horses for courses? Recovery-based care in specialist mental health services (Turton et al., 2011)	Search of electronic databases	✓ Secure forensic inpatient services ✗ General psychiatric settings	✓ UK	✓ Recovery	✓ Semi-structured interview	✓ Patient input	✓ Qualitative
120	Group climate and treatment motivation in secure residential and forensic youth care from the perspective of self determination theory (Van der Helm et al., 2018)	Search of electronic databases	✗ Secure residential youth care	✗ The Netherlands	✗ Group climate and treatment motivation	✗ Questionnaires	✓ Patient input	✗ Quantitative
121	Quality of life of forensic psychiatric inpatients (van Nieuwenhuizen & Nijman, 2009)	Search of electronic databases	✓ Secure forensic inpatient services ✗ General psychiatric settings	✗ The Netherlands	✗ Quality of life	✗ Questionnaires	✓ Patient input	✗ Quantitative
122	Unchain my heart… religious coping and well-being in a forensic psychiatric institution (van Uden & Pieper, 2007)	Search of electronic databases	✓ Secure forensic inpatient services	✗ The Netherlands	✗ Religious coping and well-being	✗ Questionnaires	✓ Patient input	✗ Quantitative
123	"But I did not touch nobody!" Patients' and nurses' perspectives and recommendations after aggression on psychiatric wards–A qualitative study (Vermeulen et al., 2019)	Search of electronic databases	✗ General psychiatric settings	✗ The Netherlands	✗ Aggression	✓ Semi-structured interview	✓ Patient input ✗ Staff input	✓ Qualitative
124	Growing older in secure mental health care: the user experience (Visser et al., 2019)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Growing older	✓ Semi-structured interview	✓ Patient input	✓ Qualitative
125	What am I doing here? Safety, certainty and expertise in a secure unit (Vivian-Byrne, 2001)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Safety, certainty and experiences	N/A	✗ No patient input	✓ Qualitative

126	English vs Dutch high secure hospitals: service user perspectives (Völlm et al., 2018)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK ✗ Netherlands	✗ Differences between services in the Netherlands and UK	✗ Participants asked to watch a documentary and provide comments in a feedback session	✓ Patient input	✓ Qualitative
127	Promoting work-related activities in a high secure setting: exploration of staff and patients' views (Völlm et al., 2014)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Work-related activities	✗ Questionnaire	✓ Patient input ✗ Staff input	✗ Quantitative
128	The patient's perspective on "providing structure" in psychiatric inpatient care: An interview study (Voogt et al., 2015)	Search of electronic databases	✗ Psychiatric inpatient care	✗ Netherlands	✗ Structure as a nursing intervention	✓ Interviews	✓ Patient input	✓ Qualitative
129	Mentalisation-based therapy (MBT) in a high-secure hospital setting: Expert by experience feedback on participation (Ware et al., 2016)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Mentalisation-based therapy	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
130	Forensic psychiatric experiences, stigma, and self-concept: a mixed-methods study (West et al., 2018)	Search of electronic databases	✓ Secure forensic inpatient services	✗ US	✗ Stigma and self-concept	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
131	An exploration of the use of a sensory room in a forensic mental health setting: Staff and patient perspectives (Wiglesworth & Farnworth, 2016)	Search of electronic databases	✓ Secure forensic inpatient services	✗ Australia	✗ Sensory rooms	✗ Standardised sensory profile assessment, sensory room evaluation form and focus group	✓ Patient input ✗ Staff input	✗ Mixed methods
132	The subjective experiences of women with intellectual disabilities and offending behaviour: exploring their experiences of 'home' (Williams et al., 2018)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Housing experiences and hope for future home and care environments	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
133	Is restraint a 'necessary evil' in mental health care? Mental health inpatients' and staff members' experience of physical restraint (Wilson et al., 2017)	Search of electronic databases	✗ General psychiatric services	✓ UK	✗ Restraint	✓ Semi-structured interviews	✓ Patient input ✗ Staff input	✓ Qualitative
134	Mental health inpatients' and staff members' suggestions for reducing physical restraint: A qualitative study (Wilson et al., 2018)	Search of electronic databases	✗ General psychiatric services	✓ UK	✗ Restraint	✓ Semi-structured interviews	✓ Patient input ✗ Staff input	✓ Qualitative

135	Older patients in an English high security hospital: a qualitative study of the experiences and attitudes of patients aged 60 and over and their care staff in Broadmoor Hospital (Yortson & Taylor, 2009)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Patients over 60	✓ Un-structured	✓ Patient input ✗ Staff input	✓ Qualitative

Results from Searches Conducted on 19th July 2022 (n = 27)

Reference		**How the citation was identified**	**Reason/s for exclusion**					
			Sample		**Phenomenon of Interest (i.e., views, experiences of…)**	**Design**	**Evaluation**	**Research type**
			Setting	**Location**				
1	Perceptions of restrictiveness in forensic mental health: Do demographic, clinical, and legal characteristics matter? (Tomlin, et al., 2020)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Restrictiveness	✗ Questionnaire	✓ Patient input	✗ Quantitative
2	"My Kids Will Always Be around Me, if Not Physically, Spiritually They Will Always Be around Me": Fathers in Forensic Inpatient Care (Wells et al., 2022)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Fatherhood	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
3	Linking the past and the present: service users' perspectives of how adverse experiences relate to their admission to forensic mental health services (Cartwright et al., 2022)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Adverse experiences and links to care	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
4	Involving service users to identify research priorities in a UK forensic mental health service (Aboaja et al., 2021)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Priority research topics	✗ Delphi	✓ Patient input	✓ Qualitative

			✗ Prison					
5	How do forensic inpatients' interpersonal sensitivity to dominance and perceptions of staff coercion impact upon anger and rates of aggression? (Holley et al., 2021)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Dominance and aggression	✗ Questionnaires	✓ Patient input ✗ Incident data	✗ Mixed
6	Growing older in secure mental health care: the user experience (Visser et al., 2021)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Being older	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
7	Accessing and engaging with primary health care services following discharge from forensic secure services: the perspectives of service users and mental health practitioners (Samuels & Moran, 2021)	Search of electronic databases	✗ Community	✓ UK	✗ Accessing primary healthcare following discharge	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
8	Exploring the Experience of a Strengths-Based Approach within a Forensic Service (Quinn et al., 2022)	Search of electronic databases	✗ Community	✓ UK	✗ Strength-based model	✓ Semi-structured interviews ✗ Survey	✓ Patient input	✗ Mixed
9	Development of the FORUM: a new patient and clinician reported outcome measure for forensic mental health services (Ryland et al., 2021)	Search of electronic databases	✗ Community	✓ UK	✗ Outcome measurement	✓ Semi-structured interviews ✗ Focus groups	✓ Patient input ✗ Stakeholders	✓ Qualitative
10	The totalising nature of secure and forensic mental health services in England and Wales (Markham, 2021)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Therapeutic alliance and recovery	✗ Opinion piece	✗ Opinion piece	✗ Opinion piece
11	Exploring forensic service users' experience of participating in a community life skills and work-readiness programme (McKenzie & Tarpey, 2019)	Search of electronic databases	✗ Community	✓ UK	✗ Community life skills and work-readiness programme	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
12	Service user experiences of risk assessment and management in a low secure service (Gray et al., 2021)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Risk assessment and management	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative

13	Helping with the pressures of the past: service-user perspectives of the sensory approaches within the National High Secure Healthcare Service for Women (Wilkinson & Beryl, 2021)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Sensory approaches	✗ Semi-structured questionnaire	✓ Patient input	✗ Mixed
14	Exploring the experiences of male forensic inpatients' relationships with staff within low, medium and high security mental health settings (Bennett & Hana, 2021)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Relationships with staff	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
15	De-escalation of conflict in forensic mental health inpatient settings: a Theoretical Domains Framework-informed qualitative investigation of staff and patient perspectives (Johnston et al., 2022)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ De-escalation of conflict	✓ Semi-structured interviews	✓ Patient input ✗ Staff input	✓ Qualitative
16	Strength-and recovery-based approaches in forensic mental health in late modernity: Increasingly incorporating a human rights angle? (Tomlin & Jordan, 2021)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Strength- and recovery-based approaches	✗ Opinion piece	✗ Opinion piece	✗ Opinion piece
17	An exploration of perceived coercion into psychological assessment and treatment within a low secure forensic mental health service (Simms-sawyers et al., 2020)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Impact of perceived coercion	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
18	Qualities valued in nursing staff working with women with a diagnosis of borderline personality disorder in secure care: a multi-perspective study (Ratcliffe & Stenfert Kroese (2021)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Qualities valued in nursing staff	✓ Semi-structured interviews	✓ Patient input ✗ Staff input	✓ Qualitative
19	Peripheral recovery:'Keeping safe'and 'keep progressing'as contradictory modes of ordering in a forensic psychiatric unit (McGrath et al., 2021)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Carceral space	✓ Interviews	✓ Patient input ✗ Staff input	✓ Qualitative

20	The experience of inequality and its impact on mental illness–thematic analysis of patients' lived experiences admitted to secure mental health hospital (Brenisin et al., 2022)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Inequalities prior to admission	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
21	Barriers and facilitators to the effective de-escalation of conflict behaviours in forensic high-secure settings: a qualitative study (Goodman et al., 2020)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ De-escalation	✓ Semi-structured interviews ✗ Focus groups	✓ Patient input ✗ Staff input	✓ Qualitative
22	Them two are around when I need their help" The importance of good relationships in supporting people with learning disabilities to be "in a good space" (Fish & Morgan, 2021)	Search of electronic databases	✓ Secure forensic inpatient services	✓ UK	✗ Supporting relationships	✗ Field notes and interview scripts	✓ Patient input ✗ Staff input	✓ Qualitative
23	Women's experience of forensic mental health services: implications for practice (Cooke & Bailey, 2011)	Manual search of references	✓ Secure forensic inpatient services	✓ UK	✗ Women's services	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
24	'First and foremost a human being…': user perspectives on mental health services from 50 mentally disordered offenders (Møllerhøj, & Os Stølan, 2018)	Manual search of references	✓ Secure forensic inpatient services ✗ Community	✗ Denmark		✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
25	A qualitative study of contemporary secure mental health services: women service users' views in England (Walker et al., 2019)	Manual search of references	✓ Secure forensic inpatient services	✓ UK	✗ Women's Enhanced Medium Secure Services (WEMSS) compared to medium secure services (MSS)	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative
26	Experiences of secure patients within forensic settings (Humphries, 2022)	Grey literature	✓ Secure forensic inpatient services	✓ UK	✗ Covid-19 pandemic	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative

27	Women Sent Away: The Needs and Experiences of Women in Prison and Forensic Inpatient Services (Galway, 2021)	Grey literature	✓ Secure forensic inpatient services	✓ UK	✗ Out of area services	✓ Semi-structured interviews	✓ Patient input	✓ Qualitative

Appendix D – CASP Qualitative Checklist (2018)

Reference:				
	Section A: Are the results valid?			
1	Was there a clear statement of the aims of the research? *Consider:* - *The goal of the research* - *Why it was thought important* - *Its relevance*	☐ Yes	☐ Can't tell	☐ No
2	Is a qualitative methodology appropriate? *Consider:* - *If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants* - *Is qualitative research the right methodology for addressing the research goal?*	☐ Yes	☐ Can't tell	☐ No
	Is it worth continuing?			
3	Was the research design appropriate to address the aims of the research? *Consider:* - *If the researcher has justified the research design (e.g. have they discussed how they decided which method to use?)*	☐ Yes	☐ Can't tell	☐ No
4	Was the recruitment strategy appropriate to the aims of the research? *Consider:* - *If the researcher has explained how the participants were selected* - *If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study* - *If there any discussions around recruitment (e.g. why some people chose not to take part)*	☐ Yes	☐ Can't tell	☐ No
5	Was the data collected in a way that addressed the research issue? *Consider:* - *If the setting for the data collection was justified* - *If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)* - *If the researcher has justified the methods chosen* - *If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)* - *If methods were modified during the study. If so, has the researcher explained how and why* - *If the form of data is clear (e.g. tape recordings, video material, notes etc.)* - *If the researcher has discussed saturation of data*	☐ Yes	☐ Can't tell	☐ No
6	Has the relationship between researcher and participants been adequately considered? *Consider:* - *If the researcher critically examined their own role, potential*	☐ Yes	☐ Can't tell	☐ No

	bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location - *How the researcher responded to events during the study and whether they considered the implications of any changes in the research design?*			
Section B: What are the results?				
7	Have ethical issues been taken into consideration? *Consider:* - *If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained* - *If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)* - *If approval has been sought from the ethics committee*	☐ Yes	☐ Can't tell	☐ No
8	Was the data analysis sufficiently rigorous? *Consider:* - *If there is an in-depth description of the analysis process* - *If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data* - *Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process* - *If sufficient data are presented to support the findings* - *To what extent contradictory data are taken into account* - *Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*	☐ Yes	☐ Can't tell	☐ No
9	Is there a clear statement of findings? *Consider:* - *If the findings are explicit* - *If there is adequate discussion of the evidence both for and* ***against the researcher's arguments*** - *If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)* - *If the findings are discussed in relation to the original research question*	☐ Yes	☐ Can't tell	☐ No
Section C: Will the results help locally?				
10	How valuable is the research? *Consider:* - *If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature)* - *If they identify new areas where research is necessary* - *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*	☐ Yes	☐ Can't tell	☐ No
Scoring				

Yes = 2
Can’t tell = 1
No = 0

Result

Total score = /20
Percentage =

Appendix E – Quality Assessment Scores for All Included Studies (*n* = 7)

	Quality Assessment Criteria (CASP) (2018)										Total Score (out of 20)	Quality Score (%)
Reference	**1****	**2****	**3**	**4***	**5***	**6***	**7***	**8***	**9****	**10****		
Baker (2017)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	20	100%
Barsky and West (2007)	Y	Y	CT	CT	CT	CT	CT	CT	Y	Y	14	70%
Laithwaite and Gumley (2007)	Y	Y	Y	CT	Y	Y	Y	Y	Y	Y	19	95%
Mezey et al. (2010)	Y	Y	Y	CT	CT	Y	CT	Y	Y	Y	17	85%
Sainsbury et al. (2004)	Y	Y	Y	CT	CT	Y	CT	Y	Y	Y	17	85%
Tapp et al. (2013)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	20	100%
Willmot and McMurran (2013)	Y	Y	Y	Y	CT	CT	Y	CT	Y	Y	17	85%

*Methodological weaknesses

**Methodological strengths

<u>Questions</u>

(1) Was there a clear statement of the 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 researcher and participants 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?

Key	Scoring
Y = Yes	Y = 2
CT = Can't tell	CT = 1
N = No	N = 0

Appendix F – Categorisation of Findings (*n* = 52)

Category	Number of individual findings
Survival strategies	26
Acceptance and inner strength	14
Learning to form relationships and develop interpersonal skills	13
Benefits of community leave	12
Benefits of psychological interventions	12
Early life experiences	12
Caring and helpful staff	11
Having no control	9
Friends and family in the community	8
Supportive alliances	8
Feeling safe	8
Exposure to challenging behaviours	8
Feeling recongised as a human being	7
Temporary suspension of responsibility	7
Developing new skills	6
A ‘normal’ life	6
Punitive and antagonistic treatment from staff	6
Benefits of activities and work	6
Quality and quantity of activities	6
Setbacks	6
Instability of care	6
Institutionalisation	6
Identities as perpetrators	5
Difficulty trusting others	5
Stigma in society	5
Commitment and persistence of staff	5
Staff passive and not understanding	5
The therapist	5
Being judged by staff	4
Sharing experiences with and relating to peers	4
Reduction in clinical symptoms / behaviour	4
Care resonating with early life experiences	4
Collaborative treatment	4
Hope for the future	4
Feeling contained	4
The security wall/fence	4
Challenges in the community	4
The admission process	4
Negatives of psychological interventions	4
Power of medical diagnoses	4
Side effects of medication	4
Friendly staff	3
Learning from peers	3
Questionable motives of staff	3
Little privileges and responsibility	3
Ability to trust	3
Feeling frightened / vulnerable	3

Sense of belonging/community	3
Discharge	3
Not being treated as a human being	3
Benefits of medical treatment	3
Leave within the hospital grounds	2
Education	2
Consistency and availability of staff	2
Staff believing in patients	2
Loss of liberties/freedom	2
Lack of motivation	2

Appendix G – Extraction of All Individual Findings According to Level of Plausibility, Categorisation and Key Theme Allocation

When extracting verbatim findings, the researcher excluded: summaries located at the beginning or end of a Results section; conjunction words and/or phrases at the beginning or within the middle of sentences (i.e., in comparison, while another, in contrast, within this category); subtitles/headings depicting themes. Where illustrations could not be separated from findings, these were marked as ‘embedded within finding’. The researcher also added information (i.e., cues) using italicised text in square brackets to ensure that individual findings retained contextual information.

Allocations

1. Unequivocal - findings accompanied by an illustration (i.e., direct quotation from a participant) that is beyond reasonable doubt and therefore not open to challenge.
2. Equivocal - findings accompanied by an illustration (i.e., direct quotation from a participant) lacking clear association with it and therefore open to challenge.
3. Unsupported - findings not supported by any data (i.e., direct quotation from a participant).

Note: All individual findings have been extracted verbatim as they were presented within the results section of each study included within this review. Italic text in square brackets has been added by the author of this thesis to provide transparency/context: [*example*]

Relationships on the ward **(*N* = 82)**				
Category	**Reference**	**Verbatim finding extracted from study results**[1]	**Verbatim illustration extracted from study results**	**Plausibility**
Learning to form relationships and develop interpersonal skills **(*n* = 13)**	Baker (2017)	Corey also described a change in relating to others:	*Being able to talk to people and open up and stuff that's definitely progress; I've never done it in the past. (Corey, 230-231)*	Unequivocal
	Baker (2017)	He used the example of the research interview as evidence of this change [*relating to others*]:	*I wouldn't have been able to talk to you like this a year ago (Corey, 21).*	Unequivocal
	Willmot and McMurran (2013)	They [*participants*] also reported a greater awareness of other people. This involved themes of greater empathy for others, greater understanding and respect for other people's perspectives, greater awareness of the effect they had on other people and a less judgmental approach to other people's views.	*I've more empathy and compassion for others, which I never really had before…I just didn't consider people to be worthy of consideration and sympathy. [P9]* *Before, I was quite a violent and aggressive person; I didn't really care about inflicting violence on other people or about being aggressive. I didn't really see it as a problem to be honest, but obviously I knew it was wrong-obviously but that didn't concern me in the slightest. [P9]* *Thinking about other people like my children and the rest of my family, and the people around me who it would affect, whereas before I wouldn't care what they thought. [P11]* *I give people a lot more respect. Before, I painted everybody with the same brush. [P11]*	Unequivocal
	Willmot and McMurran (2013)	Participants described improved interpersonal skills, such as being more assertive, and better at building stable relationships and resolving conflicts.	*I am more confident. I can stand up for myself more too. I am more assertive too. [P4]* *I go out to try and keep relationships rather than break them down all the time, I mean I'm still hypersensitive, but it's about understanding that when I*	Unequivocal

---

[1] All individual findings have been extracted verbatim as they were presented within the results section of each study included within this review. Italic text in square brackets has been added by the author of this thesis to provide transparency/context: [*example*]

			am hypersensitive, that's when I start feeling a bit paranoid in a relationship. [P8] *Working with people while I'm here is great for me, because it allows me to get to know me and get to have good relations with people that are helping me. [P7]*	
	Willmot and McMurran (2013)	Factors that participants linked to change in the other people' domain included other people listening to them, being reliable, helping with problem solving, self-disclosure and demonstrating trust.	*Talking to people and people listening to me. That's how I trust them more, because they listen to what I've got to say. [P6]* *Before I came here I wouldn't trust anybody because I'd been lied to that many times I just felt they were just going to keep me forever and were just warehousing me. But when I came here, things started moving. I feel more trust here.[P10]* *When people are trying to bully you [staff] go out of their way to make you feel comfortable, talk to the other party, tell him how he's making me feel, make us have a [meeting]. [P2]* *[Staff and patients] opened up to me; if they can open up to me I can trust them to open up to them ... They had problems and they disclosed them to me, about family or just their own personal problems. [P2]* *[In] prison I met a psychologist ... Staff wouldn't come in [to my cell] ...because of the risk I posed to people ... she came straight in, she sat on the chair and she asked me what my problem was, and I think what happened was that it showed me that there is people that care, that understand, that want to give you time. [P7]*	Unequivocal
	Baker (2017)	He now had a desire to connect with others:	*I'm learning to accept people for who they are [. . .] and that's helped me to get to a place where I can understand people and am willing to understand, want to understand them. (Alfie 210-211)*	Unequivocal
	Barsky and West (2007)	While at the MSU: [*atmosphere on the ward*]	*You're on the ward talking to all the patients. (07 Q 226)*	Unequivocal

	Baker (2017)	He also felt he had positive relationships with staff at present;	*In hospital I've never really had difficult relationships, that's prison (Richard-James, 1014).*	Unequivocal
	Laithwaite and Gumley (2007)	Participants spoke about how developing relationships with those around them helped them to learn about themselves, with there being a reciprocal relationship between learning about themselves and building relationships.		Unsupported
	Laithwaite and Gumley (2007)	The relationships described with staff seemed to be a reciprocal process of gaining trust and mutual respect.	*I—so you say the first week you were here you compared it to the prison—what was that comparison like?* *P1—it was a lot more . . . less formal. The relationships with staff was much better—more camaraderie. In prison, you can not have a laugh with the prison officers . . . it is a case of them or us, and you have to do what you are told and call them Sir or Lordship, whatever. Here the nurses treat you as a person . . . that is certainly what I have found in the time I have been here in the hospital. I have built up a relationship with the staff and mutual respect for each other as well.* *I—do the relationships with staff change over time at all?* *P1—well they become closer because the longer you know someone the more intimately you know them. You start talking about your friends, family activities and hobbies. I have seen people come in here who have been blinkered and it is a case of them and us kind of thinking. In time they do open up to staff, but they have to build up their trust. They are on the wards all day and they see staff who are more open with staff being treated with, lets say, more respect. You only get respect if you give it.*	Unequivocal
	Laithwaite and Gumley (2007)	However, doing this [*learning about* themelves] seemed to involve developing relationships with others, which participants stated was an important factor in their exploring themselves and finding out about themselves.		Unsupported
	Laithwaite and Gumley (2007)	Participants also spoke about how they had changed over the years; how this change had been facilitated by their relationships with staff and family and how those relationships had also changed during their hospital admission.		Unsupported

	Laithwaite and Gumley (2007)	Being in hospital led many participants to think about their relationships in the past and to try and build relationships with staff, patients and indeed amongst some, repair relationships with family.		Unsupported
Caring and helpful staff **(*n* = 11)**	Sainsbury et al. (2004)	The quote below [*to the right*] highlights the therapeutic impact that a strong therapeutic alliance can have:	*There's a select few staff who have a big impact on me because I find them genuine and are basically there for my good health and their help pulls me through.*	Unequivocal
	Barsky and West (2007)	Several service users said that they felt staff in the MSU were more willing to help, in direct contrast to the staff in the high-secure hospital.	*You know like you can approach any one of them and they will listen and help. (04 105-106)* *Staff here are here to help and the staff at xxx are just there for the money. (04 43-44)*	Unequivocal
	Barsky and West (2007)	Service users felt that the helpful and engaging nature of the staff at the RSU made them easier to approach and therefore more beneficial for recovery.	*I'm always talking to staff and getting their point of view. (02 313-314)*	Equivocal
	Baker (2017)	Alfie described the persistence of staff, even in the face of his verbal abuse:	*All I know is that I wasn't very nice to them verbally, but they still continued to be caring. (Alfie, 312-313)*	Unequivocal
	Willmot and McMurran (2013)	Factors that participants linked to changes in the 'self' domain included staff members giving accurate feedback on participants' behaviour, demonstrating trust in them and showing care and a non-judgmental attitude.	*I think a good working relationship is important [by] helping the person understand themselves by focusing on what they've done wrong but also focusing on their positives, which sometimes, like myself, I don't realise. [P7]* *Well because they've allowed me to do things, to have scissors out when other people's been around and it makes it go better ... That's a big trust in me ... so it gave me a good boost that. [P10]* *People were telling me not to beat myself up and to respect myself and love myself. People say I'm not worthless and I have got a meaning in life and being there for me, trusting me. [P2]* *[Named nurse] can seem to see through my crimes and he can see through the person that I was to the person that he's always suspected I am, which is*	Unequivocal

			I'm not too bad a bloke, that will make a go of it, that tries. He can see the changes. [P11]	
	Baker (2017)	Richard-James did not speak as warmly about the care within his current ward as others did; but acknowledged a difference between hospital and prison;	*They are in truth more therapeutic than prison aren't they.*	Equivocal
	Willmot and McMurran (2013)	The majority of change processes described by participants were behaviours of other people outside formal therapy sessions.		Unsupported
	Willmot and McMurran (2013)	Most of the themes relating to the process of change described the behaviour of other people. The most frequently mentioned groups of people were nursing staff and therapists, though other patients and family members were also mentioned.		Unsupported
	Baker (2017)	He [Bob] felt staff managed incidents of aggression safely, avoiding physical intervention where possible:	*They're not wanting to grapple them, they're not pulling the alarm and then grabbing them. (Bob, 501)*	Unequivocal
	Barsky and West (2007)	Five of the six participants described the staff in the medium-secure setting positively.		Unsupported
	Laithwaite and Gumley (2007)	Participants also spoke about their relationships with staff helping them to adapt to their new environment in the early months.		Unsupported
Friends and family in the community **($n = 8$)**	Baker (2017)	Family outside of hospital appeared a motivating influence for most participants:	*I always have in the back of my mind like I need to get out to them and like support my little niece and nephew. (Corey, 500).*	Unequivocal
	Baker (2017)	Similarly, Alfie appeared to desire close relationships but also found them difficult to cope with. He described a wish for family life, which he felt watching reality television gave him taste of:	*I try and see if I can get a bit of that, even just by watching something. And for that hour or however long a time, I feel I'm there. (Alfie 114-115)*	Unequivocal

	Tapp et al. (2013)	Anxieties were also encountered as a result of detention through being detached from family.	*A bit more contact with my family would have helped a bit I suppose … on the phone like knowing they are well like it's just, makes a break from you know … every time I call its like, phew. (p. 3)*	Unequivocal
	Mezey et al. (2010)	Recovery needed to extend beyond themselves, to their victim, to family members and to others they may have hurt or damaged.	*I am trying to move forward . . .. because mental illness doesn't just destroy your own life it destroys people around you. It makes you turn against your beloved people really people that loves you, you try to ignore them, you avoid them, you think differently about them really.*	Equivocal
	Baker (2017)	Steve was the only participant who did not refer to difficulties in relationships or challenging experiences growing up.		Unsupported
	Laithwaite and Gumley (2007)	It seems that this development in relationships was an important part of the adaptation to hospital, and recovery process, but that it was not always easy to achieve due to various limitations of being in hospital. This is evidenced by participant 4:	*I—you mentioned earlier about your relationships and your family, what are your relationships like?* *P4—I would say they are okay but I miss my family. I want to get back on my feet and get outside and be a support for my wee brother. With me being in the jail before here and then this time in hospital, we have not had time to form a real relationship. I have a good relationship with my mum who comes to see me every week, but really it is not much of a relationship with my family as I have had most of my life away from them, what with being in the jail and then a couple of weeks outside and then in hospital. I think the relationships are still strong, but I want to see my wee brother, I want to do well by my wee brother and give him help and support.*	Unequivocal
	Laithwaite and Gumley (2007)	In particular, participants spoke about 'building bridges' with their family and developing mutual respect and trust with staff.	*I—can you tell me about your index offence?* *P10—I took a member of my family hostage. I regret it now you know.* *I—how did that affect your relationship with your family?* *P10—well I wasn't well at the time, and my family came up to visit me here and told me that I wasn't well, and that they didn't hold it against me.* *I—how did you feel about that?* *P10—well I have accepted it. I just wish I hadn't done that to my family. With my brother no being here him no being here it sometimes makes it worse.* *P10—sometimes you have to put things behind you. My family have been very supportive and sometimes I feel I owe them my life. The hospital has helped me so much as well.*	Equivocal
	Laithwaite and	The following extract provides an example of how for participant 2, his past relationships with his family had	*I—tell me a bit more about your family.*	Equivocal

	Gumley (2007)	been poor. However, he valued the development of such relationships and believed it to be an important part of his recovery.	*P2—(silence) . . . I am not really in touch with my mum's side . . . because obviously because of my offence. My mum and dad come up and support me quite a lot . . . they give me quite a lot of support em . . . I am building up more of a relationship with my family. I am hoping to have a relationship with them, which I didn't have before.* *I—uhhuh . . .* *P2—em...I didn't really have a relationship with my family before I came in here. I never spoke to my mum and dad. I used to just stay in my room all the time. Ever since I have been in here I have been building up a relationship with them.*	
Supportive alliances **(*n* = 8)**	Sainsbury et al. (2004)	These supportive interactions [*of staff*] included providing the patient with information about available options, suggestions, validation of how difficult treatment can be, actively listening to their previous experiences within formal treatment programmes, and simply encouraging them to persist with treatment.		Unsupported
	Sainsbury et al. (2004)	This category [*support*] includes the messages and actions, both explicit and implicit, that patients perceive from staff and, at times, other patients. This is support that is provided outside the formal treatment programmes, typically by ward-based staff. Four codes were identified: encouragement to engage in treatment; encouragement to remain in treatment; help with difficulties; and feedback.		Unsupported
	Sainsbury et al. (2004)	Feedback [*from staff*] in a supportive manner about any difficulties the patient is demonstrating was described as helping to 'keep me on the right path' and is consistent with the aim of promoting the person's motivation within these codings.		Unsupported
	Sainsbury et al. (2004)	The data highlighted how repetition of such [*staff*] support may be an important factor in developing or maintaining motivation.		Unsupported
	Sainsbury et al. (2004)	This category [*external belief*] has clear links with the more general support category but others' belief in the participant's own capacity for change seemed		Unsupported

		sufficiently frequently cited and distinct to merit its own category.		
	Sainsbury et al. (2004)	Being able to ask for and receive help with everyday difficulties appeared to increase the feeling of being supported and the motivation for treatment.		Unsupported
	Tapp et al. (2013)	Supportive alliances represented trusted and caring relationships, old and new, between peers, family and professionals. These served a range of rehabilitative functions, which included: removing feelings of isolation; feeling cared for; promoting openness; emotional growth and challenging negative reactions towards ‘others’.	*I think it helps your cause if your family is involved in your care, … It just shows you that someone cares for you, … and you are not alone. (p. 9)* *I actually had a girlfriend here, it was er, best girl I met all my life, so X was a big part of my growth and my, maturity … feeling secure … It makes you more, more valued, which is important for growth I think … Not just physical growth, my emotional growth. (p. 10)* *because people had knew what I done and still spoke to me, still approached me, still encouraged me and still supported me, it meant all the views I had or distorted views about I am going to be rejected, no one cares about me, um, all these distortions I had as a kid, didn’t make sense anymore. (p. 8)*	Unequivocal
	Barsky and West (2007)	Service users explained that these factors [staff] had an important impact on their mental health and behaviour.		Unsupported
Punitive and antagonistic treatment from staff **(*n* = 6)**	Barsky and West (2007)	Several of the participants reported that staff members in the high-secure hospital were likely to display aggression.	*Yeah, the staff in xxx tend to be a bit… too ready to pin people down, patients down you know. (01 145-152)*	Unequivocal
	Barsky and West (2007)	Staff [*in high* secure] were described as antagonists by two service users, and several participants commented that they found it difficult to engage in conversation with staff members.	*You get the impression they’re not approachable you know… if you go to them with a problem, they say that’s not their bit and walk away. (04 113-128)*	Unequivocal
	Baker (2017)	Bob, Carl and Richard-James described punitive treatment from staff. Bob associated this with his previous HSU, in which he described staff as “draconian” (Bob, 282):	*Embedded within finding* *Seclusion is used a lot more frequently, for minor things, which they shouldn’t really do, that helped to condition people. (Bob, 235-236)*	Unequivocal
	Barsky and West (2007)	As well as contributing to a general feeling of tension, some service users explained that the way staff worked	*It’s just antagonising you and pushing you that little bit further until you snap and snap back at them and they turn around and say ‘see I told you’, that sort of thing. (02 254-256)*	Unequivocal

		at the high-secure hospital contributed to service users' displays of aggression.		
	Barsky and West (2007)	Contributing to this atmosphere [*in high secure*] was a feeling that social relationships between patients were discouraged.	*You couldn't joke around with people… with friends, you were told not to… (02 F 31-33)*	Unequivocal
	Barsky and West (2007)	He [*the participant*] described being treated like a prisoner, while another participant referred to staff as more akin to prison officers than nurses.		Unsupported
Commitment and persistence of staff **(*n* = 5)**	Baker (2017)	In the accounts of Bob, Alfie and Corey there was a sense that staff had been persistent in their efforts to engage and support them, despite this being challenging at times.		Unsupported
	Sainsbury et al. (2004)	This [*external belief*] category contained codes reflecting staff's continuing commitment to work with them, providing reassurance that there is still a future, not giving up during times of relapse and through reinforcing specific behaviours during periods of progress and maintenance of change.		Unsupported
	Sainsbury et al. (2004)	Consistency of staff belief over a longer period of time appears to increase its positive impact on motivation.		Unsupported
	Willmot and McMurran (2013)	Others mentioned the persistence of nursing staff and therapists, and their greater availability than in prison.	*What helped was the fact that whereas with the rest I'd be like 'piss off I don't want to talk to you' and I might have said that to [therapist] at one point but then the next week he was there again, and the following week he is there again and the following week too. It was like, do you know what, I'm actually not going to get rid of this guy; I can't get rid of this guy so I'm going to have to work with him. [P9]* *In gaol you get paranoid you've got no one, you just go to your room and stew on it, but here you can pull one of the nursing staff, and then once you talked about it at the end of it you're not as paranoid, you can see a bit of sense in it. [P12]*	Unequivocal

	Willmot and McMurran (2013)	A number of themes related to the culture of treatment in hospital. Several patients who had previously been in prison felt that the hospital took treatment more seriously and that staff were committed to treatment.	*Whereas prisons are just about confinement and containment-that's all that prisons are about. I don't care what people say like that prisons do treatments-they don't that's just merely window dressing. Whereas here, it is all about treatment and getting better. [P9]* *A lot of the staff … they're proud that they work the way they do on here, which is good, they like being caring. It's not as if they're being forced into it; they just prefer to have that approach; it's what they're here for. [P3]*	Unequivocal
Staff passive and not understanding **(*n* = 5)**	Sainsbury et al. (2004)	There were also examples of staff being seen as passive, which were interpreted as unsupportive, contributing to a decrease in motivation.		Unsupported
	Baker (2017)	Carl appeared to seek the care of staff and was preoccupied with their availability; When staff were not consistent in their support this appeared very challenging for him.	*They can't wait to break their necks and get on bloody annual leave (Carl, 1026).*	Unequivocal
	Baker (2017)	Carl felt he had very difficult relationships with staff:	*Staff are a last resort. I don't really speak to them. Cause I hate them basically*	Unequivocal
	Barsky and West (2007)	One participant talked about the lack of understanding of mental health problems displayed by the staff.		Unsupported
	Barsky and West (2007)	Five of the six participants described the staff in the high-secure units in a generally negative light.		Unsupported
The therapist **(*n* = 5)**	Sainsbury et al. (2004)	This category [*therapeutic relationship*] represents a positive therapeutic relationship that consists of many of the categories described above within the context of an individual therapeutic relationship, which appears to culminate in a pervasive sense of trust.		Unsupported
	Sainsbury et al. (2004)	There are themes of other categories in this category [*treatment*], including belief, safety and support. However, it appears that it is the combination of these aspects within the therapist's approach that is important in successfully coaxing people through denial and	*I was in denial, but I wasn't. I was waiting for someone, a reassuring person, to guide it out of me, to coax it all out of me … he wasn't aggressive he wasn't anything - he just sat there, which is basically what I needed - someone to guide me and sit there despite the fact that I was literally bouncing up and down on the chair. It didn't faze him at all, he just sat there. He wasn't taking*	Equivocal

		increasing motivation. Many of these aspects are illustrated in the following example:	*no for an answer but he wasn't aggressive. It was a turning point in my treatment.*	
	Willmot and McMurran (2013)	Where therapy was mentioned, it was generally the non-specific elements of therapy, such as the therapeutic relationship or group support, rather than therapy-specific factors, such as mindfulness or schema dialogues.		Unsupported
	Sainsbury et al. (2004)	Coaxing it out safely (the therapist's approach): This code contained examples of the importance of the therapists' response to the participants' denial of their difficulties, including their offending and the. destructive or defensive behaviours they display in the session. The data highlighted how patients were helped to develop acknowledgement and understanding of their difficulties within the treatment setting through the containment and persistence of the therapist.		Unsupported
	Willmot and McMurran (2013)	One participant also reported learning about relationships in general from his therapeutic relationships with his therapist.	*I think a good working relationship is important in places like this, because not only are you building a good relationship with people you work closely with, but also helping the person understand themselves by focusing on what they've done wrong but also focusing on their positives, which sometimes, like myself, I don't realise. [P7]*	Unequivocal
Being judged by staff **(*n* = 4)**	Baker (2017)	Richard-James and Carl suggested that FSUs are morally judged in relation to their offences which is how staff justify treating them badly:	*He feels like he's been victimised because of what he's in for [. . .] People look at your offence more than anything else. And people are not supposed to do that. (Richard-James 224-227)*	Unequivocal
	Barsky and West (2007)	One service user described at length the 'us and them' atmosphere on the wards. [*high secure]*	Embedded within finding	Unequivocal
	Baker (2017)	Corey was very aware that his "history" still influenced how others saw him and this meant staff were "cautious" in allowing him to progress (Corey, 424).	Embedded within finding	Equivocal
	Mezey et al. (2010)	Although supportive and positive staff attitudes and relationships assist recovery, unkind, insensitive, or intolerant treatment or remarks can have an equally powerful negative impact on the recovery process.	*If you make a request which is reasonable and you get…an abrupt response or someone treats you badly in that interaction, it affects the way you feel about yourself as a person, is it just me they're doing it to, is it something that I've done, or something that is wrong with me.*	Unequivocal

			I mean sometimes I feel they don't look at us as people, sometimes I feel they look at us as objects, like it's their job, that they come in and they have to do it . . ...they're just here, they're just doing their job and they want out of here and that doesn't help.	
Sharing experiences with and relating to peers **(n = 4)**	Tapp et al. (2013)	Sharing experiences with peers contributed to a greater understanding of personal difficulties and could also remove feelings of loneliness related suffering with serious problems.		Unequivocal
	Willmot and McMurran (2013)	Participants also described seeing themselves as similar to other people, both in terms of their past experiences and in the way they thought and felt. They described having changed, both in how they saw themselves and in how they related to other people.	*Just saying about their [i.e. other patients'] life outside, that they lived the same kind of life as what I did and they were putting it behind them and they were looking forward to a different life outside and getting jobs and things. I've not had a job in years and I thought well, if they're thinking that they can get out there must be some hope for me, because I'd like to get out, get some kind of work. [P6]* *... Not just nurses but fellow patients as well ... we'd be chatting and they'd say "I felt like this today", and I thought "Bloody hell, did you? So did I!" [P11]*	Unequivocal
	Willmot and McMurran (2013)	Participants identified that other patients' self-disclosure about their backgrounds and current thoughts and emotions helped to promote the belief that they were similar to other people.	*I used to think that I'm the only one that these things have happened to, and when I was listening to other people's stories and they were the same as mine, I thought well I'm not on my own. [P6]* *That [therapy] group helped a lot because I learnt that everybody's the same really, they've all go the same problems in different ways and it affects people in different ways. [P10]*	Unequivocal
	Laithwaite and Gumley (2007)	[…] although talking to other patients was generally considered helpful by most participants, they also said that discussing problems could lead to a sense of hopelessness about their circumstances. This is described by participant 4:	*I—you are saying you really do not know much about your plans . . . what is that like for you having that sort of experience?* *P 4—eh . . . I've got lots of experiences in the past that have been hard to deal with, but it is my family I feel more for. It's hard for them to deal with. They are wanting me oot, to get on with my life again. They get no information on what is happening, I am still here. I find it annoying because I want to be out there for them, I want to be there for my wee brothers and stop them from getting into trouble, and give them a bit of guidance. For me in here, you have to get things to keep you going. Do different things and all that. Sometimes you don't have the motivation for it . . . it is just a struggle.*	Equivocal

			I—what kinds of things do you do? *P4—just things like going to the fitba, that takes a lot of stress out of us. Some of the placements are alright, but in a lot of them you just sit about and drink tea and have a fag, and all people talk about is being in hospital and what is happening to them. I just want to get away from all of that. That brings you down just hearing that stuff all the time. There's cooking sessions which are alright and the visits keep me going. (Silence 10 seconds) I also turn to some of the guys in the ward as well . . . that keeps you going an all. Once you start talking you start thinking 'its just no happening' and that can bring you down.*	
Friendly staff **(*n* = 3)**	Barsky and West (2007)	Compared with the high-secure hospital, one service user believed:	*You have a lot more friendly staff here [MSU], you have twits as well but… (95298)*	Unequivocal
	Barsky and West (2007)	Many said that staff were friendlier and more willing to engage in conversation. [*in medium secure*]	*Staff are all right, you can have a laugh and a joke with them.' (07 261-263).*	Unequivocal
	Barsky and West (2007)	Two of the participants spoke of the staff at the high-secure hospital in a fairly positive light. One stated 'some are okay, some are friendly, patient' (01 Q 150), while another said the staff at the two sites were 'both the same, no difference' (03 E 155).	Embedded within finding	Unequivocal
Learning from peers **(*n* = 3)**	Baker (2017)	Relationships with peers also contributed to the safe atmosphere at times. Most participants described either helping peers who they knew were having a difficult time or being helped by others:	*Like there's another patient, I'm quite supportive to him [. . .] I've got a lot of time for him. (Corey, 67-70)*	Unequivocal
	Tapp et al. (2013)	Learning about the consequences of behaviour was reported to have been activated and fostered by interactions with peers, family and professionals.	*So you listen to other people about what they are talking about and then you try to put some of that into your life about what you did and normally it gives you an understanding … makes you aware there are other people like you, and other people got the same problems as you and you are not on your own. (p. 1)* *Sometimes when you hear other people talking about their self, you think hang on a minute I don't believe that at all … and it makes you challenge the thoughts you have, its important. (p1)*	Equivocal

			People say that is out of order, you shouldn't have done that … it makes me think I shouldn't have done it, it makes me think, re-think about it you know I just re-think the incident, so what happened, I just re-think to see whether he was right then in what he said … (p. 11)	
	Tapp et al. (2013)	Feedback from others also promoted a sense of challenging individual thinking and an awareness of the consequences of actions.		Unequivocal
Questionable motives of staff **(*n* = 3)**	Baker (2017)	Bob and Richard-James described corruption amongst staff teams in their previous HSUs. Bob referred to a staff member bringing in illegal drugs and assaulting a FSU.		Unsupported
	Baker (2017)	He [*Bob*] suggested that there was a culture within staff teams whereby they protected each other:	*If someone is informing on their group it's taken very personally and that person suffers because of it. (Bob, 340-341)*	Equivocal
	Barsky and West (2007)	Another [*participant*] questioned the motives of many working in these facilities. [*high secure*]	*They're there for the money and money only, if something goes wrong they don't care. (05 302-303)*	Unequivocal
Consistency and availability of staff **(*n* = 2)**	Baker (2017)	Several participants made reference to the consistency and availability of support from staff.		Unsupported
	Baker (2017)	A number reported feeling helped by psychology and psychiatry, but nursing staff in particular were discussed as the most present and available source of support:	*The ward environment as well that's therapeutic at times [. . .] Just being on the ward around nurses and you know you've got the support there. (Corey, 172-174)*	Equivocal
Staff believing in patients **(*n* = 2)**	Sainsbury et al. (2004)	Psychological methods: This included the feeling of safety within a therapeutic relationship with staff. It consists of staff presenting as confident about their ability to contain and manage the participants, not being afraid or frightened of them, and developing a belief in the patients that they are not going to harm or reject them, as this quote illustrates:	*He wasn't fazed by my actions, which helped a lot, he wasn't frightened or worried, a turning point in my treatment, it helped me to admit my offences.*	Equivocal
	Sainsbury et al. (2004)	Others believing in the patient's ability to successfully engage in the change process was highlighted as important in developing motivation.	*My support nurse - the confidence and faith he has in me, that I could do it.*	Equivocal

Re-enactment of adverse early life experiences and survival strategies
(N = 60)

Category	**Reference**	**Finding**	**Illustration**	**Plausibility**
Survival strategies **(n = 26)**	Baker (2017)	Richard-James and Bob both described an ability to detach from their emotions that professionals in FMHS had suggested was related to their history. Richard-James had been told by a psychologist that he was “too controlled” with his emotions (Richard-James, 575); however he felt this helped him to cope in FMHS:	Embedded within finding *I’ve seen really emotional people and they don’t get nowhere (Richard-James, 580).*	Unequivocal
	Baker (2017)	Similarly Richard James described himself acting “like an animal” in prison when he was younger and suggested that this had developed in response to repeat provocation from prison officers:	Embedded within finding *If you poke a dog he’ll bark at you won’t he (Richard-James, 471).*	Unequivocal
	Baker (2017)	Ambivalence towards relationships was evident in the majority of participant accounts and several participants described an awareness of how their present relationships were influenced by those in their past.		Unsupported
	Baker (2017)	The apparent continuity between participants’ histories and aspects of the secure environment appeared to reinforce ways of coping developed in response to the initial challenges they faced.		Unsupported
	Baker (2017)	Richard James felt his previous experiences had given him a degree of resilience;	*I can cope with difficulties quite well (Richard-James, 564).*	Unequivocal
	Baker (2017)	Described his early experiences leaving him with a strong sense of independence;	*I was used to fending for myself (Bob, 978).*	Unequivocal
	Baker (2017)	The sense of threat experienced in relationships with peers and staff in FMHS appeared to reinforce participants’ beliefs regarding the necessity of self-defense and the dangers of showing weakness.		Unsupported
	Baker (2017)	Bob described being bullied physically when he was young and, encouraged by others around him at the	*You’ve either got to fight him or look like a fool and everyone rides you. (Bob, 835-836)*	Unequivocal

		time, ultimately responded to this violently. Subsequently he described using physical strength and aggression habitually in order to protect himself, feeling this was necessary for survival. This was reinforced when he was in Young Offender Institutions:		
	Baker (2017)	He deliberately avoided opportunities for relationships:	*I choose to be a loner, if you like (Alfie, 418).*	Unequivocal
	Baker (2017)	In contrast to the other participants, Steve did not express the same desire to change as a person. He explained that previously he had been able to appear "normal" for mental health professionals and this was how he had managed being in the community:	Embedded within finding *I have the ability to you know, put on a normal face. (Steve, 475)*	Unequivocal
	Baker (2017)	Richard-James also spoke about being independent and this appeared to affect the way he engaged with staff and treatment in FMHS	*There's nothing they can do for me [. . .] it's just myself (Richard-James, 517).*	Unequivocal
	Baker (2017)	Several participants described strategies they consciously employed to help reduce their sense of disempowerment. Alfie sought to make the most of what was in his control:	*There's not much control that I have [. . .] but there are things that I can grasp control of so, one thing that I'm very controlling over is the food I eat, the smoking. (Alfie, 149-151)*	Unequivocal
	Baker (2017)	How participants experienced and managed the secure environment now as adults appeared influenced by this [*childhood*] history.		Unsupported
	Barsky and West (2007)	Another participant highlighted that the different atmospheres [*between high and medium secure*] affected the way he believed he had to present himself to other patients.	*When I first came here I was grumpy, snappy, err a bit paranoid. Ehm I was… sort of like a bit pushy. Then I learned that I didn't have to be here, you didn't have to put on a brave face or something like that. (02 M 156-159)*	Unequivocal
	Baker (2017)	In managing their disempowered positions, Carl, Steve and Bob suggested that attempts to "fight the system" (Carl, 175) were futile.	Embedded within finding	Unequivocal
	Baker (2017)	In addition to mistrust, several participants described a co-existing desire for close relationships with others, yet the prospect appeared challenging for them.		Unsupported

	Laithwaite and Gumley (2007)	Participants also spoke about their attempts to cope with difficult experiences and emotions, which appeared to derive from such negative experiences.		Unsupported
	Laithwaite and Gumley (2007)	In the discussion that preceded the following extract, participant 11 was talking about how he coped with difficult experiences in the past by retreating into his ‘shell’. He explained how this pattern of coping developed from a belief that he was worthless and stupid. He then spoke about an early memory of being bullied and feeling rejected, which he felt contributed to the development of his view of himself as worthless.	*P11—when I went into prison, that is how I dealt with things. Even before going to prison that is how I would deal with things (pause) I would just go into my shell. Some people might say I was just ‘stand offish’ but that is just how I would deal with things. When I was at school, High school, I was bullied at school. I see myself as worthless and not good enough, and . . . I am nervous about carrying on a conversation with someone in case I say the wrong things, or I say something that is stupid, so I will go into my shell and that is how I deal with things. I sort of shy away from people, and I am just quiet.*	Unequivocal
	Laithwaite and Gumley (2007)	In many cases, participants spoke about their relationships with others with the dynamics of power and control being discussed.		Unsupported
	Laithwaite and Gumley (2007)	Participants spoke about feeling dominated by others, feeling helpless and lacking control. These dynamics were reflected in different relationships including peers, teachers and parents.		Unsupported
	Laithwaite and Gumley (2007)	These experiences had an impact on participants describing a highly autonomous stance towards others, arising from the expectation that others would be domineering and controlling.		Unsupported
	Laithwaite and Gumley (2007)	In the following extract, participant 7 described a specific memory where he felt he lacked any power or control over what happened to him. This appeared to have a significant impact on him, as it made him resolute that no one else would have any power or authority over him.	*I—are you able to think of an example to describe what you are saying?* *P7—well eh, you know I was 15 years old and I was scared of this guy, as I had broke his bicycle 3 years previously and he had started demanding money for it at school . . . I was scared of him and I could not pay because my father just did not have that kind of spare money to fix his bicycle. He was just bullying me, but I stayed off school just to get away from him and I got referred to the psychiatrist and got taken into the psychiatric unit.* *I—right*	Unequivocal

			P7—I wanted to go to the school party . . . and I got dressed for the school party, as that would have been the last time that I would have seen anyone from school. I wasn't allowed to go in to this school party . . . *I—why?* *P7—. . . it was a decision eh, that wasn't mine, made by the sports staff that were providing the security for the party. That incident, that sce- nario, made a difference to the way I actually became, the person I became, because I wasn't allowed to do something I wanted to do, you see the aim was to get all dressed up, to get dolled up, in my suit and tie, and eh, but because the B became a dead end for me, and I had to go in a different direction.* *I—and how did that experience influence you?* *P7—it made me decide that I wouldn't let every- one make the decision for me, that would stop me enjoying what I wanted to do. I did that. When I made that decision, I became who I am today.*	
	Laithwaite and Gumley (2007)	For many of the participants, this [*reflecting on past selves in relation to their coping style and reactions with others]* involved describing their use of drugs and alcohol or the use of self-harming as a way of coping with difficult emotions and feelings.	*I—those are the kinds of things that have helped you feel better about yourself . . . I am just wondering if there is anything different about your- self now, which makes you feel happier about yourself?* *P1—I am a lot calmer now than I used to be when I was outside. I had never been diagnosed when I was outside either. I went from being depressed and wanting to commit suicide eh to manic and cycling 35–50 miles a day . . . and I didn't even realise I was ill. I didn't realise that my life was spinning around so much. It was when I was manic that I was using so much cannabis, and eh without the cannabis I wasn't sleeping at all. I was using it to self-medicate, although I wasn't thinking about that at the time. I thought I was addicted to cannabis. It has given me a lot of insight into the fact that I was so unwell. It has also given me a lot if hindsight into things that have happened in the past, which I didn't under- stand at the time and felt very frustrated about.*	Unequivocal
	Laithwaite and Gumley (2007)	…experiences of past relationships influenced the ease at which new relationships with staff could be formed.		Unsupported
	Laithwaite and	This [*early experiences of adversity]* appeared to influence the ease with which participants were able to form relationships with others.		Unsupported

	Gumley (2007)			
	Laithwaite and Gumley (2007)	During the interviews participants reflected on their past selves in relation to their coping style and reactions to others.		Unsupported
Early life experiences (*n* = 12)	Laithwaite and Gumley (2007)	All 13 participants spoke about the past experiences that led to their being in hospital, discussing this in terms of themselves and their relationships with others.		Unsupported
	Laithwaite and Gumley (2007)	When discussing past experiences they described parental break-up, relationship breakdown (with family and significant others) and being bullied		Unsupported
	Laithwaite and Gumley (2007)	Participants also spoke about feeling hurt in the past, and some spoke about their experiences of rejection.		Unsupported
	Laithwaite and Gumley (2007)	When talking about their past, participants spoke about the impact of those experiences on their view and development of self and how in some cases it contributed to feelings of worthlessness.		Unsupported
	Laithwaite and Gumley (2007)	Many participants spoke about early parental separation and divorce. Some spoke about how this had a long-lasting and enduring impact on them, in terms of loss or unresolved feelings.		Unsupported
	Laithwaite and Gumley (2007)	…the following paragraph is a discussion with participant 5 about the impact of his father's death on his life and sense of direction.	*P5—what was I telling you about . . . my father died when I was five so that kind of changed the direction away from me, although there was a step-father, it still didn't give me the direction.* *I—what do you mean when you say it took away your direction?* *P5—what I mean by that is that the path was no longer clear . . . the future was unknown and em, (pauses) I would have to look round the corner myself with no protection.* *I—it sounds as though you felt quite vulnerable?*	Unequivocal

			P5—(silence)—it didn't feel like I was vulnerable, it felt like I was (pauses) it felt like (pauses) I had to protect myself. *I—why do you think you felt that way?* *P5—my dad was a protector. He would have looked after me.* *I—how does it feel talking about this?* *P5—it feels a little disjointed. My whole life . . . I never found my true vocation . . . I had 16 different jobs, never ever found anything I could settle into, and em, nothing that could give me eh what my father had given me, like the, nothing could fill the gap. He died everything changed. When he died it was like being on the top of a mountain . . . everything below me was still there, but everything had changed . . . everything seemed to be worthless. My dad loved me, and I was the best to my dad and he was the best to me. (long silence 30 seconds)*	
	Laithwaite and Gumley (2007)	Participants described early experiences of rejection from parental figures and/or peers and reflected on the significance of this in terms of current feelings of worthlessness.		Unsupported
	Laithwaite and Gumley (2007)	Some of the participants spoke about their experiences of feeling on the outside and never feeling part of things.		Unsupported
	Laithwaite and Gumley (2007)	It appeared from their discussions that these earlier experiences had a significant impact on their development of self, with many of the participants perceiving themselves at some point in their lives as worthless.		Unsupported
	Laithwaite and Gumley (2007)	Participants spoke about relationships in the past as being poor and these relationships seemed to be characterized by feelings of rejection, loss (particularly primary caregivers) and lack of trust.		Unsupported
	Laithwaite and Gumley (2007)	When participants spoke about their past experiences, they spoke about their relationships with significant others.		Unsupported

	Laithwaite and Gumley (2007)	The experiences just described illustrate a consistent picture provided by all participants of their early experiences as being characterized by a strong sense of interpersonal adversity, illustrated through experiences of loss, family break-up, feelings of rejection and worthlessness.		Unsupported
Exposure to challenging behaviours (n = 8)	Baker (2017)	The majority of participants made reference to being unable to escape the difficulties of peers and one individual's behaviour could have consequences for the whole environment.		Unsupported
	Mezey et al. (2010)	Whilst a good physical environment contributed to patients feeling more valued, happier and safer, small cramped wards, and overcrowding were seen as impediments to recovery.	*If you feel really cramped . . . it affects the atmosphere, it affects the stress between individuals. Sometimes you need to be able to chill out and that. Especially when things are very noisy, that can affect people and make them feel on edge and nervous and agitated and stuff.* *There's a lot of volatile people in here, it can be quite scary, there's times where I get, not paranoid, but I think that I might get hurt in here and stuff. I mean some people in here . . . I've been punched, I've been attacked a couple of times.*	Unequivocal
	Barsky and West (2007)	The comment quoted above [*to the right*] encapsulates the feeling of several of the participants about the high-secure wards, which was said to contribute to a sense of 'feeling very tense on the ward' (01 H 52).	Embedded within finding *Yeah it was crammed and there's bound to be violence, there's bound to be… you can't work with twenty five patients and six staff, and they're all volatile patients you know, I was ready for hitting people, they were ready for hitting me for no reason simply because we were all shut in one room, we were all in each other's faces, you know it just didn't work, there was no where to go and get out of the way. (02 F 340-341)*	Unequivocal
	Barsky and West (2007)	Regarding the [*atmosphere on the ward in the*] RSU, participants commented: I think it's more stable here… more violent over There' [*high secure*] (03 H 198), and that: 'it's a different ball game [at the MSU] (04 O 168).	Embedded within finding	Unequivocal
	Tapp et al. (2013)	Safe management of the high secure environment was important to ensure the impacts of any crises were kept to a minimum.	*In general those disruptions come in manageable sizes … it is more manageable … the person who attacked me, staff are restraining him and in seclusion, so it's not like it's going to be a huge great calamity. (p. 10)*	Unequivocal

	Tapp et al. (2013)	Exposure to verbal, physical or emotional harm had clear implications for emotional well-being, and the potential toxicity from lapses in physical or procedural practices (e.g. accessing restricted items) could be equally detrimental.	*I have been bullied in the past, um, by patients and um been mistreated a little bit by staff, during another time period, … the experience what I find in top security hospitals are its quite um, it's not very easy to sort of explain, … I have experienced anxiety. (p. 2)* *There was patients on there [ward] that were smoking dope and that, and I never connected my drug and alcohol problem to my criminal history … I used to sit round smoking dope and all that, well of course my paranoia got worse. (p. 6)*	Unequivocal
	Baker (2017)	Carl referred to relationships with peers as follows:	*Pure evil in here like, poison. Like if someone sees you doing well in here [. . .], you've got to look after yourself, self-defense like. (Carl, 565-566)*	Unequivocal
	Baker (2017)	Bob described a confrontation with a peer in which he did not wish to lose face:	*I'm not being chased off the day room by him (Bob, 224).*	Unequivocal
Difficulty trusting others (*n* = 5)	Baker (2017)	Alfie described an anticipation that others would let him down and also experienced "paranoia", often worrying whether others were speaking about him behind his back (Alfie, 162).	Embedded within finding	Unequivocal
	Baker (2017)	Corey and Bob also reported difficulties trusting others.		Unsupported
	Baker (2017)	Carl spoke extensively about difficulties in his relationships with staff who he felt could not be trusted.		Unsupported
	Barsky and West (2007)	The difficulties in engaging with or trusting staff had important implications for service users' subsequent behaviour.	*Well, it makes you frustrated really, and it changes your personality… you draw into yourself, a little problem gets bigger and bigger until an incident or something. (04 117-118)*	Unequivocal
	Laithwaite and Gumley (2007)	Most participants spoke about the need for trust and how this took time to develop.		Unsupported
Care resonating with early life experiences	Baker (2017)	Participants' experiences in FMHS appeared to resonate with aspects of their lives prior to detention.		Unsupported

(*n* = 4)		As evidenced in the other subthemes within **‘disempowered, dehumanised’ participants’ described** a degree of deprivation and mistreatment within FMHS and this was consistent with the early experiences they discussed.		
	Baker (2017)	The majority of participants, three of whom had been in care, spoke about challenging experiences when they were younger including abuse, neglect or mistreatment from people in positions of trust.		Unsupported
	Baker (2017)	Corey did not discuss his early childhood in detail, but did give a sense of being in a hostile environment;	*I was brought up in quite a critical environment (Corey, 533).*	Unequivocal
	Baker (2017)	It appeared being moved within FMHS may have echoed early rejections in a family context for some participants.		Unsupported
Feeling frightened / vulnerable (*n* = 3)	Sainsbury et al. (2004)	Exposing vulnerabilities: Having to expose their weaknesses and the perceived vulnerabilities associated with changing were identified as having a negative effect on motivation to engage in treatment.		Unsupported
	Baker (2017)	Bob reflected on how difficult he found it when he first came to medium secure care after being in a HSU. He found the increased access to facilities daunting and avoided using them initially; he commented	*I felt like a child that had to learn again* (Bob, 223).	Equivocal
	Laithwaite and Gumley (2007)	All participants spoke about their experiences of being in hospital. This included accounts of their early experiences of being in hospital, which many participants described as frightening.		Unsupported
Loss of liberties/freedom (*n* = 2)	Baker (2017)	There was also reference to the loss of certain liberties. Bob explained how he missed not being able to buy things for himself and described the impact of losing such freedoms:	*You know a lot of people don’t realise what it does to you to have all those things taken from you. (Bob, 482-483)*	Unequivocal
	Baker (2017)	A number of participants described a sense of loss in relation to interests and aspects of their lives that were important to them when in the community:	*The internet was a big part of my life. Being online. When that’s taken away from you it seems to be a big loss. (Steve, 28-29)*	Unequivocal
Personal recovery				

(*N* = 43)				
Category	**Reference**	**Finding**	**Illustration**	**Plausibility**
Acceptance and inner strength **(*n* = 14)**	Baker (2017)	Several participants made reference to an internal quality that helped them cope with setbacks;	*It's some kind of inner strength (Steve, 428).*	Unequivocal
	Baker (2017)	He [*Richard*-James] and Alfie also appeared to take motivation from a very firm belief that change for them was necessary;	*Wanting to change. Needing to change (Alfie, 201).*	Unequivocal
	Baker (2017)	Of further help to Alfie was an apparent acceptance that the journey would be challenging:	*You don't get to the top of a mountain just by looking at it (Alfie 411-412).*	Unequivocal
	Baker (2017)	All participants however, described factors that helped maintain their motivation, enabling them to "keep going" (Steve, 408), "keep motivated" (Carl, 54) and "keep focused" (Corey, 500).	Embedded within finding	Unequivocal
	Mezey et al. (2010)	Increased self-esteem, confidence, and self-belief were frequently mentioned as indicators of mental health recovery.	*you know as far as mental illness go I've made quite a lot of progress, but after the last time I was ill, it really knocked my confidence quite a lot and my self-esteem and my belief in myself, because I was ill for so long, in such a bad way.*	Unequivocal
	Mezey et al. (2010)	Hope and self-acceptance are two of the central tenets of the recovery approach. Some patients felt that it was important to be hopeful and positive about their illness and their future, which included not committing further crimes.	*As far as having total recovery, to the point that I was when I was 20 years old before I got ill, well, I had belief in myself to the point where I thought I could do just as well as anybody else. I hope that's its possible, I'm working towards it, but I don't know for certain it's possible.* *I'm actually in the process of trying to find hope again, you know I'm coming to that point, but you know if you haven't got hope then it really hinders your recovery.*	Equivocal
	Mezey et al. (2010)	Another patient stated, in response to a direct question about the importance of hope in recovery:	*Hope will get you nowhere I don't think. They just forget about you.*	Unequivocal
	Sainsbury et al. (2004)	Whilst participants were not asked directly about internal motivation, codes relating to internal motivation emerged, including: reminding self of achievements; valued activities; wishing to leave secure institutions; not wanting to waste one's life; being with	*I thought, I am only young and I want to get out of here and do something good.*	Equivocal

		family/community; freedom; having a future; to prove to others that they have changed and do something good; to be something other than a bad person.		
	Sainsbury et al. (2004)	Internal motivators were described as helpful in maintaining motivation during difficult periods.		Unsupported
	Willmot and McMurran (2013)	Participants described having a more positive view of themselves than they had previously, and as seeing themselves as capable of changing for the better:	*Being somebody I think is important to me, instead of just "I'm nobody". [P1]* *Now with the insight and the confidence to feel that I am changing and that my outlook is different, there is a possibility that I have got a future outside and I can get out and I can do what I've always wanted to do. [P8]*	Unequivocal
	Baker (2017)	There was a suggestion in participant accounts of resilience, motivation and hope but also co-existing constraints, ties and barriers and overall a sense of struggle between the two.		Unsupported
	Baker (2017)	Progress itself appeared self-perpetuating; noticing changes increased participants' sense of hope and motivation.		Unsupported
	Baker (2017)	Similarly Alfie described what making progress felt like for him:	*It makes me feel happy. Makes me feel like I've accomplished something. Makes me feel that just maybe my life isn't going to be a f**k up like it has been for the last 30 years. Maybe the next 30 years are going to be the better years. (Alfie, 357-359)*	Unequivocal
	Laithwaite and Gumley (2007)	With regard to adapting to the environment of the hospital, participants spoke about developing a strategy of being 'open-minded' and trying not to have preconceived ideas. This was difficult for many as coming into hospital was a frightening experience for most of those interviewed. It was marked by their experiencing extreme fearful paranoia and feeling threatened by others.		Unsupported
Developing new skills	Willmot and McMurran (2013)	They described developing skills that allowed them to engage in goal-directed behaviour, such as decision making and target setting.	*I'm more able to make up my mind. [P2]*	Unequivocal

(*n* = 6)			*It feels good to have a target, even if it's next Sunday I'll have achieved this and I achieve it, that's a hell of a lot more than I was doing, and it gives you confidence in yourself. [P8]*	
	Willmot and McMurran (2013)	Participants also described being better able to regulate their thoughts, impulses and emotions. While some participants attributed this in part to the effects of medication in slowing down their thoughts, participants also described a range of effective self-regulation skills:	*My head used to run at 100 mph, and now I know coping strategies and took new medication it's slowed down my thinking processes so I don't think of more than one thing at a time. [P2]* *It's about breathing exercises and listening to relaxing music and slowing yourself down until you're ready to start thinking. [P2]* *DBT; that helped me to understand my emotions and regulate them. [P8]* *I've never been able to relax before; they've told me how to relax and not be uptight all the time, because I've been violent all my life and relaxation was something that never came into my life. [P6]*	Unequivocal
	Willmot and McMurran (2013)	They [*participants*] also presented as more self-aware, better able to understand their current behaviour and to accept and make sense of early traumas:	*Insight. Understanding that a lot of my problems stem from me, whereas years ago I'd think that a lot of problems stemmed from other people. [P8]* *I think that one important thing for me is to gain knowledge of my past, instead of growing up being a nobody and rejected and believing that it was my fault for what happened to me many years ago, when it's not my fault, it was other people's fault. [P1]*	Unequivocal
	Laithwaite and Gumley (2007)	Participants spoke about the process of learning about themselves and how being in hospital involved a process of making sense of past experiences.		Unsupported
	Laithwaite and Gumley (2007)	In order to tolerate this [*the lack of certainty regarding their stay in hospital and the effects on their family*], participants spoke about coping strategies such as the use of distraction, attending placements (e.g., cooking, sports and recreation) and talking to other patients.		
	Laithwaite and Gumley (2007)	Integral to this process of learning about self, was the capacity to reflect on past experiences and to recognize where things could have been different.		Unsupported

Reduction in clinical symptoms / behaviour **(*n* = 4)**	Mezey et al. (2010)	Symptom reduction was regarded as necessary, but not sufficient, to indicate recovery.		Unsupported
	Baker (2017)	Alfie reported he had been able to stop self-harming since coming to hospital and had also come off prescribed medication, which he was pleased with, as he had previously thought he needed this in order to function.		Unsupported
	Baker (2017)	He described being very unwell prior to admission and explained he did not feel like himself when he was like this:	*Being unwell it changes your personality [. . .] I've got no patience for anything I'm just loud and obnoxious. And not that nice to be honest. (Steve, 335-338).*	Unequivocal
	Laithwaite and Gumley (2007)	In the next extract, participant 10 is reflecting on how he has changed since being in the hospital:	*I—do you feel you have changed at all since being in the hospital? P10—oh yes, I am an entirely different person now. Before I came in here, I was just a junkie, and then I realised I don't need drink and drugs to lead a normal life. I know I don't need them. I just hope in the future I don't fall back into the same trap. But as I say, I have looked into it a lot, and I don't think I will fall back into the same trap. That was 23 years I was taking the drugs.*	Unequivocal
Little privileges and responsibility **(*n* = 3)**	Barsky and West (2007)	Some participants spoke of the increased freedom on the wards of the RSU and 'that little bit more trust' (02 F 360) they received.	Embedded within finding	Unequivocal
	Barsky and West (2007)	[*in medium secure*] Kitchen access to make tea and coffee, and access to bedrooms throughout the day were described as 'little privileges that make you feel better' (04 I 198).	Embedded within finding	Unequivocal
	Sainsbury et al. (2004)	It appears from the data that a sense of belonging develops through consistent input over time and through practical methods, e.g. giving patients more responsibilities.		Unsupported
Ability to trust **(*n* = 3)**	Laithwaite and Gumley (2007)	Participants discussed what helped them to adapt to the hospital and spoke about issues such as *relationships with staff and family*; the *development of trust*; *coping*; and their *valued outcomes* in terms of recovery.		Unsupported

	Laithwaite and Gumley (2007)	This theme of trust in relationships and feeling valued was developed further and considered by participants to be a significant theme in their recovery.		Unsupported
	Willmot and McMurran (2013)	Participants described their perceptions of other people as being more trustworthy and less hostile than they had been previously:	*I assume people are there to help me, whereas before I didn't see people as there to help me, I saw them as there to drag me down. I always used to think if they talk to me they're after something, but now I realise that people can talk to me and they're not after something, they're interested in me. [P6]*	
Setbacks **(*n* = 6)**	Baker (2017)	Alfie seemed to describe a sense of exhaustion at having to pick himself up after repeat setbacks:	*I always end up back at square one [. . .] it was so many times that I was tired of dragging myself up and fighting me way back to where I was and trying again, trying again, trying again. (Alfie, 403-404)*	Unequivocal
	Baker (2017)	Two participants discussed periods of feeling suicidal and it appeared that this was what giving up represented to them and was the alternative to progress.		Unsupported
	Baker (2017)	Such incidents could lead to a loss of hope; Steve, Alfie and Corey all described the temptation to "give up" (Steve, 370).	Embedded within finding	Unequivocal
	Baker (2017)	Every participant had experienced setbacks within FMHS and these were often in the form of incidents of self-harm or aggression.		Unsupported
	Baker (2017)	The majority of participants reported that experiencing incidents of self-harm or aggression had a significant negative impact emotionally.		Unsupported
	Baker (2017)	Steve described trying to make progress as like "snakes and ladders" (Steve,408), demonstrating that the process was not linear and it often felt like "one step forward and two steps back" (Steve, 404).	Embedded within finding	Unequivocal
Identities as perpetrators **(*n* = 5)**	Baker (2017)	Bob spoke about a desire to make a new name for himself, one not associated with violence and crime; He had legally changed his name in order to help this.	*I'm hoping once I get out there to do something with me life, make a new name (Bob, 941).*	Unequivocal
	Baker (2017)	There appeared to be a range of factors impeding this development of a new sense of identity, with ties to		Unsupported

		participants' pasts both in the context of FMHS and within themselves.		
	Baker (2017)	Bob and Carl also made reference to the victims of their offences, consideration of whom was another reality of returning to the community and a very clear reminder of their identities as perpetrators.		Unsupported
	Baker (2017)	This theme [*The struggle*] was evident in all participants' accounts and describes the challenges of trying to progress through FMHS and trying to develop a sense of identity for their future lives beyond FMHS.		Unsupported
	Baker (2017)	In describing helping others, Bob made several references to the use of physical aggression, which appeared to suggest that it was still an important part of how he saw himself:	*I've seen parents they hold their child by the arm and they're slapping them really hard [. . .] and I'm like how about you feel my fist in your face. (Bob, 920-921)*	Equivocal
Lack of motivation **($n = 2$)**	Laithwaite and Gumley (2007)	For some, however, the process of being in hospital was a negative experience, which seemed to have exerted a negative influence on their sense of self, contributing to low self-esteem and feelings of worthlessness. This was reflected in how they spoke about themselves in the interview.	*I—so what's it like for you being in the hospital?* *P8—good most of the time. I do nothing but lie on the couch.* *I—why is that?* *P8—I don't want to do anything else. I have become so big and put on so much weight since I came in here that I can't do much else. All I want to do, all I want to do right now is sleep.*	Equivocal
	Laithwaite and Gumley (2007)	Towards the end of the interview, this participant decided that she no longer wanted to be interviewed and stated the following:	*P8—You can repeat basically what I have said which is some lonely lassie whose not got very much in her life, where she is in hospital with lots of people that she doesn't like, perhaps eh, she doesn't like socialising with them . . . social nights is not what she wants because she has put on a lot of weight.*	Unequivocal
Physical and psychological safety **($N = 29$)**				
Category	**Reference**	**Finding**	**Illustration**	**Plausibility**
Feeling safe **($n = 8$)**	Baker (2017)	Alfie described his current environment within FMHS as safe and acknowledged that staff worked hard in order to provide such care:	*One thing is the care that we get. Nobody sees what goes on behind the scenes, just to keep me here. Keep me safe, keep me fed, keep me warm. (Alfie, 293-294)*	Unequivocal

	Baker (2017)	This subtheme [*Becoming a person* again] describes participants' awareness of changes within themselves in the context of the safe environment described.		Unsupported
	Sainsbury et al. (2004)	This represents the need to feel safe within the environment before being able to engage fully in treatment, as highlighted in the following quote:	*If you are not in a safe environment, you don't feel motivated for treatment because you'd be more worried about your safety, and you are less free minded to continue with your treatment.*	Unequivocal
	Sainsbury et al. (2004)	Practical methods: This represents an awareness of the range of practical measures that maintain patients' and others' physical safety from attack or accusation, e.g. CCTV, personal alarms, experience of the abilities of staff to physically intervene quickly and effectively.	*The cameras are reassuring, as you know you are not going to get attacked.*	Equivocal
	Barsky and West (2007)	Others referred to the 'peace and quiet' they were able to get on the wards of the RSU.	Embedded within finding	Unequivocal
	Barsky and West (2007)	Four of the six participants talked at length about the difference in atmosphere between the two hospitals.		Unsupported
	Barsky and West (2007)	The different atmospheres [*between high and medium secure*] meant that another participant was no longer 'always tensed up in the head', he added:	Embedding within finding *I feel a lot easier about things (01 H 287).*	Unequivocal
	Mezey et al. (2010)	Patients tended to feel that locked doors and security of the unit were for their benefit, to protect and shield them from a hostile and uncomprehending public, as much as for the protection of the public.		Unsupported
Feeling recongised as a human being (*n* = 7)	Mezey et al. (2010)	Positive relationships with staff and fellow patients, may be particularly important for forensic patients, because of the length of time they spend locked up and the frequent absence of positive and affirming relationships outside the hospital.	*If you haven't got friends and family or other positive relationships around you it can make you feel a bit down about life and you're not actually connected with anybody and you haven't got much care or love in your life you know.* *When I was unwell I never had any kind of, any support from anyone, I was totally alone . . ...now I'm here it is important to have recognition and*	Unequivocal

			support by people because it helps…it makes you feel that you deserve something, that you're recognized as a person for who you are, not as something to be, uh, ridiculed against or something negative . . . it makes you feel have self-worth *and that means you matter rather then not mattering at all.*	
	Baker (2017)	Bob also perceived that staff used a "human touch" in the way they supported FSUs (Bob, 524) and reported staff of all grades joined in activities on the ward.	Embedded within finding	Unequivocal
	Baker (2017)	Bob described a humane quality to the way staff treated FSUs;	*People are being treated like people (Bob, 508).*	Unequivocal
	Baker (2017)	Bob (479) reported feeling "like a person" again; this was consistent with the nature of the changes discussed by others.	Embedded within finding	Equivocal
	Baker (2017)	'Coming back to life' was particularly prominent in Alfie, Bob and Corey's accounts, although Richard-James' and Steve's experiences were consistent with some aspects of the theme.		Unsupported
	Baker (2017)	Coming back to life' described a contrasting experience of FMHS for participants. This included care that was safe and humane, in the context of which some participants noticed changes in themselves, which Bob described as making him feel more "like a person" (Bob, 414).	Embedded within finding	Equivocal
	Mezey et al. (2010)	A strong theme that emerged was the importance of feeling valued, respected, and cared for on self-esteem and recovery.		Unsupported
Temporary suspension of responsibility (n = 7)	Mezey et al. (2010)	Unlike general psychiatric patients, forensic patients are usually legally detained for treatment on an involuntary basis, for prolonged periods of time. The majority of patients regarded their detention in a secure unit as having been helpful and even necessary for their recovery.		Unsupported

	Mezey et al. (2010)	The passage of time was regarded as helping recovery in a number of ways; some patients referred to the importance of being able to 'stay put' for a while, others saw themselves as 'doing time' for their crime, or of having 'time out' and the opportunity to reflect on, or try to forget, what they had done.	*You can sit and think here and just reflect on everything, and that really does help, that's what helped me anyway…just having time out. And you're away from the wider world, you're away from it all, it's just really peaceful'.* *Because what I done was pretty serious. I mean I know that, I'm really, really sorry, I mean I wish …it's the worst mistake of my life I wish I could take it back. But I can't and.*	Equivocal
	Tapp et al. (2013)	The temporary suspension of individual responsibility through the process of being detained in high security provided respite from a less structured, at times destructive, lifestyle on the outside.	*I actually said, that I am actually having a better quality of life in Broadmoor, than I actually have ever had in my life as a teenager or young child, and people couldn't understand that. (p. 8)*	Equivocal
	Tapp et al. (2013)	Responsibility suspended whilst in high security, through enhanced (intensive) levels of care, equally managed presenting risks of harm to the person.	*Even though it's not quite like a monastery, it is because there are less distractions, you don't have to worry about going shopping or, going here or going here, all things are all sorted, I can take time to think about more subtle things, which I wouldn't take notice of perhaps if I was in the community. (p. 10)*	Equivocal
	Sainsbury et al. (2004)	Many patients described the secure unit and their ward specifically, as a safe space, which provided them with a 'free bed' and 'free meals' physical security and sanctuary and allowed them to build up their confidence and self-esteem, free from the pressures and responsibilities of the outside world.	*I'm really glad to be here at the moment, I feel safe, I feel I have a roof over my head, everything's taken care of and the nurses are lovely…we get a cozy bed, with a duvet, you know and it doesn't cost much, so you know it's important.* *Sometimes if you're unwell you need things put in place that help you through that period of time where you're not quite responsible for one reason or another you know.*	Equivocal
	Laithwaite and Gumley (2007)	In the following extract, participant 11 reflected on overdoses he took in the past, with the current perspective of having a greater understanding of why he carried out such behaviours:	*P11—There's things in my life that I wish I had done differently. I wish I hadn't taken those seven overdoses. Eh I know I was impulsive. One of the reasons I took an overdose was I was writing a book and I sent it away to get published and it got rejected and I took an overdose. I wish I hadn't been so foolish. There was another time when my giro cheque wasn't in on time and I took an over- dose. I was so impulsive and stupid. There was things when I wish I had calmed down and hadn't been so quick to react to things.*	Equivocal
	Laithwaite and Gumley (2007)	However, some participants also spoke about their admission to hospital as an opportunity to get 'respite' from their experiences and hence felt it was a relatively positive experience for them.	*I—so what led to you being in the hospital?* *P9—I was in prison as well. My cell mate says to me that I should watch this guys eyes and I did. Being in here was a rest initially.* *I—when you say it has been a rest, how has it been restful for you?*	Equivocal

			P9—nae violence, hallucinations. Quiet, quiet.	
Collaborative treatment (*n* = 4)	Baker (2017)	In contrast to the care described above in 'disempowered, dehumanised', there was a sense of treatment being collaborative, rather than FSUs being "done to". Corey for instance described staff working *with* him:	Embedded within finding *But it's the work they've done with me as well, you know the effort they've put in with me since I've been here. (Corey, 559)*	Unequivocal
	Sainsbury et al. (2004)	Treatment content: This describes having a shared influence on the agreement of treatment options with the clinical team and the content of the interventions, e.g. skills training		Unsupported
	Tapp et al. (2013)	Collaboration in care was an essential element, which included: a shared (patient and professional) understanding of personal difficulties, being transparent and proactive in care pathway planning and promoting autonomy in care decisions.		Unsupported
	Tapp et al. (2013)	These [*elements of collaboration in* care] were valued in terms of: increasing insight into difficulties and how to support change; reducing the risk of hopelessness and setting achievable goals; fostering motivation and engagement.	*so they [clinical team] worked it out, so, and since I worked out what my actual problem is, and they realised it's not a mental illness, it's a personality disorder, it doesn't need medication, but it just needs me to have a better understanding that there are people around who is willing to look after me, and help me. (p. 2)*	Equivocal
Sense of belonging/community (*n* = 3)	Baker (2017)	He [Bob] and Alfie described staff and FSUs joining together for celebrations and events. This appeared suggestive of a sense of community and belonging:	*Say someone's leaving and we'll all chuck in a couple of pound together, we cook it and then we have a nice little meal all together, staff and the patients. (Bob, 526-527)*	Unequivocal
	Sainsbury et al. (2004)	Codes reflecting a sense of belonging were noted across a number of categories including support and treatment. It is because of its repeated appearance within other categories in a supportive role that it has been placed in a separate category.		Unsupported
	Mezey et al. (2010)	Many patients said they that the unit had provided them with a sense of belonging, acceptance, inclusion, and companionship that they had never previously encountered.	*Even though it is not ideal to be in this place for so many years, the way people make me feel about myself makes me a lot happier.* *I get a lot of understanding here . . .. and we help each other by creating a little society you know where we all try and make it work.*	Unequivocal

			I always thought to myself that I was not worthy of, you know, as a human being, but we did some work and . . . she showed me that I was a worthwhile person so that's important to me, that I understand that about myself.	

Disempowerment and dehumanisation
(*N* = 28)

Category	Reference	Finding	Illustration	Plausibility
Having no control **(*n* = 9)**	Baker (2017)	Consistent with this lack of voice, Richard-James described being 'done to' by the clinical team:	*At the end of it they have a meeting and decide what to do with you, whether to admit you or… or whatever they're going to do with you, send you back to prison or whatever. (Richard-James 423-424)*	Unequivocal
	Tapp et al. (2013)	Where no choice or control over care was experienced, the value of care was lost, and shifts from having no control to losing control presented a heightened risk	*The thing is the problem with Broadmoor is we are asked to do things that we don't want to do … and it takes away the value of doing it, it makes it unpleasant it becomes like a chore, which then brings on anxiety, then makes a person have more chance of becoming unwell. (p. 10)* *The way the doctors was talking they was just you carry on the way you are going nowhere … well if you have got no hope of going out, what does, I had no worries with harming people, what was the point in um, keeping control instead of losing control … you ain't going nowhere. (p. 3)*	Unequivocal
	Baker (2017)	Prominent in all participant accounts was discussion of their powerless positions and the limited control they had over their lives within FMHS: Carl's comment here suggests that his voice has no impact.	*You're very, very powerless in these environments. You can say what the hell you want but it will never reach or anything happen about it. (Carl, 521)*	*Equivocal*
	Sainsbury et al. (2004)	Waiting for treatment: This reflects the impact of long waiting times, triggering negative interpretations about the Directorate.	*It's almost like they are teasing you. I think the time we are waiting, the bureaucracy is a bit too much and my patience had run out.*	Unequivocal
	Baker (2017)	Several participants who had been in high secure units (HSUs) discussed medical treatment as another way in which power was enacted by clinical teams, at times imposed without consent and with physically harmful consequences:	*The medication done something to his heart like a bad side effect [. . .] the doctors said to him I know the medication has done damage to you and I know it could kill you but I recommend you stay on it.* *(Richard-James, 438-441)*	Unequivocal

	Laithwaite and Gumley (2007)	All of the participants stated that being in hospital had made them feel 'stuck' and entrapped. The main reason for this was the lack of a fixed time scale, which they would have if they were sentenced to prison.		Unsupported
	Laithwaite and Gumley (2007)	This *[lack fixed sentence]* created a sense of uncertainty and uneasiness in most of the participants, which some described as having a negative impact on their mood		Unsupported
	Laithwaite and Gumley (2007)	Participants also spoke about feelings of being 'entrapped' in the hospital and trying to adjust to hospital life.		
	Laithwaite and Gumley (2007)	Participants spoke about how they found it difficult to cope being in the hospital and how this was generally created by the lack of certainty regarding their stay in hospital and the effects of their being in hospital on their family.		Unsupported
Instability of care **(*n* = 6)**	Sainsbury et al. (2004)	The data highlighted that repeated changes in the patient's psychologist or named nurse, unexpected losses of the therapeutic relationship and a lack of stable replacement had negative effects on feelings of ability to cope and ultimately diminished motivation.	*I sort of went down because I had lost a good psychologist that I enjoyed working with. and I was working well with.*	Equivocal
	Tapp et al. (2013)	Barriers to building alliances and, therefore, reported benefits were also experienced.	*I find it disgusting how this ward is because it been open now about 18 months and in that time I have had 7 primary nurses, 7 secondary nurses and about 8 back up nurses, you cannot build a relationship with staff like that, it's impossible … I have a problem trusting people at the best of times, I am not going to be made a fool of, even though I am on me way. (p. 12)*	Equivocal
	Baker (2017)	Consistent with the feeling of being warehoused, several participants described being moved around within FMHS, moving between wards, hospitals and at times secluded, with apparently little control over this.		Unsupported
	Barsky (2017)	Alfie described having been "got rid of" (Alfie, 426) and two participants had experienced the breakdown of multiple placements with foster carers and in residential settings.	Embedded within finding	Unequivocal

	Sainsbury et al. 2004)	Conversely, when treatment stops, particularly if this is sudden, it can have a significant negative impact on motivation, as highlighted here:	*When therapy stopped ... and I started getting wound up, I went right down, I just didn't feel interested in anything.*	Unequivocal
	Baker (2017)	The frequent moves participants had made within FMHS appeared reminiscent of the lack of stability several participants described in their early lives.		Unsupported
Institutionalisation **(*n* = 6)**	Baker (2017)	Bob and Carl appeared to describe a degree of institutionalisation. Carl referred to having spent a month in seclusion and suggested that you can get used to situations however undesirable they are:	*It sounds pretty sick but you get adjusted to it, you know you're not going to be in there forever but what can you do really? (Carl, 276-277)*	Unequivocal
	Barsky and West (2007)	Participants felt that time off the wards was vitally important for recovery from mental health problems and general behavioural difficulties.	*If you're on the ward twenty-four seven your mental health is going to get deteriorated… the longer they are on the ward the more they are institutionalised, and the more angry and frustrated the patient is going to be. (05 F 69, 401-402)*	Unequivocal
	Tapp et al. (2013)	Suspending responsibility for too long whilst in hospital, for example on intensive care wards, was experienced as detrimental to well-being.		Unsupported
	Baker (2017)	This builds on Bob's suggestion that FSUs are conditioned and suggests a degree of learned helplessness develops in response to their prolonged experience of disempowerment.		Unsupported
	Baker (2017)	Discussion of the need to comply with treatment was evident in most participants' accounts;	*Keep ticking the boxes and keep following the rules (Steve, 57).*	Unequivocal
	Baker (2017)	It appeared within FMHS the degree of individuation between FSUs was limited and they sometimes felt treated as a group, rather than as individuals.		Unsupported
Feeling contained **(*n* = 4)**	Baker (2017)	They described being "contained" without being helped in a meaningful way and there were aspects of the environment that appeared reminiscent of participants' difficult early experiences.	Embedded within finding	Equivocal
	Baker (2017)	This subtheme [*"contained" and deprived*] describes participants' experience of feeling merely held, warehoused or "contained" within FMHS, without	*I don't think nothing is done to really help people to go out there and be assets to society instead of liabilities [. . .] the only thing that these institutions do is to contain people. (Richard-James, 203-205)*	Equivocal

		attempts being made to help them work toward a better future:		
	Baker (2017)	The environments in which FSUs were "contained" were experienced as depriving, as Corey's description of his previous HSU indicates:	Embedded within finding *They lock you up at night, let you out in the day, they don't talk to you, they give you your meds and that was it. (Corey, 211-212)*	Unequivocal
	Baker (2017)	Being "contained" in such close proximity to other FSUs was also problematic.	Embedded within finding	Equivocal
Not being treated as a human being **(*n* = 3)**	Baker (2017)	This theme [*Disempowered, Dehumanised*] describes participants' experiences of disempowering and punitive environment within FMHS.		Unsupported
	Baker (2017)	His [Carl's] experience of the environment and relationships within it remained consistent with that described within the superordinate theme, 'disempowered, dehumanised'.		Unsupported
	Baker (2017)	Overall the nature of the experiences described suggested there were times participants felt they were not treated as human beings. All participants had experienced FMHS in this way at some point and so all contributed to this theme.		Unsupported
A future in the community **(*N* = 26)**				
Category	**Reference**	**Finding**	**Illustration**	**Plausibility**
A 'normal' life **(*n* = 6)**	Baker (2017)	Several participants referred to the idea of having a "normal" life in future (Carl, 21; Corey, 50; Alfie 401).	Embedded within finding	Equivocal
	Baker (2017)	For most participants this [*idea of having a 'normal' life*] included employment, a place to live and having a family.		Unsupported
	Baker (2017)	There was suggestion in several participant accounts of who they wanted to be in this "normal" life.	Embedded within finding	Equivocal

	Baker (2017)	Trying to progress in FMHS was challenging and there were ups and downs and obstacles in working toward the "normal life" (Carl, 21; Corey, 50; Alfie, 401) that participants hoped for.	Embedded within finding	Equivocal
	Mezey et al. (2010)	Feeling better about oneself as a person, being accepted by and making a useful contribution to the community, getting into work or education, finding a home, settling down with a partner, not re-offending, and simply being able to lead an ordinary life.	*If you feel you are capable of living your life…doing things that the average person does, you know, just even getting to an average standard of competence in certain areas of life…being just worthy as a person.* *Getting to a point in my life where I'm living in a place where I like…and not being unwell, because I haven't relapsed, also doing positive things, that are not negative, and that people around me think are on the right path and doing well for myself.*	Equivocal
	Laithwaite and Gumley (2007)	Participants spoke about having 'valued outcomes' such as achievements, gaining confidence and developing a good life as important factors in recovery.		Unsupported
Stigma in society **(*n* = 5)**	Baker (2017)	Several participants made reference to stigma in society and thought that their identities as ex-offenders and mental health service users would not be acceptable to some.		Unsupported
	Baker (2017)	Bob described the limiting impact this [*stigma in society*] had on how he could relate to others when outside of the hospital, as the secure unit was "hated" in the local area (Bob, 777).	Embedded within finding	Equivocal
	Baker (2017)	Richard-James discussed the difficulties seeking employment people in his position face;	*There'd be a lot of stigma. If I go to get a job or whatever (Richard-James, 278).*	Unequivocal
	Mezey et al. (2010)	Patients saw recovery, not just in terms of their mental illness, but also in terms of no longer being seen as a risk. Many patients referred to the double stigma of being seen as both 'mad' and 'bad' which they regarded as a barrier to being able to achieve even relatively modest goals in the future.	*Forensic mental health patients that's probably as big a stigma as you can get I think…it heaps a lot of pressure on my mind the fact that…you've got to be guarded against talking about your past in some way.* *When you've committed a serious offense like I have when you was unwell, you spend a lot of time locked up in prisons or secure hospital that puts a lot more pressure on you for the rest of your life you know…as far as work goes, as far as relationships goes, as far as interaction with anyone, new friends*	Unequivocal

			goes…that you made a mistake once when you was very unwell and that…will always hold you back in some way. *When you hear on the news about people escaping from hospital and going into the community and killing people, that makes it worse for certain patients who are still in hospital, because it could stop them getting released. I get worried when things like that happen, what's going to happen to me, if it's going to affect me.*	
	Mezey et al. (2010)	Patients appeared to recognize that, regardless of whether they were able to accept themselves, they would find it difficult to gain acceptance or forgiveness in the outside world.	*when they give you antipsychotic medication then you start recovery and then you realise oh you have done this and that and then you start regretting it, but actually, when you are mentally ill, when you are in psychosis, you never ever know exactly what it is what you are doing.*	Equivocal
Hope for the future **(*n* = 4)**	Willmot and McMurran (2013)	Participants described being more hopeful and positive about the future:	*When I came here I thought I wouldn't see the outside world again. I thought I'd be here for the rest of my life till I die. But now I can see a bit of a future, where I can get to a (less secure unit) and start again. [P6]*	Unequivocal
	Willmot and McMurran (2013)	They also described finding it easier to consider the future, particularly the long-term future:	*Before I didn't really care about my future, about how things were for me; I lived day to day and I didn't set any targets, have any goals, whereas now I do look at my future and I look at setting a goal for where I'm going to be this time next year and having a target for that and my ultimate goal is to be able to get out and run my own tattooist shop. [P8]*	Unequivocal
	Baker (2017)	Alongside the hopes he expressed regarding a different future, ties to who he had been remained present. Here he describes an intention to remain loyal to friends from his past:	*Making a new life, new friends - keep some of the old ones obviously; I wouldn't ignore all my lads that have been good to me over the years. (Bob, 1333-1334)*	Unequivocal
	Willmot and McMurran (2013)	Factors that participants linked to change in the 'future' domain included talking about the future.	*It's been a gradual change. Just talking to staff, them saying wouldn't you like to be outside and go for a meal and go for a walk in the park, things like that; that's things that I've missed. [P6]*	Unequivocal
The security wall/fence **(*n* = 4)**	Barsky and West (2007)	One participant referred to the prison-like atmosphere that the wall created [*high secure*]		Unsupported

	Barsky and West (2007)	Another [*participant*] referred to the impact the wall had on their access to the normal goings-on of everyday life. [*high secure*]	*All you see is that big wall, you were just fascinated to see a bus or a car go past, you know, things like that. (04 H 54-56)*	Unequivocal
	Barsky and West (2007)	The security fence at the MSU allowed participants to see beyond the boundaries of the hospital grounds, affecting the way one participant felt.	*You can see through the fence… it makes you feel great, it does. You can see the countryside, you see the animals. You can see off in distances, you see people walking round… (02 L 126-130)*	Equivocal
	Barsky and West (2007)	Many participants described the security wall at the high-secure unit in an unfavourable light.		Unsupported
Challenges in the community **(*n* = 4)**	Baker (2017)	Bob, Richard-James and Corey all spoke about the challenges of someone in their position returning to the community.		Unsupported
	Baker (2017)	Some participants described restrictions dictating where they would be able live due to multi-agency public protection arrangements (MAPPA).		Unsupported
	Mezey et al. (2010)	It [discharge] was also described as a potential destabilizer, which could set back recovery, if not carefully planned and sensitively handled. For many patients, discharge represented a significant loss; of relationships, companionship, structured activities, physical care and the sanctuary of the secure unit, which they had come to regard as their home, rather than simply a hospital ward.	*I'm really frightened at the moment . . . . . . that I've been doing all this work here and it's all going to go to waste because I'm just going to go out there into a bed and breakfast or something and I know things will probably go wrong because I'm not strong enough yet.*	Equivocal
	Laithwaite and Gumley (2007)	Participants also stated that it was difficult to think of the future and that they had to learn to focus on the 'here and now' as a way of coping. For example, participant 4 described the following:	*I—what's it like for you being here in the hospital?* *P4—sometimes it is a struggle. It is hard to keep yourself motivated and keep the momentum going. There is plans for us to move on and all that, it's just the time is taking too long and you just don't know where to be and all that. There's no date to look to. You are just stuck here without knowing what is going to happen. It's hard. It's hard thinking about the future and all that.*	Equivocal
Discharge **(*n* = 3)**	Mezey et al. (2010)	Patients considered that discharge from hospital was an important indicator of recovery.		Unsupported

	Mezey et al. (2010)	The prospect of discharge was often regarded with some trepidation in terms of what they might encounter outside the safe confines of the unit.	*I am looking forward to going out into the community but sometimes it can be scary, especially after being in a place like this for so long…other people have told me that it is safer in here and they wouldn't want to go out and live in the community, other people have told me that.* *It might be a bit of culture shock going back into the community you know, after being in here wrapped up in cotton wool in this place and then going back into err somewhere so fast and busy*	Unequivocal
	Laithwaite and Gumley (2007)	In the following extract, participant 3 described his anxieties about moving on from the hospital as he recalled past experiences where he had found it difficult to cope with his life outside, and described using drugs and alcohol to cope.	*I—What does it mean to you to be here?* *P3—eh . . . that I don't think it would be possible for me to live out there in the community . . . to live normally out there in the community and not be capable of murder, suicide, whatever. I can't see how it would be possible for me to live outside. Even though it wasn't like the jail, life was stress- ful—it was stressful. Having to go to work, having to be mates with everybody, all of it just became stressful. The way I dealt with it was through smoking hash and eh that gave me voices and paranoia. The voices and paranoia were part of the drink and drugs I thought.*	Unequivocal
Entering and leaving the ward **(N = 18)**				
Category	**Reference**	**Finding**	**Illustration**	**Plausibility**
Benefits of community leave **(n = 12)**	Baker (2017)	Bob talked about his experience of community leave in his current hospital.	*It gives you life again (Bob, 414).*	Unequivocal
	Baker (2017)	Being able to pay for things made him feel "human" and he spoke about the small interactions he had with others whilst on [*community*] leave;	Embedded in finding *It just felt nice you know, it was real, there were no cuffs (Bob, 471-472).*	Unequivocal
	Baker (2017)	For Bob getting his community leave gave him	*Something to fight for (Bob, 452).*	Unequivocal
	Barsky and West (2007)	At the MSU the possibility of leave outside the hospital fence was viewed favourably. Accessing the wider (non-secure) hospital grounds was highly valued, even when staff escorted such leave.		Unsupported

	Barsky and West (2007)	One benefit [*of leave outside the hospital fence at the MSU*] was the opportunity for socialising with other patients.	*Yeah, I often see some patients out, I go out and have a chat to them, you know what I mean, sit and have a chat in the car park. (07 F 273-274)*	Unequivocal
	Barsky and West (2007)	The opportunity for leave into the community was another important factor cited by participants [*in medium secure*]		Unsupported
	Barsky and West (2007)	One participant alluded to the scope for independence and rehabilitation that shopping in the community gave him. [*in medium secure*]	*I went [shopping] yesterday for the week, I got some baccy and some shopping… [I cook] Mondays, Wednesdays and Friday tea-time. (01 L 134,118)*	Equivocal
	Barsky and West (2007)	Some participants talked of the sense of social inclusion that community access gave them, and the impact it had on their confidence: [*in medium secure*]	*I catch the bus to xxx twice a week and there's this little old lady who catches the bus back with me and she always says 'oh I'm glad you're still here, it means the bus hasn't gone yet' so it's something simple like that, she's not giving me that stigma* *(02 D 469-472)*	Unequivocal
	Barsky and West (2007)	Participants compared access off the wards at the two sites. At the high-secure hospital, leave from the ward was generally limited to within the hospital wall. At the medium-secure unit, increased leave was granted on a graded basis, starting within the hospital's security fence. Service users could then access the wider hospital grounds and, if. deemed appropriate, could then go to the local village and town. Staff escorts would be a necessary security measure until it was deemed safe for a service user to be alone.		Unsupported
	Barsky and West (2007)	For others it [*leave outside the hospital fence*] instilled a sense of hope. [*in medium secure*]	*You get a sense of how long is it going to be before I get out of here, I could be that person walking through the grounds and someone from a mental health home could be saying good morning to me.* *(05 H 108-111)*	Unequivocal
	Barsky and West (2007)	Some referred to the sense of hope and progress this [*leave into the community*] instilled. [*in medium secure*]	*There's light in the tunnel. (02 F 325)* *You can get unescorted community leave, I'm hoping to get mine this week. (07 F 349)*	Unequivocal

	Barsky and West (2007)	Others talked explicitly of the impact this [*community access in medium secure*] had on their mental health.	*I haven't been depressed really since I've been here. Providing you get out in the grounds, providing you get escorted community leave… (07 K 99-100)*	Unequivocal
The admission process (*n* = 4)	Laithwaite and Gumley (2007)	It seemed that for some participants, the process of being hospitalized initially exacerbated their distress. The following extract describes this participant's early experience of the hospital:	*P4—At first I thought, when I just came into the hospital, I thought there was a conspiracy going on or something like that . . . to kill me. There were patients coming in from outside, and I thought they were people coming off the street to get at me, know what I mean. It was a really frightening experience. I thought the full ward was against me to harm me.* *I—what was it like for you?* *P4—it was constantly going in my head, know what I mean. Just constantly going through my head. I was waiting for someone to attack me. I never spoke to anybody once. I wouldn't talk to anybody. I just kept myself to myself. I wouldn't speak to the staff or the patients. I thought the staff were involved in it and all. This went on for a few months.*	Unequivocal
	Laithwaite and Gumley (2007)	Participants described what it was like for them coming into the hospital. For some, the experience of being admitted and being in hospital was frightening. This was mainly to do with their being extremely distressed by their voices or fearful paranoia.		Unsupported
	Baker (2017)	Bob reported he was accepted to stay on the ward despite having difficulties when he was initially admitted.		Unsupported
	Laithwaite and Gumley (2007)	…some participants described their admission to hospital as a positive experience, creating for them a sense of safety		Unsupported
Leave within the hospital grounds (*n* = 2)	Barsky and West (2007)	With regard to the quality of leave within the security wall at the high-secure unit, one participant commented that all they could do was 'walk in a circle' (04 H 200)	Embedded within finding	Unequivocal
	Barsky and West (2007)	While another stated that when this leave [*within the high-security wall*] was granted 'you were on your own' (02 F 142).	Embedded within finding	Unequivocal

Psychological interventions **(*N* = 16)**				
Category	**Reference**	**Finding**	**Illustration**	**Plausibility**
Benefits of psychological interventions **(*n* = 12)**	Baker (2017)	Carl identified psychological work as important to Mental Health Review Tribunals (MHRTs) and several participants discussed it as a necessary task to be completed in order to "get out" (Steve, 49).	Embedded within finding	Unequivocal
	Baker (2017)	It [psychology] was seen as the most important part of treatment;	*The only thing you need to do is psychology (Carl, 917).*	Unequivocal
	Baker (2017)	He [Alfie] also described being able to manage worries that others were talking about him differently, which he attributed to a psychology group he had undertaken, despite initially doubting its relevance to him.		Unsupported
	Mezey et al. (2010)	Patients considered that psychological work and being educated about their illness helped recovery by providing them with strategies to understand, monitor, and control their mental state. It also created a valuable space, in which patients felt they were encouraged to talk, were listened to, and were taken seriously.	*All these things I have learnt in here, its given me building blocks really to reflect more about my past and what I have done and try to find the solution to my problem…that's how I have managed to recover because I have understood exactly what my illness is about and I have tried to find ways for me to prevent it from happening again.* *Having a psychologist has worked, having therapeutic chats and having someone take an interest you know and um, she doesn't talk down to me, you know, she talks to me like an equal, she tries to get to the bottom of what it is that's really bothering me and I've found I'm able to talk to her and I'm able to ask her questions.* *Once I learnt about it and how it was affecting my life then I could start to deal with it and start to understand where things have gone wrong…trying to keep yourself well and keep you at a level where you don't get as ill as you did before.*	Unequivocal
	Sainsbury et al. (2004)	Preparation for and support during treatment: This incorporates aspects of the treatment process that provides information about future treatments, in	*Before the group, the facilitators took on my concerns about the group and helped me manage.*	Equivocal

		particular group programmes, as highlighted below: [*to the right*]		
	Tapp et al. (2013)	Talking therapies represent specific psychotherapy interventions (one to one or group), which provide an opportunity for exploring and understanding difficulties (increased insight) and developing coping and problem-solving skills for managing these.	*I think psychotherapy helped me to explain to myself, you know you talk about something, as you are talking you can negotiate better understanding for yourself. (p. 10)* *I was quite an angry person, but I learnt a lot from self-talk (anger management), I still get angry, I lose it, and don't keep control of it, but, it's better than it was, I have been able to control it most of the time … (p. 12)*	Equivocal
	Tapp et al. (2013)	The latter benefits [*increased insight, developing coping strategies and problem-solving* skills] make talking therapies distinctive from those experiences in learning from others, which also helps to gain an understanding about personal experiences.		Equivocal
	Barsky and West (2007)	This use of psychological therapies [*in high secure*] was seen as beneficial for recovery by four of the participants.	*Q. Did they help you?* *A. Erm… the alcohol and drug awareness did, them classes… erm I also did mental health awareness classes, they helped… I guess it helped cause I got myself better in the end... (02 283-295)*	Unequivocal
	Barsky and West (2007)	Five of the six participants said that access to psychological therapies was better in the high secure setting.	*Q. And with the psychology department, you've not had any contact?* *Well just short, you know a questionnaire thing, I saw two psychologists, but one left and one's busy.* *Q. Did you have any trouble [seeing a psychologist] at xxx?* *Oh no, it's a lot better. (03 174 – 180)*	Equivocal
	Sainsbury et al. (2004)	A large portion of the data was directly related to formal treatments, including assessment, individual and group treatments.		Unsupported
	Laithwaite and Gumley (2007)	Participants spoke about developing awareness of triggers for relapse and how they learnt about these triggers from attending psychological therapies and sharing experiences with other patients. Participant 1 described his valued outcomes:	*I—how does it affect you knowing what you were like back then—is it something that concerns you about the future?* *P1—well eh . . . I have had quite a few stable years now, and although I get mood swings, they are just fluctuations in my mood, like I get a bit fed up or I feel happy. I have not even been elated or depressed for quite a number of years . . . the medication seems to be working. It has been changed quite a few times, and before the incident I am talking about—being shaved and the mirror—I got ECT—and seemingly it was the ECT that brought me back into consciousness again.*	Unequivocal

			A general mixing of the medication and care of myself such as making sure I get regular sleep and I eat properly, keeping an eye on these things . . . they are my triggers. I did 'Coping with Mental Illness' (hospital group), the group and they eventually helped me identify early trigger signs for becoming unwell. I feel more in control now . . . If I am having trouble sleeping I will let staff know.	
	Laithwaite and Gumley (2007)	It appeared that such relationships, in particular those with staff, had enabled participants to acquire a language that helped them make sense of their experiences. This is described further by participant 10:	*P10—I have a lot of insight into my illness now* *I—what has helped to give you that insight?* *P10—eh, I've done groups. I've done 'coping with mental illness'* (A hospital education group). *The doctor sat down with me and told me what my illness was and she spoke with my family. My key-worker supports me and helps me to be aware of when I am paranoid and the signs of it and all that.*	Unequivocal
Negatives of psychological interventions **(*n* = 4)**	Baker (2017)	This included psychological intervention, which despite having engaged with, some participants did not see as necessary or helpful:	*I didn't benefit nothing from it, it was a waste of time (Richard-James, 318-319).*	Unequivocal
	Willmot and McMurran (2013)	Although participants were selected on the basis that they had made progress as a result of psychological therapy, specific therapeutic techniques were not commonly cited as change processes.		Unsupported
	Willmot and McMurran (2013)	For the two main personality disorder-specific therapies used in the service, the 12 participants made a total of 10 references to dialectical behaviour therapy and 18 references to schema therapy.		Unsupported
	Sainsbury et al. (2004)	Relevance of the assessment process: Understanding the relevance of the assessment process and treatments that participants found tedious or difficult was reported as helpful in maintaining motivation.		Unsupported
Occupational activities (*N* = 14)				
Category	**Reference**	**Finding**	**Illustration**	**Plausibility**

Benefits of activities and work **(*n* = 6)**	Barsky and West (2007)	Participants described the positive impact this [*activities in medium secure*] had on their quality of life, and one spoke proudly of his achievements in the vocational training center.	*I've done [gardening] out there, all that out them back there, I've done all that. (05 K 126-129)*	Equivocal
	Barsky and West (2007)	Two of the participants spoke fondly of some of the activities they did at the high-secure hospital.	*I was internal maintenance, ehh that was near five days a week. (05 260-264)* *I had a job in a shop, crayoning Christmas cards… that helped. (07 175)*	Unequivocal
	Tapp et al. (2013)	The importance of work opportunities as a part of the recovery process in high security was voiced.	*They took me down the gardens and that stopped me self-harming for quite a while, because you couldn't see Broadmoor from the garden … if you turned round you actually couldn't see any of Broadmoor. (p. 6)* *Think working in the canteen gave me more confidence, and it made me feel that I was worth something. (p. 1)*	Unequivocal
	Tapp et al. (2013)	The opportunity to occupy oneself from thoughts of being in Broadmoor, and respite from the ward environment, was helpful for individual well-being.		Unequivocal
	Tapp et al. (2013)	Work activities also provided a sense of improved self-efficacy and self-esteem through acquiring new skills and socializing with others.		Equivocal
	Willmot and McMurran (2013)	One participant talked about how achieving something outside of psychological therapy changed the way he felt about himself.	*In woodwork I made a big totem pole for a family theme park; it's got all animals' faces and stuff on it; it took about a year to do, and it's up in the park now. People from all over the hospital they'd be coming to the woodwork area to have a look at it. I seemed to get a lot of respect from people, I didn't feel worthless, I felt like I'm good at something, there's more to my life than hitting and walloping people. [P11]*	Unequivocal
Quality and quantity of activities **(*n* = 6)**	Baker (2017)	Several participants described there being a lack of meaningful activity available in hospital;	*Every day for two years I've been bored out my face (Richard-James, 266).*	Unequivocal
	Baker (2017)	Richard-James was also concerned that the occupational activities available to FSUs did not lead to qualifications that would translate to employment once back in the community.		Unsupported

	Barsky and West (2007)	Participants referred to the long waiting lists and the lack of choice at the high secure hospitals. These problems were identified as having a detrimental impact on one participant's mental health.	*It… made you feel a bit sluggish if you know what I mean… monotonous… it just made you feel horrible… not this [activity] again, not that again. (02 F 734-75)*	Equivocal
	Barsky and West (2007)	Another [*participant*] maintained that there was no difference between the activities at the two hospitals.		Unsupported
	Barsky and West (2007)	Five of the six participants referred to the increased access to activities at the MSU [*compared to high security*]. Service users explained that there was more variety in the activities they could access. In addition they could change the sessions every few months.	*Here you've got a choice of things to do during the day… whereas at xxx it was, you just had one thing to do and that was it for year after year after year. (02 E 70-72)*	Equivocal
	Baker (2017)	Carl felt he had no reason to get up in the morning:	*What are you getting up for? [. . .] You're up and sitting and staring at four walls or asking for an argument or being provoked. (Carl, 422-424)*	Unequivocal
Education **(*n* = 2)**	Baker (2017)	Richard-James felt he was "transformed" (Richard-James, 10) through education and wished in the future to use his understanding of socio-cultural issues to effect change within society.	Embedded within finding	Equivocal
	Baker (2017)	For Richard-James it was education that protected him from feeling powerless;	*Knowledge empowers you (Richard-James, 84).*	Unequivocal
Medical treatment and diagnoses (*N* = 11)				
Category	**Reference**	**Finding**	**Illustration**	**Plausibility**
Power of medical diagnoses **(*n* = 4)**	Baker (2017)	Participants experienced power enacted over them in a range of ways. Diagnosis was one aspect of this.		Unsupported
	Mezey et al. (2010)	The majority of patients thought that being given a diagnosis, understanding their illness and receiving medication were necessary for their recovery.	*If you don't understand what illness you have got then and what it is about then you are just going round with blinkers on, or a blindfold and err what's the point of having the treatment if you are not going to understand what the problem is.*	Unequivocal
	Mezey et al. (2010)	Most of them valued and respected their doctor's advice and		Unsupported

		input and deferred to them for validation and guidance.		
	Baker (2017)	Richard-James and Bob did not agree with their diagnoses. Carl described confusion regarding his:	*There's loads of different ones. I don't know if they make them up as they go along. Or I don't really revise or look up on them things, but people who go uni, college, training or whatever they know that sort of thing. (Carl, 498-500)*	Unequivocal
Side effects of medication **(*n* = 4)**	Mezey et al. (2010)	Only two patients expressed concerns about the side effects of the medication and one patient described medication as unnecessary and irrelevant.		Unsupported
	Tapp et al. (2013)	These [medication] also had an adverse impact on functioning and engaging with other therapeutic activities.	*Well if you are asleep how can you go onto a group and concentrate, a group session if you, I mean I have fallen asleep in them. (p. 3)* *I am not suicidal as I was so it [ECT] was a plus that way but it mucks your memory up … that's what it has done to me, I used to be a lot sharper than what I am.*	Unequivocal
	Tapp et al. (2013)	For others, medication was considered less a 'cure' and more a 'cover', with underlying problems remaining unresolved.	*Neuroleptics doesn't work for me, they have been more of a hindrance I would say … they suppress the illness, um, they don't go to the root. (p. 10)*	Unequivocal
	Tapp et al. (2013)	It was evident that establishing a steady medication regime took time and could be a difficult process before experiencing the benefits, with side effects being the inevitable cost. This included for ECT as well.		Unsupported
Benefits of medical treatment **(*n* = 3)**	Baker (2017)	Steve attributed the changes he had noticed since coming to hospital to his medication, which he was pleased with.		Unsupported
	Tapp et al. (2013)	Medication and electroconvulsive therapy (ECT) were valued medical interventions for putting an end to suffering from positive and negative symptoms of psychosis.	*At the moment I am on Clozapine and it is probably the best I have ever been. It makes me feel relaxed, my thinking is a bit slower, so I can think better, and I feel quite happy. (p. 9)* *All I remember, I used to hear voices and see things, and I was paranoid and then after that [ECT], everything, all that had gone away … it's a real godsend. (p. 7)*	Unequivocal

			it [medication] still helped the therapies though, I could rationalize more … I could see where other people were coming form, whereas before I thought they were just out to wind me up. (p. 5)	
	Tapp et al. (2013)	Benefits were also reported for improvements in social functioning and engaging with other therapeutic activities.		Equivocal

Appendix H - Literature Reviews Related to TiC Retrieved from Scoping Exercises

Domain	Review	Setting/s	Location/s
General mental health	Trauma-informed approaches to primary and community mental health care: protocol for a mixed-methods systematic review (Dawson et al., 2021)	Primary and community mental healthcare	Published UK References included N/A (protocol)
General mental health	Integrating trauma and violence informed care in primary health care settings for First Nations women experiencing violence: a systematic review (Cullen et al., 2021)	Primary healthcare	Published Australia References included Australia (2), Canada (2), Hawaii (1), Mexico (1)
General mental health	A trauma-informed approach in Canadian mental health policies: A systematic mapping review (Lee et al., 2021)	Policy re mental health practise	Published Canada Studies included Canada (60)
General mental health	A systematic review and synthesis of trauma-informed care within outpatient and counseling health settings for young people (Bendall et al., 2020)	Outpatient and counselling health settings for young people.	Published Canada Studies included Not specified (13)
General mental health	Nursing interventions for adults following a mental health crisis: A systematic review guided by trauma-informed principles (Nizum et al., 2020)	Physical/mental health inpatient/emergency services	Published Australia Studies included US, Europe (Netherlands, Switzerland, Norway, UK, France) Asia & Australia (21)
General mental health	Health professionals' experiences of providing trauma-informed care in acute psychiatric inpatient settings: A scoping review (O'Dwyer et al., 2020)	Acute psychiatric inpatient services	Published Australia Studies included Australia (2), US (2), UK (2), Germany (1), Finland (1)
General mental health	Can mental health nurses working in acute mental health units really be trauma-informed?" An integrative review of the literature (Wilson et al., 2020)	Acute inpatient services	Published Australia Studies included Not specified (10)
General mental health	An overview of trauma-informed care and practice for eating disorders (Brewerton, 2019)	Eating disorder services	Published USA Studies included N/A (narrative review)
General mental health	How do mental health services respond when child abuse or neglect become known? A literature review (Read et al., 2018)	Adult mental health services (in and out patient)	Published UK Studies included US (4), New Zealand (4), UK (3), Sweden (1), Australia (1)
General mental health	Do adult mental health services identify child abuse and neglect? A systematic review (Read et al., 2018)	Mental health services	Published UK Studies included US (8), New Zealand (6), Australia (2), UK (5)
General mental health	Literature review of trauma-informed care: Implications for mental health nurses working in acute inpatient settings in Australia (Wilson et al., 2017)	Acute inpatient settings	Published Australia Studies included Not specified (10)
General mental health	Trauma-informed mental healthcare in the UK: what is it and how can we further its development? (Sweeney et al., 2016)	UK mental health services	Published UK Studies included N/A (narrative overview)

General mental health	A synthesis of the literature on trauma-informed care (Reeves, 2015)	Healthcare settings	Published US Studies included Not specified (26)
General mental health	Trauma-informed care in inpatient mental health settings: A review of the literature (Muskett, 2014)	Inpatient mental health settings	Published Australia Studies included US (9), Norway (1), Australia (1), UK (1), not specified (1)
General mental health	Sanctuary: A content analysis of literature on trauma informed psychiatric inpatient treatment for female survivors of rape and sexual assault under involuntary hold (Muche, 2013)	Acute inpatient psychiatric units	Published US Studies included US (60%), Australia (10%), UK (6.7%), Finland (6.7%), Canada (6.7%), Norway (3.3%), US and Canada (3.3%) (30)
General mental health	Despite the evidence–why are we still not creating more trauma informed mental health services? (Rose et al., 2012)	Mental health service policy	Published UK Studies included N/A (narrative overview)
Schools and education	A systematic review on the impact of trauma-informed education programs on academic and academic-related functioning for students who have experienced childhood adversity (Roseby & Gasgoigne, 2021)	Preschool, primary/elementary, and high school settings.	Published Australia Studies included Not specified (15)
Schools and education	Trauma-informed high schools: a systematic narrative review of the literature (Cohen & Barron, 2021)	High schools	Published US Studies included US (9)
Schools and education	Systematic Review of School-Wide Trauma-Informed Approaches (Avery et al., 2020)	Schools	Published US Studies included US (4)
Schools and education	Buffering the effects of childhood trauma within the school setting: A systematic review of trauma-informed and trauma-responsive interventions among trauma-affected youth (Fondre et al., 2020)	Schools	Published US Studies included Global (62)
Schools and education	A review of school trauma-informed practice for Aboriginal and Torres Strait Islander children and youth (Miller & Berger, 2020)	Schools for Aboriginal and Torres Strait Islander students	Published Australia Studies included N/A (narrative review)
Schools and education	Multi-tiered approaches to trauma-informed care in schools: A systematic review (Berger, 2019)	Schools	Published Australia Studies included US (8), Bosnia (1), Chili (1)
Schools and education	Creating a culturally safe space when teaching Aboriginal content in social work: A scoping review (Fernando & Bennett, 2019)	Social work in education	Published Australia Studies included Australia (20), US/Canada (8)
Schools and education	A systemic framework for trauma-informed schooling: Complex but necessary! (Howard, 2019)	Schools	Published Australia Studies included N/A (narrative review)
Schools and education	Effects of trauma-informed approaches in schools: A systematic review (Maynard et al., 2019)	Schools	Published Australia Studies included N/A (non-included)
Schools and education	Trauma-informed practices in schools across two decades: An interdisciplinary review of research (Thomas et al., 2019)	Schools	Published Australia Studies included US (24), Israel (2), New Jersey (1), Lebanon (1), UK (1), New

			Zealand (1), Denmark (1), Australia (1), Turkey (1)
Schools and education	Trauma-informed practices in schools: A narrative literature review (Record-Lemon & Buchanan, 2017)	Schools	Published Canada Studies included US (14), Israel (5), Netherlands (2), UK (2), Australia (1), Norway (1), Canada (1), Turkey (1)
Schools and education	Promoting resilience through trauma-focused practices: A critical review of school-based implementation (Zakszeski et al., 2017)	Elementary schools	Published US Studies included Not specified (39)
Schools and education	A selected review of trauma-informed school practice and alignment with educational practice (Bodgett & Dorado, 2016)	Schools	Published US Studies included N/A (narrative review)
Criminal justice	Trauma-informed courts: A review and integration of justice perspectives and gender responsiveness (McKenna & Holtfreter, 2021)	Courts	Published US References included N/A (narrative overview)
Criminal justice	Much to do about trauma: A systematic review of existing trauma-informed treatments on youth violence and recidivism (Zettler, 2021)	Juvenile justice settings	Published US References included N/A (narrative overview)
Criminal justice	Towards trauma-informed legal practice: a review (James, 2020)	Legal practise	Published Australia References included N/A (narrative overview)
Criminal justice	Intervention Response to the Trauma-Exposed, Female Juvenile Offender: A Review of Effectiveness in Reducing Recidivism (Thomann, 2019)	Juvenile justice settings (female)	Published US References included N/A (narrative review)
Criminal justice	The Relationship of Childhood Trauma and Subsequent Mental Health Concerns Among Incarcerated Women and the Effectiveness of Trauma-focused Interventions Compared to Holistic Interventions (Ante, 2018)	Female prison	Published US References included N/A (no access)
Criminal justice	Integrating Trauma Informed Care into the Treatment of Adult Male Sex Offenders: A Systematic Review (Janssen, 2018)	Sexual offending	Published US References included N/A (narrative review)
Criminal justice	Trauma-informed juvenile justice systems: A systematic review of definitions and core components (Branson et al., 2017)	Juvenile justice systems	Published US References included Not specified (10)
Criminal justice	Trauma exposure and subsequent offending among first-time juvenile arrestees: An exploratory analysis by sex, race, and Hispanic ethnicity (Jackson, 2010)	Juvenile justice systems	Published US References included N/A (narrative review)
Residential care for children and/or adolescents	Trauma-informed care as a rights-based “standard of care”: A critical review (Bargeman et al., 2020)	Child welfare, education, juvenile justice, health, and multiple sectors.	Published Canada References included Not specified (49)
Residential care for children and/or adolescents	Lowenthal, A. (2020). Trauma-informed care implementation in the child-and youth-serving sectors: A scoping review (Lowenthal, 2020)	Child- and youth-serving sectors	Published Canada References included Canada (2), Australia (2), International (3), US (47)

Residential care for children and/or adolescents	Trauma informed child welfare systems—A rapid evidence review (Bunting et al., 2019)	Child welfare system	Published UK References included Not specified (42)
Residential care for children and/or adolescents	Systematic review of organisation-wide, trauma-informed care models in out-of-home care (Oo HC) settings (Bailey et al., 2019)	Out of home care for children	Published Australia References included US (7)
Residential care for children and/or adolescents	What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review (Bryson et al., 2017)	Youth inpatient psychiatric and residential treatment settings	Published US References included US (13)
Physical health	Trauma-Informed Care in Primary Health Settings—Which Is Even More Needed in Times of COVID-19 (Tomaz & Castro-Vale, 2020)	General practitioner services	Published Portugal References included N/A (narrative review)
Physical health	Implementing trauma-informed care in primary medical settings: evidence-based rationale and approaches (Hamberger et al., 2019)	Primary physical healthcare	Published US References included /A (narrative review)
Physical health	Trauma informed care in medicine (Raja et al., 2015)	Daily healthcare practice	Published US References included /A (narrative review)
Mixed	Systematic review of evaluations of trauma-informed organizational interventions that include staff trainings (Purtle, 2020)	General mental health, physical health, juvenile justice, child/adolescent services	Published US References included Not specified (23)
Mixed	Nationwide efforts for trauma-informed care implementation and workforce development in healthcare and related fields: a systematic review (Oral et al., 2020)	Healthcare, education, juvenile justice, and child welfare settings.	Published US References included Not specified (144)
Other	Systems measures of a trauma-informed approach: A systematic review (Champine et al., 2019)	Measures of a trauma-informed approach	Published US References included Individual measures (49)
Other	Shelter from the storm: Trauma-informed care in homelessness services settings (Hopper et al., 2010)	Homelessness service settings	Published Canada References included N/A (narrative review)

Appendix I – Results of Electronic Database, Journal, and Grey Literature Searches

Search Terms

Unless otherwise specified, the following search terms were used:

Trauma* informed* or trauma adj3 (sensitiv* or respons* or focus* or intervention* or aware* or treat* or care or approach* or reduc* or principle* or value* or think*)

OR

Retraumati* or trauma*induc* or iatrogenic adj3 (harm* or effect* or impact*)

AND

Secure or forensic or locked adj3 (mental health* or care* or ward* or unit* or rehab* service* or discharg* or admit* or detention* or hospital* or facilit* or treatment* or provision* or psychiatr* or system* or pathway* or setting* or patient* or inpatient* client* or service user* or expert* or offend* or individ* or resident* or people* or person*)

(1) Electronic Database Searches

Searches were conducted on the 4th, 5th, and 12th November 2021. Refined date ranges were chosen for most databases in response to the high volume of hits retrieved (6000+) from initial searches. The purpose of this was to obtain the most relevant search results and keep the search strategy manageable for the researcher. For those databases that still revealed a higher number of hits (1000+), the researcher chose to conduct two separate searches within 'All fields' and 'Abstract only'. Additional limits were sparingly applied as they were found to significantly reduce the number of results.

(i) Applied Social Sciences Index and Abstracts (ASSIA; 2011 to 2021)
Searched 4th November 2021
Results from search of 'Abstract' only before limits applied 68
Filters applied: Date range (2011 to 2021), NOT (children and youth), (children), (adolescent), (adolescents), and (education).
Results from search of 'Abstract' only after limits applied: 54
Results from search of 'All fields' before limits applied: 1619
Limited applied: English Language, Year (2000 to current)
Results from search of 'All fields' after limits applied: 1,495

Total results combined = [1,424]

(ii) Cumulative Index to Nursing and Allied Health Literature (CINAHL) Plus (2011 to 2021)
Searched 12th November 2021
Results from search of 'All fields': 94
Limits applied: None
Total results = [94]

(iii) PsychINFO (2000 to 2021)
Searched 5th November 2021
Results from search of 'Abstract' only before limits applied: 68
Limited applied: English Language, Year (2000 to current)
Results from search of 'Abstract' only after limits applied: 54
Results from search of 'All fields' before limits applied: 1619
Limited applied: English Language, Year (2000 to current)
Results from search of 'All fields' after limits applied: 1,495
Total results [1,549]

(iv) Web of Science (1990 to 2021)
Searched 4th November 2021
Results from search of 'All fields': 204
Limits applied: None
Total results = [204]

(2) Journal Searches

Searches were conducted on the 12th and 19th November 2021. All date ranges were set from 2000 to 2021. The free-text term "trauma-informed" was used to search the six journals specific to the field of forensic mental health. The free-text terms "forensic mental health" and "secure inpatient" were used to search the two journals specific to trauma. For the same reasons mentioned above, the researcher chose to conduct two separate searches within 'Anywhere' and 'Abstract only'.

(i) Journal of Forensic Psychiatry and Psychology

Searched 12th November 2021

Free-text search terms: trauma-informed

Limits applied: date range (2011 to 2021)

Results from search of ‘Abstract’: 11

Results from search of ‘Anywhere’: 322

Total results = [333]

(ii) International Journal of Forensic Mental Health

Searched 12th November 2021

Free-text search terms: trauma-informed

Limits applied: date range (2011 to 2021)

Results from search of ‘Abstract’: 5

Results from search of ‘Anywhere’: 160

Total results = [165]

(iii) Journal of Forensic Psychology Research and Practice

Searched 12th and 19th November 2021

Free-text search terms: trauma-informed

Limits applied: date range (2011 to 2021)

Results from search of ‘Abstract’: 5

Results from search of ‘Anywhere’: 163

Total results = [168]

(iv) Journal of Forensic Social Work

Searched 12th and 19th November 2021

Free-text search terms: trauma-informed

Limits applied: date range (2011 to 2021)

Results from search of ‘Abstract’: [1]

Results from search of ‘Anywhere’: 25

Total results = [26]

(v) Criminology and Criminal Justice

Searched 12th and 19th November 2021

Free-text search terms: trauma-informed
Limits applied: date range (2011 to 2021)
Results from search of ‘Abstract’: 59
Results from search of ‘Anywhere’: 98
Total results = [157]

(vi) Criminal Behaviour and Mental Health
Searched 12th and 19th November 2021
Free-text search terms: trauma-informed
Limits applied: date range (2011 to 2021)
Results from search of ‘Abstract’: 8
Results from search of ‘Anywhere’: 222
Total results = [230]

(vii) Journal of Aggression, Maltreatment and Trauma
Searched 12th November 2021
Free-text search terms: forensic mental health and secure inpatient
Limits applied: date range (2011 to 2021)
Results from search of ‘Anywhere’: 140 and 28
Total results = 168

(viii) Journal of Trauma and Dissociation
Searched 12th November 2021
Free-text search terms: forensic mental health and secure inpatient
Limits applied: date range (2011 to 2021)
Results from search of ‘Anywhere’: 59 and 24
Total results = [83]

(3) Grey Literature Searches

A search of ProQuest Dissertations and Theses was completed on 12th November 2021. Date ranges were set after 2000 and the limit of Doctoral Dissertations was applied. A search of National Institute for Clinical Excellence (NICE) Evidence was completed on 10th December

2021. The free-text terms “trauma-informed forensic” were used and filtered according to evidence type of primary research only.

(i) ProQuest Dissertations and Theses (Global)
Searched 12th November 2021
Results from search of ‘All fields’ before limits applied: 161,219
Limits applied: date range (2000 to 2021) and Doctoral Dissertations only
Results from search of ‘All fields’ after limits applied: 35
Total results = [35]

(ii) National Institute for Health and Care Excellence (NICE)
Searched 10th December 2021
Free-text search terms: trauma-informed forensic
Limits applied: Evidence type (Primary Research) only
Total results = [50]

Appendix J – Full-Text References Excluded Following Application of the Selection and Screening Tool

		Reason/s for exclusion		
Reference	**How reference was identified**	**Sample (setting and population)**	**Phenomenon of interest**	**Publication type**
Traumatic events, PTSD, and psychiatric comorbidity in forensic patients–assessed by questionnaires and diagnostic interview (Garieballa et al., 2006)	Manual search		No mention of "trauma-informed" (etc)	
Post-traumatic stress disorder caused in mentally disordered offenders by the committing of a serious violent or sexual offence (Gray et al., 2003)	Manual search		No mention of "trauma-informed" (etc)	
Childhood experiences of patients with schizophrenia and a history of violence: a special hospital sample (Heads et al., 1997)	Manual search		No mention of "trauma-informed" (etc)	
Examining the effect of childhood trauma on psychological distress, risk of violence and engagement, in forensic mental health (Macinnes et al., 2016)	Manual search		No mention of "trauma-informed" (etc)	
Childhood sexual abuse, adult psychiatric morbidity, and criminal outcomes in women assessed by medium secure forensic service (Dolan et al., 2013)	Manual search		No mention of "trauma-informed" (etc)	
The association of adverse childhood experiences and appetitive aggression with suicide attempts and violent crimes in male forensic psychiatry inpatients (Dudeck et al., 2016)	Manual search		No mention of "trauma-informed" (etc)	
The journey from despair to hope: an exploration of the phenomenon of psychological distress in women residing in British secure mental health services (Parkes et al., 2012)	Electronic database search		Experiences of psychological distress No mention of "trauma-informed" (etc)	
An evaluation of the staff training within the trauma and self injury (TASI) programme in the	Electronic database search		No mention of "trauma-informed" (etc)	

National High Secure Healthcare Service for Women (NHSHSW) (Robertson et al., 2013)				
Trauma in relation to psychosis and hospital experiences: The role of past trauma and attachment (Berry et al., 2015)	Electronic database search		No mention of "trauma-informed" (etc)	
Barriers and facilitators to the effective de-escalation of conflict behaviours in forensic high-secure settings: a qualitative study (Goodman et al., 2020)	Electronic database search		No mention of "trauma-informed" (etc)	
Victimization, trauma, and mental health: Women's recovery at the interface of the criminal justice and mental health systems (Rossiter et al., 2012)	Electronic database search	Inpatient and outpatient forensic mental health		
Coping, mental health, and subjective well-being among mental health staff working in secure forensic psychiatric settings: Results from a workplace health assessment (Cramer et al., 2020)	Electronic database search	Staff	Staff wellbeing	
Physical restraint and the therapeutic relationship (Knowles et al., 2015)	Electronic database search	Secure and non-secure	Restraint	
Violent women: A multicentre study into gender differences in forensic psychiatric patients (de Vogel et al., 2016)	Electronic database search		Gender differences	
Control and restraint in the UK: service user perspectives (Sequeira & Halstead, 2002)	Electronic database search		Restraint	
Implementing a program to reduce restraint and seclusion utilization in a public-sector hospital: Clinical innovations, preliminary findings, and lessons learned (Dike et al., 2020)	Electronic database search	Variety of inpatient services	Restraint and seclusion	
Childhood trauma, social cognition and schizophrenia: Specific association between physical neglect and cognitive theory of mind in homicide offenders (Vaskinn et al., 2021)	Electronic database search	Secure and non-secure units	Trauma, social cognition, and homicide	
Coping with violence in mental health care settings: patient and staff member perspectives on de-	Electronic database search	Variety of inpatient services	De-escalation	

escalation practices (Berring et al., 2016)				
The perceived impact of trauma-focused research on forensic psychiatric patients with lifetime victimization histories (Goossens et al., 2016)	Electronic database search		Trauma-focused research	
Staff support procedures in a low-secure forensic service (Cooper & Inet, 2018)	Electronic database search		Staff support	
An exploration of the links between trauma and delusional ideation in secure services (Calvert et al., 2008)	Electronic database search		Trauma and delusions	
Complex posttraumatic stress disorder and child maltreatment in forensic inpatients. (Spitzer et al., 2006)	Electronic database search		Childhood trauma and PTSD (no mention of TiC)	
The psychological effects on nursing staff of administering physical restraint in a secure psychiatric hospital:'When I go home, it's then that I think about it' (Sequeira & Halstead, 2004)	Electronic database search		Impact of restraint on staff	
Safewards impact in inpatient mental health units in Victoria, Australia: Staff perspectives (Fletcher et al., 2019)	Electronic database search	Variety of inpatient services	Safewards	
A qualitative study of contemporary secure mental health services: women service users' views in England (Walker et al., 2019)	Electronic database search		Women services	
Recovery from psychosis in a forensic service: Assessing staff and service users' perspectives using q methodology (Jackson-Blott et al., 2019)	Electronic database search		Personal recovery	
Beyond Window Dressing: Does Moving to a New Building Really Shape the Perception of, and Actual Safety on Forensic Inpatient Programs? (Bridekirk et al., 2021)	Electronic database search		Therapeutic Climate Study (TCS)	
Comorbidity of post traumatic stress disorder and paranoid schizophrenia: A comparison of	Electronic database search	Forensic and general psychiatric inpatients (not	Rates of trauma and PTSD	

offender and non-offender patients (Sarkar et al., 2005)		primary focus on forensic)		
Childhood trauma, antisocial personality typologies and recent violent acts among inpatient males with severe mental illness: Exploring an explanatory pathway (Bruce & Laporte, 2015)	Electronic database search		Pathways to offending and assessment	
Dealing with trauma in individuals with Autism Spectrum Disorders: trauma informed care, treatment, and forensic implications (Faccini & Alley, 2021)	Electronic database search	All forensic areas	Trauma and autism	
Are women really difficult? Challenges and solutions in the care of women in secure services (Bartlett & Somers, 2017)	Electronic database search		Views of senior clinicians	
Women's secure hospital care pathways in practice: a qualitative analysis of clinicians views in England and Wales (Somers & Bartlet, 2014)	Electronic database search		Care pathways for women	
Recovery, turning points and forensics: views from the ward in an English high secure facility (Chandley & Rouski, 2014)	Electronic database search		Individual views of recovery	
Making sense of complexity: A qualitative investigation into forensic learning disability nurses' interpretation of the contribution of personal history to offending behaviour (Lovell & Skellern, 2020)	Electronic database search		Nurses understanding of offending behaviour	
Reducing use of restraints and seclusion to create a culture of safety (Chandley, 2012)	Electronic database search	Locked community hospital unit		
Strategies for assessing and preventing inpatient violence in forensic hospitals: A call for specificity (Dexter & Vitacco, 2020)	Electronic database search		Reducing violence	Non-empirical research
Helping with the pressures of the past: service-user perspectives of the sensory approaches within the National High Secure Healthcare Service for Women (Wilkinson & Beryl, 2021)	Electronic database search		Sensory approaches	

A charter for trainers in the prevention and management of workplace violence in mental health settings (Paterson et al., 2014)	Electronic database search	Forensic and other clinical settings	Management of violence	
Impact of a program for the management of aggressive behaviors on seclusion and restraint use in two high-risk units of a mental health institute. (Geoffrion et al., 2018)	Electronic database search	Intensive care and emergency units		
Hurt people hurt people: using a trauma sensitive and compassion focused approach to support people to understand and manage their criminogenic needs (Taylor & Hocken, 2021)	Electronic database search	Forensic practitioners	Compassion focused therapy	
Sensory modulation and trauma-informed-care knowledge transfer and translation in mental health services in Victoria: Evaluation of a statewide train-the-trainer intervention (McEvedy et al., 2017)	Electronic database search	19 different mental health services		
What kind of support and training do junior qualified nurses working with women with learning disabilities in a secure setting require when dealing with violence and aggression*?* (Goulding & Riordan, 2016)	Electronic database search		Support and training for nurses	
Advancing health equity and social justice in forensic nursing research, education, practice, and policy: Introducing structural violence and trauma-and violence-informed care. (Befus et al., 2019)	Electronic database search	Forensic nursing practice		Non-empirical research
Profiling referrals to a trauma support service: needs and outcomes for staff working in a secure adult developmental disorder pathway (Webb et al., 2021)	Electronic database search		Trauma support for staff	
Childhood trauma and the risk of violence in adulthood in a population with a psychotic illness (Bosqui et al., 2014)	Electronic database search	Community forensic		

Job stress, burnout and job satisfaction in staff working with people with intellectual disabilities: community and criminal justice care (Søndenaa et al., 2015)	Electronic database search		Staff levels of burnout etc	
The power threat meaning framework and forensic mental health settings (Ramsden, 2019)	Electronic database search		PTMF in forensic settings	Non-empirical research
Psychiatric treatment in forensic hospital and correctional settings (Kapoor et al., 2018)	Electronic database search			Non-empirical research
Clinical and forensic psychology:(Un) comfortable bedfellows? (Beckley & Fisher, 2017)	Electronic database search			Non-empirical research
Trauma-informed care in forensic settings: Current challenges and future directions for effective treatment and practices (Mann, 2018)	Electronic database search	'Forensic setting' (unclear if secure inpatient or prison)		
Training needs analysis of nurses caring for individuals an intellectual disability and or autism spectrum disorder in a forensic service (Burke & Cocoman, 2020)	Electronic database search		Training needs	
"Part of being human": evaluating the 4Ps model to support inpatient staff teams in reflecting on interpersonal dynamics (Jones & Annesley, 2019)	Electronic database search		Training for staff working with complexity	
A preliminary model of forensic practitioner resilience within a learning disabilities service (Harvey & Quinn, 2012)	Electronic database search		Resilience within LD service	
Moore, E. (2019). Treating Trauma for Public Safety: the Contribution of Psychological Support for Patients in High Security Hospitals (Moore, 2019)	Electronic database search			Non-empirical research
Trauma-informed care: Responding to the call for action (Peternelj-Taylor, 2018)	Electronic database search	Forensic nursing		Non-empirical research
Trauma-Informed Nursing Improves Equity (Laughon & Lewis-O'Connor, 2019)	Electronic database search	Forensic nursing		Non-empirical research

Women service users' experiences of inpatient mental health services and staff experiences of providing care to women within inpatient mental health services: A systematic review of qualitative evidence (Scholes et al., 2021)	Electronic database search	Inpatient mental health services		Systematic review
How distress is understood and communicated by women patients detained in high secure forensic healthcare, and how nurses interpret that distress: An exploration using a Multi-perspective Interpretative Phenomenological Analysis (Jones, 2021)	Electronic database search			Masters thesis
Invisible trauma: Women, difference and the criminal justice system. Routledge (Motz et al., 2020)	Electronic database search			Non-empirical research
Co-occurring substance use, PTSD, and IPV victimization: Implications for female offender services (McKee & Hilton, 2019)	Electronic database search	Prison		Review
Assessment of risk for seclusion among forensic inpatients: Validation and modification of the risk of administrative segregation tool (RAST) (Hilton et al., 2019)	Electronic database search		Risk of seclusion	
Psychiatric-mental health nurses leading a culture of safety (Dilks, 2020)	Electronic database search	Mental health nursing		Non-empirical research
Staff experiences and understandings of the RE s TRAIN Yourself initiative to minimize the use of physical restraint on mental health wards (Duxbury et al., 2019)	Electronic database search	Acute mental health wards		
A proposed model for evaluating the impact of participating in trauma-focused research (Collings, 2019)	Electronic database search	Undergraduate students		
Treatment for Emotional Difficulties Related to Offending for People with an Intellectual Disability (Oxnam & Gardner, 2019)	Electronic database search			Non-empirical research

Infusing the principles of trauma-informed care into emergency nursing: a comprehensive approach to change practice (Cochran, 2019)	Electronic database search	Emergency nursing		
Preventing vicarious trauma (VT), compassion fatigue (CF), and burnout (BO) in forensic mental health: Forensic psychology as exemplar (Pirelli et al., 2020)	Electronic database search	Forensic mental health as a discipline		
Pains of imprisonment beyond prison walls: Qualitative research with females labelled as not criminally responsible (Mertens & Vander Laenen, 2020)	Electronic database search	Prison		
Doctorate in Clinical Psychology: Main Research Portfolio (Stewart, 2020)	Electronic database search	Not specific to forensic/secure mental health services		
Childhood abuse, attachment, and psychopathy among individuals who commit sexual offenses (Grady et al., 2019)	Electronic database search	Prison		
Managers' experiences of prevention and management of workplace violence against health care staff: A descriptive exploratory study (Morphet et al., 2019)	Electronic database search	Healthcare		
Recovery, desistance, and the role of procedural justice in working alliances with mentally ill offenders: A critical review (Wittouck & Vander Beken, 2019)	Electronic database search		Recovery and procedural justice	Review
Working towards least restrictive environments in acute mental health wards in the context of locked door policy and practice (Fletcher et al., 2019)	Electronic database search	Acute mental health		
Implementation of trauma-informed care and brief solution-focused therapy: A quality improvement project aimed at increasing engagement on an inpatient psychiatric unit (Aremu et al., 2018)	Electronic database search	Inpatient psychiatric unit		
The needs of staff who care for people with a diagnosis of personality disorder who are	Electronic database search	Staff needs Not specific to secure inpatient		

considered a risk to others (Kurz, 2005)				
Fear and blame in mental health nurses' accounts of restrictive practices: Implications for the elimination of seclusion and restraint (Muir-Cochrane et al., 2018)	Electronic database search	Mental health nurses		
Transforming Environments and Rehabilitation: A Guide for Practitioners in Forensic Settings and Criminal Justice (Akerman et al., 2017)	Electronic database search			Non-empirical research
Disabilities in Secure Mental Health Settings in the United Kingdom (Taylor & Morrissey, 2018)	Electronic database search			Non-empirical research
Promoting therapist longevity: exploring sexual offending treatment providers' experiences of workplace support (Willis et al., 2018)	Electronic database search	Forensic mental health as a field		
Quasi-qualitative evaluation of progressive counting in secure accommodation in Scotland: an exploratory cluster case study (Barron & Tracey, 2018)	Electronic database search		Exposure therapy	
Why call someone by what we don't want them to be? The ethics of labeling in forensic/correctional psychology (Willis, 2018)	Electronic database search	Forensic/correctional psychology		
Effects of a staff training intervention on Seclusion rates on an adult inpatient psychiatric unit (Newman et al., 2018)	Electronic database search	Psychiatric inpatient		
Patient perspectives on barriers and enablers to the use and effectiveness of de-escalation techniques for the management of violence and aggression in mental health settings (Price et al., 2018)	Electronic database search	Mental health settings	De-escalation and aggression	
Forensic psychology in the context of trauma (Dalenberg et al., 2017)	Electronic database search	Forensic psychology as a discipline		Non-empirical research
The positive practice of safety: Reductions in workplace violence through increases in safety and security at organisational and interpersonal levels (Bowen, 2017)	Electronic database search			Non-empirical research

Trauma and its treatment in forensic settings (Hughes, 2017)	Electronic database search		Psychological treatment	Non-empirical research

Appendix K – Quality Assessment Tools

The AXIS for Cross-Sectional Research (Downes et al., 2016)

Reference:					
Introduction					
		Yes	**Can't tell**	**No**	**Comments**
1	Were the aims/objectives of the study clear?				
Methods					
2	Was the study design appropriate for the stated aim(s)?				
3	Was the sample size justified?				
4	Was the target/reference population clearly defined? (Is it clear who the research was about?)				
5	Was the sample frame taken from an appropriate population base so that it closely represented the target/reference population under investigation?				
6	Was the selection process likely to select subjects/participants that were representative of the target/reference population under investigation?				
7	Were measures undertaken to address and categorise non-responders?				
8	Were the risk factor and outcome variables measured appropriate to the aims of the study?				
9	Were the risk factor and outcome variables measured correctly using instruments/measurements that had been trialled, piloted or published previously?				
10	Is it clear what was used to determined statistical significance and/or precision estimates? (eg, p values, CIs)				
11	Were the methods (including statistical methods) sufficiently described to enable them to be repeated?				
Results					
12	Were the basic data adequately described?				
13*	Does the response rate raise concerns about non-response bias?				
14	If appropriate, was information about non-responders described?				

15	Were the results internally consistent?				
16	Were the results for the analyses described in the methods, presented?				
	Discussion				
17	Were the authors' discussions and conclusions justified by the results?				
18	Were the limitations of the study discussed?				
	Other				
19*	Were there any funding sources or conflicts of interest that may affect the authors' interpretation of the results?				
20	Was ethical approval or consent of participants attained?				

Scoring
Yes = 2
Can't tell = 1
No = 0
Evidence for and against = .5

Result
Total score = /40
Percentage =

** 'No' is a positive response so reverse scored.

CASP Qualitative Checklist for Qualitative Research (CASP) (2018)

Reference:				
	Section A: Are the results valid?			
1	Was there a clear statement of the aims of the research? *Consider:* - *The goal of the research* - *Why it was thought important* - *Its relevance*	☐ Yes	☐ Can't tell	☐ No
	Comments:			
2	Is a qualitative methodology appropriate? *Consider:* - *If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants* - *Is qualitative research the right methodology for addressing the research goal?*	☐ Yes	☐ Can't tell	☐ No
	Comments:			
	Is it worth continuing?			
3	Was the research design appropriate to address the aims of the research? *Consider:* - *If the researcher has justified the research design (e.g. have they discussed how they decided which method to use?)*	☐ Yes	☐ Can't tell	☐ No
	Comments:			
4	Was the recruitment strategy appropriate to the aims of the research? *Consider:* - *If the researcher has explained how the participants were selected* - *If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study* - *If there any discussions around recruitment (e.g. why some people chose not to take part)*	☐ Yes	☐ Can't tell	☐ No
	Comments:			
5	Was the data collected in a way that addressed the research issue? *Consider:* - *If the setting for the data collection was justified* - *If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)*	☐ Yes	☐ Can't tell	☐ No

	- *If the researcher has justified the methods chosen* - *If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)* - *If methods were modified during the study. If so, has the researcher explained how and why* - *If the form of data is clear (e.g. tape recordings, video material, notes etc.)* - *If the researcher has discussed saturation of data*			
	Comments:			
6	Has the relationship between researcher and participants been adequately considered? *Consider:* - *If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location* - *How the researcher responded to events during the study and whether they considered the implications of any changes in the research design?*	☐ Yes	☐ Can't tell	☐ No
	Comments:			
Section B: What are the results?				
7	Have ethical issues been taken into consideration? *Consider:* - *If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained* - *If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)* - *If approval has been sought from the ethics committee*	☐ Yes	☐ Can't tell	☐ No
	Comments:			
8	Was the data analysis sufficiently rigorous? *Consider:* - *If there is an in-depth description of the analysis process* - *If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data* - *Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process* - *If sufficient data are presented to support the findings* - *To what extent contradictory data are taken into account* - *Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*	☐ Yes	☐ Can't tell	☐ No

	Comments:			
9	Is there a clear statement of findings? *Consider:* - *If the findings are explicit* - *If there is adequate discussion of the evidence both for and against the researcher's arguments* - *If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)* - *If the findings are discussed in relation to the original research question*	☐ Yes	☐ Can't tell	☐ No
	Comments:			
Section C: Will the results help locally?				
10	How valuable is the research? *Consider:* - *If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature)* - *If they identify new areas where research is necessary* - *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*	☐ Yes	☐ Can't tell	☐ No
	Comments:			
Scoring Yes = 2 Can't tell = 1 No = 0 Result Total score = /20 Percentage =				

Mixed Methods Appraisal Tool for Mixed Methods Research (MMAT) (Hong et al., 2018)

Reference:					
Screening questions (for all types)					
		Yes	**Can't tell**	**No**	**Comments**
S1	Are there clear research questions?				
S2	Do the collected data allow to address the research question?				
Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.					
Section 1: Qualitative					
1.1	Is the qualitative approach appropriate to answer the research question?				
1.2	Are the qualitative data collection methods adequate to address the research question?				
1.3	Are the findings adequately derived from the data?				
1.4	Is the interpretation of results sufficiently substantiated by data?				
1.5	Is there coherence between qualitative data sources, collection, analysis and interpretation?				
~~**Section 2: Quantitative randomised controlled trials**~~					
~~**2.1**~~	~~Is randomization appropriately performed?~~				
~~**2.2**~~	~~Are the groups comparable at baseline?~~				
~~**2.3**~~	~~Are there complete outcome data?~~				
~~**2.4**~~	~~Are outcome assessors blinded to the intervention provided?~~				
~~**2.5**~~	~~Did the participants adhere to the assigned intervention?~~				
Section 3: Quantitative non-randomized					
3.1	Are the participants representative of the target population?				
3.2	Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
3.3	Are there complete outcome data?				

3.4	Are the confounders accounted for in the design and analysis?				
3.5	During the study period, is the intervention administered (or exposure occurred) as intended?				
~~Section 4: Quantitative descriptive~~					
~~4.1~~	~~Is the sampling strategy relevant to address the research question?~~				
~~4.2~~	~~Is the sample representative of the target population?~~				
~~4.3~~	~~Are the measurements appropriate?~~				
~~4.4~~	~~Is the risk of nonresponse bias low?~~				
~~4.5~~	~~Is the statistical analysis appropriate to answer the research question?~~				
Section 5: Mixed methods					
5.1	Is there an adequate rationale for using a mixed methods design to address the research question?				
5.2	Are the different components of the study effectively integrated to answer the research question?				
5.3	Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
5.4	Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
5.5	Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				
Scoring Yes = 2 Can't tell = 1 No = 0 Evidence for and against = .5 Result Total score = /34 Percentage =					

Appendix L – Quality Assessment Scores for All Included Studies (*N* = 11)

Mixed Methods Appraisal Tool for Mixed Methods Research (MMAT) (Hong et al., 2018)																		
Reference	**S1**	**S1**	**1.1**	**1.2**	**1.3**	**1.4**	**1.5**	**3.1**	**3.2**	**3.3**	**3.4**	**3.5**	**5.1**	**5.2**	**5.3**	**5.4**	**5.5**	**Total Score (out of 34)**	**Quality Score (%)**
Brackenridge and Morrissey (2010)	2	2	2	2	1	1	1	2	1	1	2	2	2	1	1	2	1	**26**	**65**

<u>Questions</u>

(S1) Are there clear research questions? (S2) Do the collected data allow to address the research questions? (1.1) Is the qualitative approach appropriate to answer the research question? (1.2) Are the qualitative data collection methods adequate to address the research question? (1.3) Are the findings adequately derived from the data? (1.4) Is the interpretation of results sufficiently substantiated by data? (1.5) Is there coherence between qualitative data sources, collection, analysis and interpretation? (3.1) Are the participants representative of the target population? (3.2) Are measurements appropriate regarding both the outcome and intervention (or exposure)? (3.3) Are there complete outcome data? (3.4) Are the confounders accounted for in the design and analysis? (3.5) During the study period, is the intervention administered (or exposure occurred) as intended? (5.1) Is there an adequate rationale for using a mixed methods design to address the research question? (5.2) Are the different components of the study effectively integrated to answer the research question? (5.3) Are the outputs of the integration of qualitative and quantitative components adequately interpreted? (5.4) Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? (5.5) Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?

<u>Key (scoring)</u>

2 = Yes
1 = Can't tell
0 = No
Evidence for and against = .5

CASP Qualitative Checklist for Qualitative Research (CASP; 2018)

Reference	1	2	3	4	5	6	7	8	9	10	Total Score (out of 20)	Quality Score (%)
Cartwright (2020)	2	2	1	2	2	2	2	2	2	2	**19**	**95%**
Owens (2021)	2	2	2	2	1	1	2	1	1	2	**16**	**80%**
Stamatopoulou (2019)	2	2	2	1.5	2	2	2	2	2	2	**19.5**	**97.5%**

Questions

(1) Was there a clear statement of the 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 researcher and participants 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?

Key (scoring)
2 = Yes
1 = Can't tell
0 = No
Evidence for and against = .5

Mixed Methods Appraisal Tool for Mixed Methods Research (MMAT) (Hong et al., 2018)																		
Reference	**S1**	**S1**	**1.1**	**1.2**	**1.3**	**1.4**	**1.5**	**3.1**	**3.2**	**3.3**	**3.4**	**3.5**	**5.1**	**5.2**	**5.3**	**5.4**	**5.5**	**Total Score (out of 34)**	**Quality Score (%)**
Brackenridge and Morrissey (2010)	2	2	2	2	1	1	1	2	1	1	2	2	2	1	1	2	1	**26**	**65**

<u>Questions</u>

(S1) Are there clear research questions? (S2) Do the collected data allow to address the research questions? (1.1) Is the qualitative approach appropriate to answer the research question? (1.2) Are the qualitative data collection methods adequate to address the research question? (1.3) Are the findings adequately derived from the data? (1.4) Is the interpretation of results sufficiently substantiated by data? (1.5) Is there coherence between qualitative data sources, collection, analysis and interpretation? (3.1) Are the participants representative of the target population? (3.2) Are measurements appropriate regarding both the outcome and intervention (or exposure)? (3.3) Are there complete outcome data? (3.4) Are the confounders accounted for in the design and analysis? (3.5) During the study period, is the intervention administered (or exposure occurred) as intended? (5.1) Is there an adequate rationale for using a mixed methods design to address the research question? (5.2) Are the different components of the study effectively integrated to answer the research question? (5.3) Are the outputs of the integration of qualitative and quantitative components adequately interpreted? (5.4) Are divergences and inconsistencies between quantitative and qualitative results adequately addressed? (5.5) Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?

<u>Key (scoring)</u>
2 = Yes
1 = Can’t tell
0 = No
Evidence for and against = .5

Appendix M - Key Alliance Concepts and Measures

Key Alliance Concepts (Taken and Adapted from Elvins & Green, 2008 and Horvath, 2018)

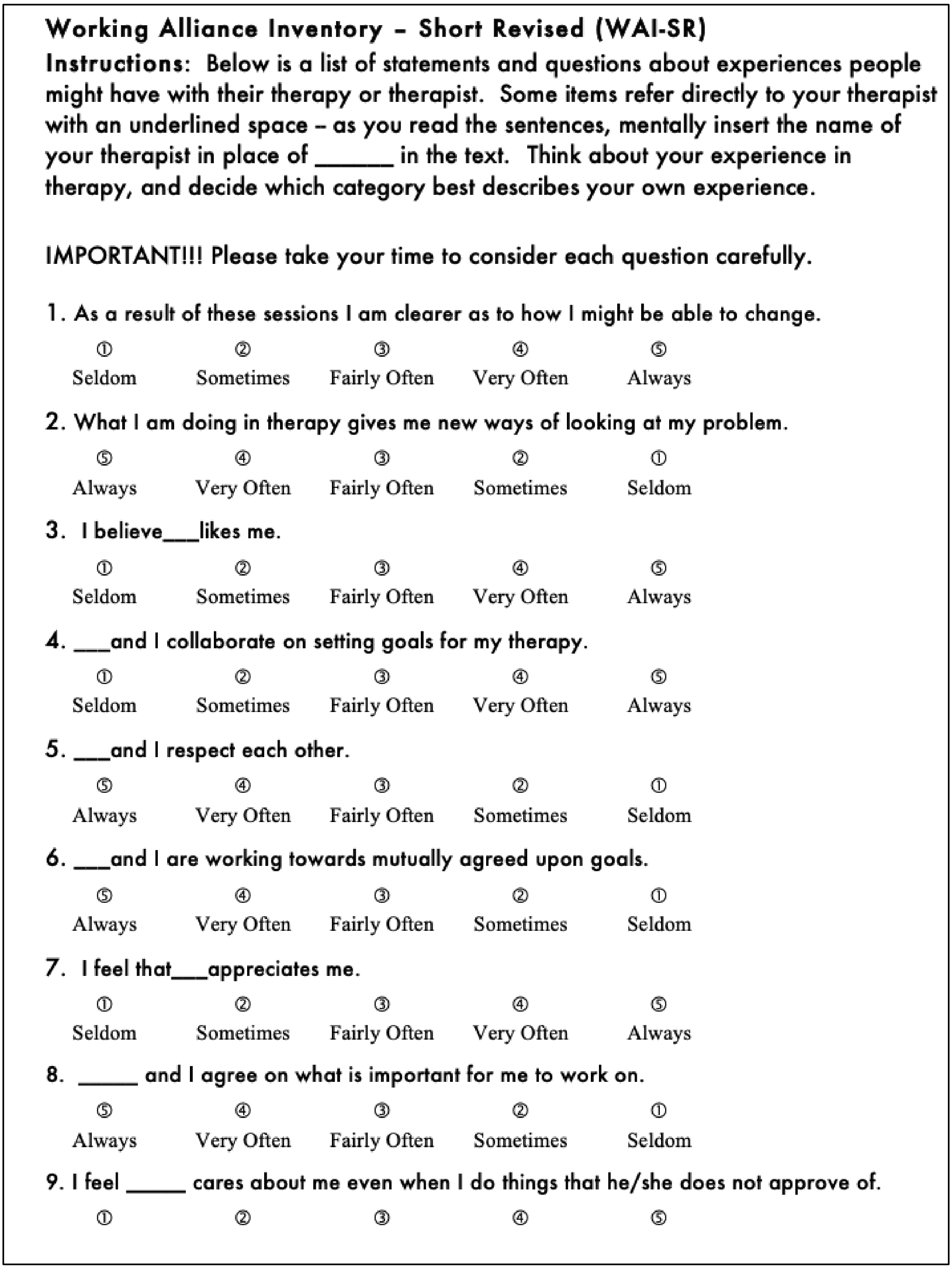
Author/s	Study
Freud (1912)	The dynamics of transference.
Zetzel (1956)	An approach to the relation between concept and content in psychoanalytic theory: With special reference to the work of Melanie Klein and her followers.
Rogers (1965)	Client-centered therapy, its current practice, implications, and theory.
Orlinsky and Howard (1975)	Varieties of Psychotherapeutic Experience: Multivariate Analysis of Patients' and Therapists Reports.
Greenson (1965)	The working alliance and the transference neurosis.
Strong (1968)	Counselling: an interpersonal influence process.
Bordin (1979)	The generalizability of the psychoanalytic concept of the working alliance.
Luborsky and DeRubeis (1984)	The use of psychotherapy treatment manuals: A small revolution in psychotherapy research style.
Frank and Frank (1991)	Persuasion and healing: a comparative study of psychotherapy.
Hougaard (1994)	The therapeutic alliance–A conceptual analysis.

Key Alliance Measures (Taken and Adapted from Elvins & Green, 2008)

Measure	Author/s
Barrett-Lennard's relationship inventory	Barrett-Lennard (1986)
Counselling evaluation inventory (CEI)	Linden et al. (1965)
Therapy session report scale (TRSR)	Orlinsky and Howard (1966)
The counsellor rating form (CRF)	Bachelor (1987)
The Penn alliance scales	Luborsky (1976)
The Vanderbilt scales	Gomes-Schwartz (1978)
Toronto scales	Marziali et al. (1981); Marmar et al. (1986)
Menninger alliance rating scale or collaboration scale	Allen et al. (1984)
Psychotherapy status report (PSR)	Frank and Gunderson (1990)
Patient collaboration scale (PCS)	Svensson and Hansson (1999)
California scales (CALPAS)	Marmar et al. (1989)
Therapeutic bond scales (TBS)	Saunders et al. (1989)
Working alliance inventory (WAI)	Horvath and Greenberg (1989)
Child psychotherapy process measures (CPPM)	Smith-Acuna et al. (1991)
Therapeutic alliance scales for children (TAC)	Shirk and Saiz (1992)
Treatment alliance scales (TAS)	Sarlin (1992)
Adapted psychotherapy process (PPI)	Gorin (1993)
Adolescent working alliance inventory (AWAI)	DiGiuseppe et al. (1996); Florsheim et al. (2000)
Helping alliance scales (HAS)	Priebe and Gruyters (1993)

Empathy and understanding questionnaire (EUQ) / Family engagement questionnaire (FEQ)	Green et al. (2001); Kroll and Green (1997)
Barriers to treatment participation scale	Kazdin et al. (1997)
Therapist alliance focus scale (TAFS)	Molinaro (1998)
Adolescent therapeutic alliance scale (ATAS)	Johnson et al. (1998)
Agnew relationship measure (ARM)	Agnew-Davies et al. (1998)
Child psychotherapy process scale (CPPS)	Estrada and Russell (1999)
Family therapy alliance scale (FTAS)	Pinsof (1999)
Early adolescent therapeutic alliance scale (EATAS)	Johnson (2000)
Kim alliance scale	Kim et al. (2001)
System for observing family therapy alliance (SOFTA)	Friedlander et al. (2006)
The therapy process observational coding system – alliance scale (TPOCS)	McLeod and Weisz (2005)
Scale to assess therapeutic relationship (STAR)	McGuire-Snieckus et al. (2007)

Appendix N - Full WAI-SR and Scoring Key[2]



Working Alliance Inventory – Short Revised (WAI-SR)

Instructions: Below is a list of statements and questions about experiences people might have with their therapy or therapist. Some items refer directly to your therapist with an underlined space – as you read the sentences, mentally insert the name of your therapist in place of ______ in the text. Think about your experience in therapy, and decide which category best describes your own experience.

IMPORTANT!!! Please take your time to consider each question carefully.

1. As a result of these sessions I am clearer as to how I might be able to change.

① Seldom ② Sometimes ③ Fairly Often ④ Very Often ⑤ Always

2. What I am doing in therapy gives me new ways of looking at my problem.

⑤ Always ④ Very Often ③ Fairly Often ② Sometimes ① Seldom

3. I believe___likes me.

① Seldom ② Sometimes ③ Fairly Often ④ Very Often ⑤ Always

4. ___and I collaborate on setting goals for my therapy.

① Seldom ② Sometimes ③ Fairly Often ④ Very Often ⑤ Always

5. ___and I respect each other.

⑤ Always ④ Very Often ③ Fairly Often ② Sometimes ① Seldom

6. ___and I are working towards mutually agreed upon goals.

⑤ Always ④ Very Often ③ Fairly Often ② Sometimes ① Seldom

7. I feel that___appreciates me.

① Seldom ② Sometimes ③ Fairly Often ④ Very Often ⑤ Always

8. _____ and I agree on what is important for me to work on.

⑤ Always ④ Very Often ③ Fairly Often ② Sometimes ① Seldom

9. I feel _____ cares about me even when I do things that he/she does not approve of.

① ② ③ ④ ⑤

---

[2] Reprinted by permission of the Society for Psychotherapy Research © 2016 (see Appendix P).

Seldom	Sometimes	Fairly Often	Very Often	Always

10. I feel that the things I do in therapy will help me to accomplish the changes that I want.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

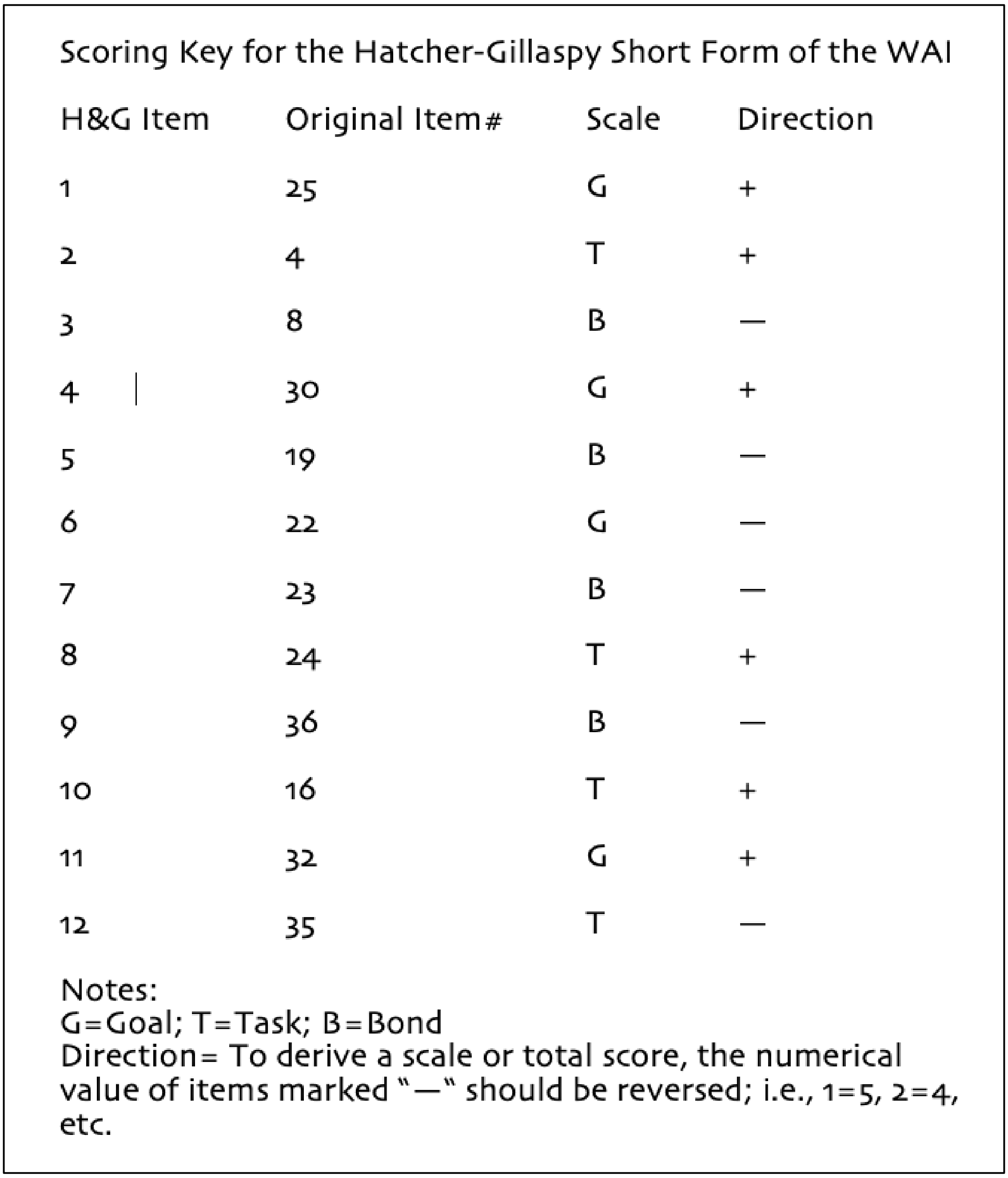
11. _____ and I have established a good understanding of the kind of changes that would be good for me.

⑤	④	③	②	①
Always	Very Often	Fairly Often	Sometimes	Seldom

12. I believe the way we are working with my problem is correct.

①	②	③	④	⑤
Seldom	Sometimes	Fairly Often	Very Often	Always

Note: Items copyright © Adam Horvath. Goal Items: 4, 6, 8, 11; Task Items: 1, 2, 10, 12; Bond Items: 3, 5, 7, 9



Scoring Key for the Hatcher-Gillaspy Short Form of the WAI

H&G Item	Original Item#	Scale	Direction
1	25	G	+
2	4	T	+
3	8	B	—
4	30	G	+
5	19	B	—
6	22	G	—
7	23	B	—
8	24	T	+
9	36	B	—
10	16	T	+
11	32	G	+
12	35	T	—

Notes:
G=Goal; T=Task; B=Bond
Direction= To derive a scale or total score, the numerical value of items marked "—" should be reversed; i.e., 1=5, 2=4, etc.

Appendix O – WAI-SR in the Literature

	Full title, author/s and date	Version	Profession / Population	Primary Research*	Psychometric Properties
1	Psychometric evaluation of the Working Alliance Inventory—Therapist version: Current and new short forms (Hatcher et al., 2019)	Therapist	Psychotherapy at college counselling services	✓	✓
2	The Relations Among Neurocognition, Symptoms, And Therapeutic Alliance In Compensatory Cognitive Training (Johnson et al., 2019)	Therapist and Client	Outpatients with Schizophrenia	✓	
3	Therapists' mentalization capacity and its relationship to the therapeutic relationship: the "real relationship" of the working alliance (Woodall, 2019)	N/A	N/A	✓	
4	Group cognitive behavioural therapy of physical and psychological menopausal symptoms of Chinese women, delivered via Internet and mobile phone versus face to face: A protocol for a randomized non-inferiority trial (Li, et al., 2019)	Client	Group CBT with 'menopause syndrome'	✓	
5	The working alliance in stuttering treatment: a neglected variable? (Sønsterud et al., 2019)	Client	Speech and language therapy in the community	✓	
6	Differences in baseline and process variables between non-responders and responders in Internet-based cognitive behavior therapy for chronic tinnitus (Probst et al., 2019)	Client	Internet based CBT for chronic tinnitus in the community	✓	
7	Electronic Media and its Applications in Psychotherapy: Methods and a Geriatric Case Study (Hobbs et al., 2019)	Client	Geriatric psychiatric inpatients	✓	
8	Therapeutic alliance in inpatients with severe anorexia nervosa (Marzola et al., 2019)	Client	Psychiatric inpatients	✓	
9	The Therapeutic Relationship in Forensic and General Psychiatric Settings (Otte et al., 2018)	Client	Forensic and psychiatric inpatients	✓	
10	An Investigation of the Impact of Client Requirements for Alliance on the Alliance-Outcome Association (McCarrick, 2018)	Client	Psychology treatment in the community	✓	
11	Attachment Orientation and Relationships With Physicians and Nurses Among Israeli Patients With Advanced Cancer (Bar-Sela et al., 2018)	Client	Advanced cancer patients	✓	
12	Jonas, B., Tensil, M. D., Tossmann, P., & Strüber, E. (2018). Effects of Treatment Length and Chat-Based Counseling in a Web-Based Intervention for Cannabis Users: Randomized Factorial Trial (Jonas et al., 2018)	Client	Digital interventions for problematic cannabis use	✓	
13	Heim, E., Rötger, A., Lorenz, N., & Maercker, A. (2018). Working alliance with an avatar: How far can we go with internet interventions? (Heim et al., 2018)	Client	Internet intervention for insomnia	✓	

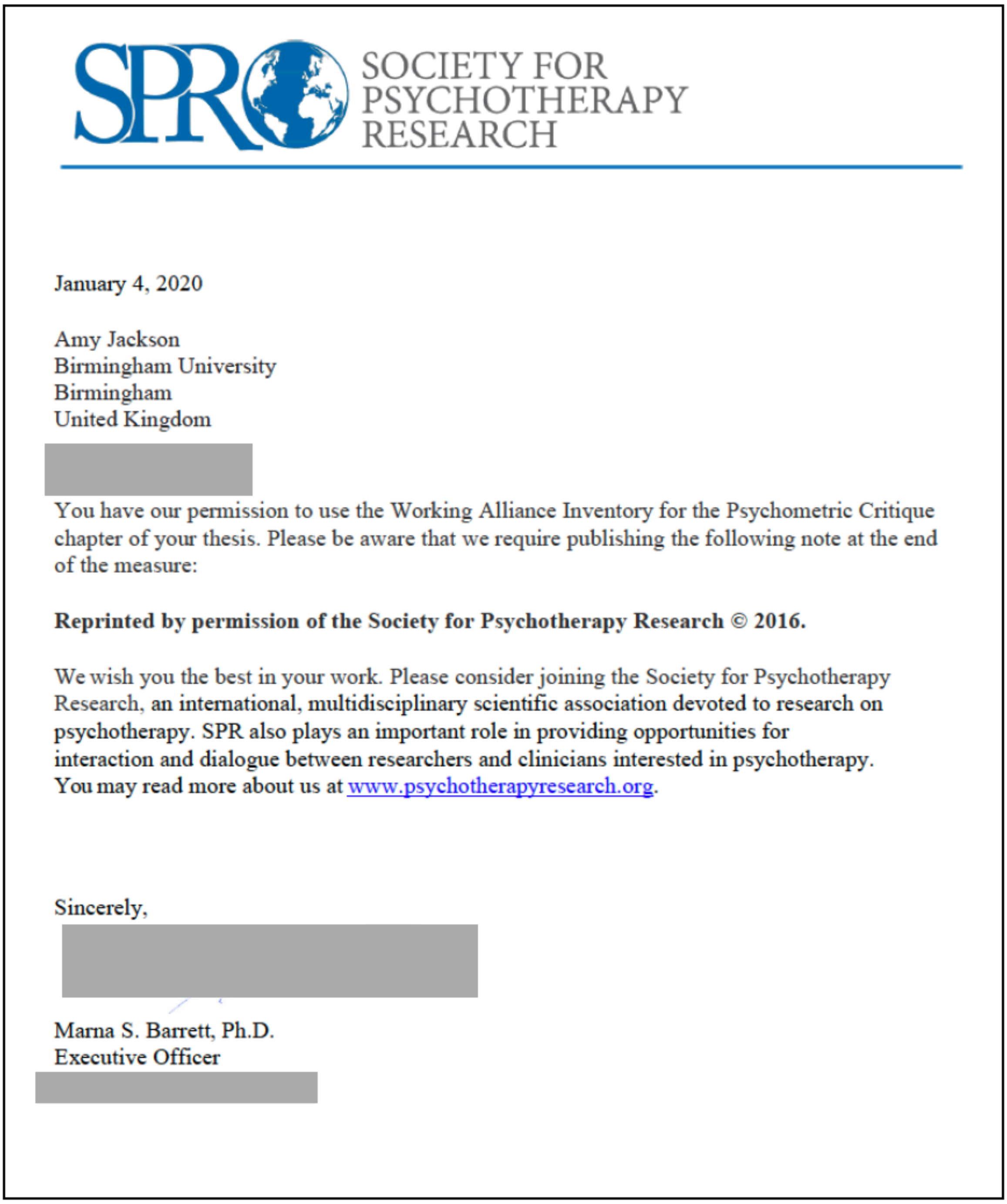
14	The Therapeutic Relationship Matters: Working Alliance Quality as a Predictor of Post-Treatment Insomnia Severity in Cognitive-Behavioral Therapy for Insomnia (CBT-I) (Robertson et al., 2018)	Client	CBT addressing sleep disruption and insomnia symptoms in a community sample	✓	
15	Treatment Outcome in Compensatory Cognitive Training for Schizophrenia: Therapeutic Alliance vs Learning Potential (Jones et al., 2017)	Client	Outpatients with schizophrenia enrolled in Compensatory Cognitive Training (CCT)	✓	
16	*The Prognostic Value of Working Alliance on Pain and Functional Outcomes in a Young Adult Male with Chronic Neck Pain* (Gullen, 2017)	Client	Physical rehabilitation in patients with chronic neck pain	✓	
17	Family support, religiosity, spirituality, and working alliance in stress reduction group therapy (Chavers, 2016)	Client	Stress reduction group therapy in the community	✓	
18	Item response theory analysis of Working Alliance Inventory, revised response format, and new Brief Alliance Inventory (Mallinckrodt & Tekie, 2016)	Client	Community counselling		✓
19	Disclosure to Spouses–What Patients Reveal About Their Individual Psychotherapy (Khurgin-Bott et al., 2016)	Client	Outpatient psychotherapy	✓	
20	Therapeutic alliance and obesity management in primary care–a cross-sectional pilot using the Working Alliance Inventory (Sturgiss et al., 2016)	Client and Therapist	Weight management programme in general practice	✓	
21	The association between the strength of the working alliance and sharing concerns by advanced cancer patients: a pilot study (Bar-Sela et al., 2016)	Client	Advanced cancer patients	✓	
22	Perceptions of the working alliance among medical staff and cancer patients (Bar-Sela et al., 2015)	Client and Therapist	Advanced cancer patients	✓	
23	Corrective relational experiences in psychodynamic-interpersonal psychotherapy: Antecedents, types, and consequences (Huang et al., 2016)	Client	Community psychodynamic-interpersonal psychotherapy	✓	
24	Exploratory study of mindfulness in modern-day sport psychology consulting relationships (Jooste et al., 2016)	Therapist	Sports psychology practitioners	✓	
25	The short Working Alliance Inventory in parent training: Factor structure and longitudinal invariance (Hukkelberg & Ogden, 2016)	Client	Parents receiving Parent Management Training	✓	✓
26	National evaluation of the effectiveness of cognitive behavioral therapy for insomnia among older versus younger veterans (Karlin et al., 2015)	Client	CBT for veterans with insomnia	✓	
27	Confirmatory factor analysis of the patient version of the Working Alliance Inventory–Short Form Revised (Falkenström et al., 2015)	Client	Community and psychiatric patients receiving therapy (psychotherapy or CBT)	✓	✓

28	National dissemination of interpersonal psychotherapy for depression in veterans: Therapist and patient-level outcomes (Stewart et al., 2014)	Client and Therapist	Interpersonal therapy for depression with Veterans	✓	
29	The working alliance in a randomized controlled trial comparing Internet-based self-help and face-to-face cognitive behavior therapy for chronic tinnitus (Kasper et al., 2014)	Client and Therapist	Internet based interventions for depression	✓	
30	Factors that promote and inhibit client disclosure of suicidal ideation (Orf, 2014)	Client	Patients involved in psychotherapy with a risk of suicide	✓	
31	Comparison of the effectiveness of cognitive behavioral therapy for depression among older versus younger veterans: Results of a national evaluation (Karlin et al., 2013)		CBT for depression with Veterans	✓	
32	Working alliance in communication skills training for oncology clinicians: A controlled trial (Meystre et al., 2013)	Client and Therapist	Stimulated patient interviews with oncology physicians and nurses	✓	
33	Effectiveness of acceptance and commitment therapy for depression: Comparison among older and younger veterans (Karlin et al., 2013)	Client	Acceptance and Commitment Therapy for depression with Veterans	✓	
34	Sexual orientation microaggressions in psychotherapy (MacDonald, 2013)	Client	Patients who identified as lesbian, gay, or bisexual in psychotherapy treatment	✓	
35	A comparison of two online cognitive-behavioural interventions for symptoms of depression in a student population: the role of therapist responsiveness (Richards et al., 2013)	Client	Self-administered online CBT for University students	✓	
36	Development pattern of working alliance and impact of client attachment in psychological counseling (Niu et al., 2013)	N/A	N/A	✓	
37	National dissemination of cognitive behavioral therapy for depression in the Department of Veterans Affairs health care system: therapist and patient-level outcomes (Karlin et al., 2012)	Client and Therapist	CBT for depression with Veterans	✓	
38	Group treatment for adult survivors of sexual trauma: The relationship between social bonds and symptom severity (Lange, 2012)	Client and Therapist	Group treatment for survivors of sexual trauma	✓	
39	The effect of self-identified stage of change and therapeutic alliance on attrition in treatment in incarcerated juvenile males (Fitch, 2012)	Client	Adolescent offenders receiving rehabilitative services	✓	
40	Relationships among client–therapist personality congruence, working alliance, and therapeutic outcome (Taber et al., 2011)	Client	University counselling	✓	
41	The Relationship Between Adolescents' Stage of Change and Their Ability to	Client	Group psychotherapy to	✓	

	Establish a Working Alliance in Psychotherapy (Grote, 2011)		improve family communication and adolescent functioning		
42	Working Alliance Inventory-Short Revised (WAI-SR): psychometric properties in outpatients and inpatients (Munder et al., 2010)	Client	Inpatients and outpatients	✓	✓
43	An offender version of the working alliance inventory-short revised (Tatman & Love, 2010)	Client and Therapist	Offenders on probation or parole	✓	✓
44	The psychometric properties of the WAI in a career counseling setting: Comparison with a personal counselling sample (Perdix et al., 2010)	Client	Career counselling	✓	✓
45	The effects of pretreatment preparation with clients in a substance abuse treatment (Guajardo, 2008)	Client	Psychoeducation intervention for expectations and fears about psychotherapy	✓	
46	The relationship between Adlerian personality priorities of clients and counselors and the therapeutic working alliance (Shojaian, 2007)	Client and Therapist	University Counselling programme	✓	
47	Development and validation of a revised short version of the Working Alliance Inventory (Hatcher & Gillaspy, 2006)	Client	Adult psychotherapy and counselling centers	✓	✓

*WAI-SR administrated to a new sample of participants.

Appendix P - Copyright Permission for the WAI-SR



SOCIETY FOR
PSYCHOTHERAPY
RESEARCH

January 4, 2020

Amy Jackson
Birmingham University
Birmingham
United Kingdom

[redacted]

You have our permission to use the Working Alliance Inventory for the Psychometric Critique chapter of your thesis. Please be aware that we require publishing the following note at the end of the measure:

Reprinted by permission of the Society for Psychotherapy Research © 2016.

We wish you the best in your work. Please consider joining the Society for Psychotherapy Research, an international, multidisciplinary scientific association devoted to research on psychotherapy. SPR also plays an important role in providing opportunities for interaction and dialogue between researchers and clinicians interested in psychotherapy. You may read more about us at www.psychotherapyresearch.org.

Sincerely,

[redacted]

Marna S. Barrett, Ph.D.
Executive Officer
[redacted]

Appendix Q - Demographic and General characteristics of Six WAI-SR Psychometric Studies

Study 1: Development and Validation of a Revised Short Version of the Working Alliance Inventory (Hatcher & Gillaspy, 2006)		
	Sample 1*	**Sample 2****
Total (*N*)	231 (clients and therapists)	235 (64 clients and 171 therapists)
Clients		
Gender	Female (148, 64%) Male (83, 36%)	Male (56, 24%) Female (167, 71%) Unidentified (12, 5%)
Age (years)	Range (18 to 65) Mean (28.5) SD (7.2) Median (27)	Range (18 to 63) Mean (28.4) SD (9.9) Median (25)
Ethnicity	White (219, 95%) African American (4, 1.5%) Hispanic (4, 1.5%) Asian (2, 1%) Unidentified (2, 1%)	White (87%) African American (4%) Native American (2.7%) Hispanic (2%) Asian (1%) Other (3%)
Socioeconomic Status	-	-
Diagnoses	Most had "neurotic problems" (i.e., depression, anxiety, relationship problems) Some had "mild character disorders"	-
WAI administration (sessions)	Rage (2nd to 274th) Mean (51) SD = (58) Median (34)	After 3rd session
Therapists		
Gender	Female (68%) Male (32%)	-
Experience	Predoctoral interns with 1-5 years (67%) Postdoctoral fellow with 6 or more years and senior staff (33%)	Psychology practicum and internship trainees (111, 65%) Licensed psychologists (46, 27%) Social workers (7, 4%) Other (7, 4%)
Treatment Approaches	Psychotherapy	CBT (~33%) Psychodynamic (25%) Person-centered (10%) Systemic (10%) Other (22%)

*Adult psychotherapy clinic at a large midwestern university.

**A number of counselling centers and outpatient facilities from southwestern US.

Study 2:
Working Alliance Inventory-Short Revised (WAI-SR): Psychometric Properties in Outpatients and Inpatients (Munder et al., 2010)

	Sample 1*	**Sample 2****
Total (*N*)	88 (outpatient clients)	243 (inpatient clients)
	Clients	
Gender	Female = 63%	Female = 75.4%
Age (years)	Mean = 35.2 SD = 11.4	Mean = 38.6 SD = 12.4
Ethnicity	-	-
Socioeconomic Status	-	-
Diagnoses	Four most frequent: Depressive disorders = 42.6% Anxiety disorders = 20.4% Adjustment disorders = 18.5% Personality disorders = 5.6%	Four most frequent: Depressive disorders = 54.8% Eating disorders = 12.1% Anxiety disorders = 11.3% Adjustment disorders = 5.4% Personality disorders = 5%
WAI administration (sessions)	Third = 15.9% Tenth =55.7% Twentieth = 28.4%	Four weeks = 89.9% Eight weeks = 10.1%
	Therapists	
Gender		-
Experience	Master-level clinical psychologists enrolled in a training program for CBT	Physicians and clinical psychologists, both with intensive psychotherapeutic training.
Treatment Approaches	-	Treatment tailored to individual need with psychodynamic framework.

*Outpatients in ongoing psychotherapy at a university outpatient clinic in southwest Germany

**Inpatients from two inpatient clinics (*n* = 158, *n* = 85) in southwest Germany.

Study 3:
Confirmatory Factor Analysis of the Patient Version of the Working Alliance Inventory–Short Form Revised (Falkenström et al., 2015)

	Sample 1*	**Sample 2****	**Sample 3*****
Total (*N*)	See Sample 2 from Hatcher and Gillaspy (2006)	634 patients	234 inpatients
		Clients	
Gender	As above	Female = 74%	-
Age (years)	As above	Mean = 37.3 Median = 35 SD = 14.3 Range = 14-88	-
Ethnicity	As above	-	-
Socioeconomic Status	As above	-	-
Diagnoses	As above	-	-

WAI administration (sessions)	As above	Third session	Third session
Therapists			
Gender	As above	-	-
Experience	As above	-	-
Treatment Approaches	As above	Psychotherapy of different orientations (most CBT or psychodynamic)	Psychotherapy of different orientations

* The second sample used by Hatcher and Gillaspy (2006) in the development of the WAI-SR.

**Patients attending primary care counselling at two service regions in Sweden. Demographic information only available for between 75 and 85% of patients.

***Patients from specialist psychiatric departments throughout Sweden, from an ongoing naturalistic study of therapy delivered in inpatient care.

Study 4 [Part 1 of 2]:
Item Response Theory Analysis of Working Alliance Inventory, Revised Response Format, and New Brief Alliance Inventory (Mallinckrodt & Tekie, 2016)

	Sample 1*	**Sample 2****	**Sample 3*****	**Sample 4******
Total (*N*)	72 clients	107 clients	38 clients	231 clients
Clients				
Gender	Female = 71%	Female = 87%	Female = 67%	Female = 64%
Age (years)	-	-	-	-
Ethnicity	White = 90%	White = 91%	White = 91%	White = 95%
Socioeconomic Status	-	-	-	-
Diagnoses	-	-	-	-
WAI administration (sessions)	Third or fourth session	5-8 = 33.3% 9-15 = 33.3% 16-62 = 33.3%	4-8	2-274 Mean = 34
Therapists				
Gender	-	-	-	-
Experience	Masters and doctoral students (mixture unknown)	Masters and doctoral students = 75% (approx.) Psychologists = 25%	Masters and doctoral students, interns and staff (mixture unknown)	65 therapists (67% interns, 33% postdoctoral fellows)
Treatment Approaches	-	-	-	-

*Community residents/training clinic taken from Mallinckrodt (1993)

**Community residents/training clinic and university or community college counselling center, taken from Mallinckrodt et al. (1995)

***University counselling center taken from Study 1, Mallinckrodt et al. (2005)

****Outpatient clinic clients taken from Hatcher and Barends (1996) and Hatcher and Gillaspy (2006)

Study 4 [Part 2 of 2]:
Item Response Theory Analysis of Working Alliance Inventory, Revised Response Format, and New Brief Alliance Inventory (Mallinckrodt & Tekie, 2016)

	Sample 5*	Sample 6**	Sample 7***
Total (*N*)	235 clients	49 clients	1054 clients
Clients			
Gender	Female = 71%	Female = 66%	Female = 67%
Age (years)	-	-	-
Ethnicity	White = 87%	White = 85%	White = 78%
Socioeconomic Status	-	-	-
Diagnoses	-	-	-
WAI administration (sessions)	Completed at least 3 sessions	-	-
Therapists			
Gender	-	-	-
Experience	171 therapists (65% practicum students or interns, 27% licensed psychologists, 4% social workers, 4% other)	Masters and doctoral students, interns and staff (mixture unknown)	Center staff, interns, and practicum students
Treatment Approaches	-	-	-

*University counselling centers and outpatient clinics taken from Gillaspy (1997) and Hatcher and Gillaspy (2006)

**University counselling center taken from Mallinckrodt et al. (2015)

***University counselling centers taken from the National Research Consortium of Counseling Centers in Higher Eductation (NRCCCHE)

Study 5:
The Psychometric Properties of the WAI in a Career Counseling Setting: Comparison with a Personal Counseling Sample (Perdrix et al., 2010)

	Sample 1*	Sample 2**
Total (*N*)	188 clients	95 clients
Clients		
Gender	Female = 96 Male = 92	Female = 62 Male = 33
Age (years)	Mean = 21.4 SD = 7.10 Range = 14 to 56	Mean = 23.9 SD = 3.21 Range = 18 to 34
Ethnicity		-
Socioeconomic Status	-	-
Diagnoses	-	Seeking help for: Adaption = 56.4% Mood = 18.2% Anxiety disorders = 14.5%

		11.8% = personality disorder
WAI administration (sessions)	Third session	Second session
	Therapists	
Gender	-	-
Experience	-	-
Treatment Approaches	Compulsory career counselling	Four sessions of Brief Psychodynamic Investigation

*Clients engaged in a compulsory face-to-face career intervention at the career counselling service at the University of Lausanne, Switzerland.
**Clients who had sought help for personal issues at the university-based counselling clinic in Lausanne.

Study 6:
An Offender Version of the Working alliance Inventory-Short Revised (Tatman & Love, 2010)

	Sample 1 (test)*	**Sample 2 (retest)****
Total (*N*)	182 clients	174 clients
	Offenders	
Gender	Male = 100%	Male = 100%
Age (years)	(a) Average = 39.6 SD = 14.9 (b) Average = 32.9 SD = 9.4	See below
Ethnicity	(a) Caucasian = 55 African America = 4 Hispanic/Latino = 1 (b) Caucasian = 78 African American = 24 Hispanic/Latino = 12 Asian = 2 Pacific Islander = 1 Korean American = 1 Unidentified = 4	See below
Socioeconomic Status	-	-
Index Offences	(a) Sexual offenders = 60 (b) Domestic abusers = 122	See below
WAI administration (sessions)		Duration of supervision with their particular PO: Range = 1 month to 40 months Average = 6.89 months Mode = 6 months
	Therapists (Probation Officer/s)	
Gender	-	-
Experience	-	-

Treatment Approaches	Court-ordered sex offender treatment or “batterers’ education group” treatment.	Court-ordered sex offender treatment or “batterers’ education group” treatment.

*Adult male offenders on probation or parole for either sexual offences or domestic abuse.

**For a variety of reasons (illness, unwillingness to participate, or arrest, a reduction of 8 participants from the test administration. The 8 participants who did not participate in the retest consisted of 2 sex offenders (2 Caucasian; mean age = 32.4; SD = 8.4) and 6 domestic abusers (4 Caucasian and 2 African American; mean age = 28.2; SD = 4.2).