EXPERIENCES OF SECURE SERVICES FOR OLDER ADULTS WHO HAVE A FORENSIC HISTORY

by

JADE MITCHELL

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Thesis overview

This research project explores the lived experiences of older adults who have offended, on life in secure forensic services. Chapter one delves into how this population have coped in prison and/or secure forensic mental health units. Through a systematic review and narrative synthesis of relevant literature in the field, findings involved themes around religion, social support, activities, treatment/rehabilitation, a sense of belonging and acceptance.

Chapter two turned the focus to secure forensic mental health units in particular, given the lack of research in this area. A qualitative methodology utilised semi-structured interviews to explore participant's sense making of living in secure forensic mental health units as an older adult. Themes included: the relational power of staff members in secure care, the experience of living with other patients with forensic and mental health needs, the stressors of being an older adult in secure care, and coping.

Dedication

To my wonderful husband David. I dedicate my achievements to you through your unconditional love and support throughout the challenges of this journey. To my beautiful boys, Leo and Logan, for providing the purest of light in the darker moments and reminding me of the good in the world.

To our future.

Acknowledgements

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Contents

F: Coding on a transcript

G: Final GET table

H: Ethical approval

I: Service recommendations

J: Information on articles excluded from the literature review

List of tables

Chapter 1:

Chapter 2:

Chapter one: Coping with life in prison and/or secure forensic mental health services: The experience of older adults

Abstract

Purpose: To systematically review how older adults who have offended cope with life in secure services.

Methods: Seven databases plus relevant reference lists were searched. Following application of inclusion criteria, identified articles were assessed using structured quality appraisal tools. Narrative synthesis supported analysis.

Results: Searches generated 312 potential articles, with reference lists identifying a further 5; 138 duplicates were removed and following screening, 40 articles were identified. Eligibility assessments produced 12 final articles.

Conclusions: Themes in prison focused on the benefit of religious activities for older adults, the importance of maintaining a social network, the experience of personal growth through age, reflection, and acceptance, becoming a role model to younger prisoners, and finding comfort in having one's needs met in prison. In secure mental health hospitals, themes included treatment and rehabilitation, keeping busy with daily activities, seeking social support in the absence of family, and finding a sense of belonging and acceptance through faith.

Introduction

In the UK and Wales, the age of prisoners has dramatically increased in the last 10 years, with the percentage of older adults in prison almost doubling (House of Commons, 2022). In recent years, over a third of individuals in inpatient mental health facilities have also been over the age of 50 (NHS digital, 2022). The 'greying' of the detained population has been explained by the influx of historical sex abuse cases being trialled in the present day, the increased life span of the general population, more frequent use of life sentences, and changes to the previous 'leniency' given to older adults presenting in court (Atkinson, 2008; Natarajan & Mulvana, 2017; Yorston & Taylor, 2006).

Researchers are yet to reach a consensus on the age cut-off for 'older adult offenders', with ages between 39 and over 65 being proposed (Girardi et al., 2018; Merkt et al., 2020; Yorston & Taylor, 2006). The variation comes from the 'accelerated ageing' of those who have offended; older adults within the Criminal Justice System often present with health risks and chronic conditions advancing the chronological age prematurely by around 10-15 years (Greene et al., 2018; Merkt et al., 2020). This is generally impacted by psychosocial factors like substance misuse, homelessness, disability, lack of positive social networks, limited access to healthcare, functional impairment, and low socio-economic status (Kakoullis et al.,2010; Merkt et al., 2020; Parrott et al., 2019; Solares et al., 2020).

The increased rates of older adults in secure forensic mental health hospitals (SFMHH) poses additional challenges for already overcrowded, over-stretched services in managing their complex needs and increased vulnerabilities (Hayes et al., 2012; Ismail & Forrester, 2020; Yorston & Taylor, 2006). The cost of managing older adults has been estimated to be three times that of managing younger individuals who have offended (McKillip & Boucher,

2018). This population are a particularly vulnerable, disadvantaged group and their needs can take up considerable resources (Snyder et al., 2009).

The Stresses Of Detainment

Sykes' (1958) 'pains of imprisonment' framework has long dominated research into prisons; Sykes (1958) listed five 'pains' that can negatively influence the prison experience, which Crewe (2011) later expanded (See Table 1).

Table 1

'The Pains of Imprisonment'

Sykes' (1958) original 'pains'	**Crewe's (2011) additional 'pains'**
Deprivation of liberty	Indeterminacy and uncertainty
Deprivation of goods and services	Psychological assessment
Deprivation of sexual relationships	Self-government
Deprivation of autonomy	
Deprivation of security	

Such pains negatively impact on mental health, and contribute to a criminogenic environment, promoting anti-social values, increasing recidivism rates, and use of poorer coping styles in general (Edgemon & Warner, 2018; Haggerty & Bucerius, 2020; Listwan et al., 2013; Sykes, 1958; Zamble & Porporino, 1990). Alongside this, individuals are faced with stressors such as overcrowding, increased noise levels, long periods of isolation, increased risk of violence, boredom, and sadly, separation from and loss of loved ones on the

outside (Harner et al., 2010; Hendry, 2009; Negy et al., 1997; Paulus & Dzindolet, 1993; Sultan et al., 1984).

The experience of life in secure hospitals is less understood. Research suggests that involuntary detention under the mental health act can be 'frightening and distressing' (Akther et al., 2019). Time spent in mental health facilities can be less definitive than fixed prison sentences, leaving individuals feeling uncertain about their future and in a position of non-acceptance (Kallert et al., 2008; Seed et al., 2016). On top of this, coercive interventions such as restraint and seclusion can give rise to fear and traumatisation (Andreasson & Skärsäter, 2012).

Differing Needs And Considerations Of Older Adults

The needs of older adults who have offended are becoming more differentiated from their younger counterparts and understood to be a complex interplay between criminogenic, mental and physical health factors (De Smet et al., 2015; Solares et al., 2020). Such complex needs make it particularly difficult for individuals to cope, creating additional barriers to effective rehabilitation and recovery. Elderly offenders can present a host of medical needs due to their declining physical health (Cipriani et al., 2017; Lewis et al., 2006) and higher rates of psychiatric morbidity compared to the general public are observed (Hayes et al., 2012; Kingston et al., 2011; Murdoch et al., 2008; Solares et al., 2020; Tomar et al., 2005; World Health Organisation, 2017).

In prison services, older adults can be especially vulnerable. Not only do problems with mobility, balance, eyesight, and hearing restrict access to facilities and activities, they can also create a vulnerability to victimisation (Das et al., 2012; Gross, 2007; Turner et al., 2018). Turner et al. (2018) noted older adults in prison can be at risk of exploitation for their medical

prescriptions, with physical frailty making it harder to protect themselves (Gross, 2007). Davoren et al. (2015) reported 38% of older adult prisoners in their study had documented histories of victimisation and bullying, compared to only 12% of the younger prisoners. Likewise, in a study by Visser et al. (2021) in a secure mental health setting, most of the older adults reported feeling at risk, with several individuals describing experiences of bullying by younger patients. Mortality can also become a more conscious concern as age progresses. Whilst death rates in prison tend to be high due to suicide, violence, illnesses, and accidents (Handtke & Wangmo, 2014), older adults can be susceptible to reduced life expectancies because of declining physical health, limited access to appropriate healthcare, and increased vulnerability to violence (Novisky et al., 2022).

Many services set up to manage offenders have been designed to accommodate younger individuals, and present environmental challenges for those with additional ageing needs (Her Majesty's Inspectorate of Prisons; HMIP, 2004). Prison activities of daily living (such as standing up for head counts, navigating long corridors and stairways, getting in and out of bunk beds, listening to orders from staff members, timed activities, and long distances between amenities; Gross, 2007; Psick et al., 2017; Trotter & Baidawi, 2015) can all be particularly challenging for those experiencing age-related functional decline; intensifying mental and physical health difficulties (Trotter & Baidawi, 2015). The adaptions needed to support older individuals in prison (for example extra time to complete tasks, additional linen during cold weather, hand-rails and anti-slip mats in shower rooms) are rarely implemented, and their needs can be ignored entirely; a situation often described as 'double-punishment' through 'institutional thoughtlessness' (Crawley, 2005; Crawley & Sparks, 2005; Trotter & Baidawi, 2015). Secure mental health settings appear to be more accommodating, as Visser et al. (2021) found that comparative to the negative effects of inflexibility and restrictions in the

prison environment, older patients in secure mental health services generally regarded the experience as positive.

Coping

Lazarus and Folkman (1984) initiated the exploration of the concept of coping and proposed two distinctions: problem-focused coping (aimed at solving the problem), and emotion-focused coping (regulating emotions related to the problem). The Ways of Coping Questionnaire (WCQ; Lazarus & Folkman, 1995) followed, which defined the following coping strategies: planful problem-solving, escape/avoidance, accepting responsibility, positive reappraisal, confrontive coping, distancing, self-controlling, and seeking social support. However, Lazarus and Folkman's (1984) distinctions received much criticism for oversimplifying a complex process, with many scholars arguing that both problem-focused and emotion-focused strategies were intertwined (Compas et al., 2001; Stanislawski, 2019). As research continued to explore the phenomenon, various proposals were made on the conceptualisation of coping, yet a consensus was never successfully reached (Skinner et al., 2003). As a resolution, Stanislawski (2019) proposed the Coping Circumplex Model (CCM), offering an amalgamation of the various dimensions of coping in the literature. The CCM holds foundations in the original emotion and problem-focused distinctions whilst incorporating a circling continuum of coping styles (Stanislawski, 2019; see Figure 1).

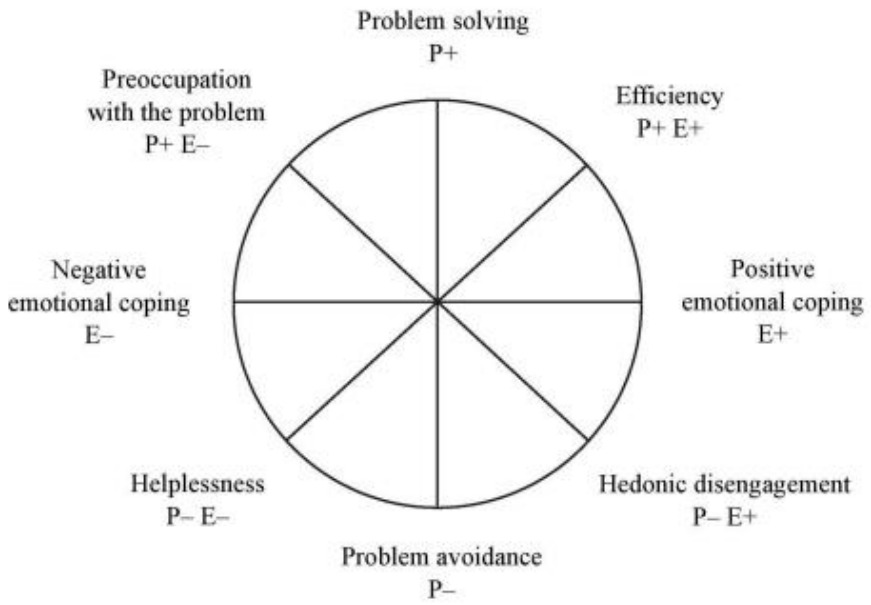


Figure 1

The Coping Circumplex Model (CCM) taken from Stanislawski (2019)

For older adults, the understanding around coping becomes increasingly complex; in part, because older adults have been reported to live through an increased number of stressful experiences with an increased vulnerability to stress (Maschi & Aday 2014). Yet, evidence suggests that they often report less stress (Frydenberg, 2014). Based on existing findings (for example, Aldwin, 2007; Boeninger et al., 2009; and Tedeschi, 2004), Frydenberg (2014) concluded that older adults develop more efficient ways of appraising and coping with stress through post-traumatic growth, building resilience, and maintaining balanced perspectives; all from being 'toughened' through more life experience. However, Moos et al. (2006) found that middle-older aged adults who had experienced more frequent life stressors had an inflated threat appraisal and resorted to avoidance coping or emotional discharge. Older adults have been found to utilise fewer coping strategies/apply less effort in order to preserve limited resources (Folkman, 2011); but can have a greater ability (from experience) to select the most appropriate coping strategy for the situation (Aldwin et al., 1996).

In considering coping within a forensic context, General strain theory (GST; Agnew, 1992) is useful. The GST posits that when individuals are exposed to difficult circumstances, their reactive emotional states such as anger, sadness, and anxiety can lead to the use of negative, or even criminal, means of coping in order to survive (Novisky et al., 2022). Circumstantial stressors can amplify the level of strain an individual experiences, impacting their emotional wellbeing and ability to problem-solve, thus increasing the likelihood of unhelpful responses (Agnew, 2017). Through a GST lens, it can be acknowledged that for older individuals living in captivity, positive coping may be limited, especially given the additional needs and challenges faced in the environment. Research has identified a handful of ways in which older adults cope in prisons and secure mental health hospitals which is helpful for services to be aware of in order to reduce the strain on said individuals. For example, De Smet et al (2017) found that activities allowing for social interactions within prisons was positively correlated with increased quality of life for older adults; having more time outside of their cells was deemed helpful. Similarly, Krabill and Aday (2005) found that peer relationships helped older females to cope, particularly when they had limited access to family support. Yorston and Taylor (2009) found that having increased opportunities to attend education and leisure activities helped individuals in a secure hospital to cope day-to-day, as well as being able to have times of 'peace and quiet'. And finally, Visser et al (2021) reported that individuals expressed preferences for managing their physical health needs independently to avoid embarrassment and feel more in control. It is hypothesised that for older individuals to better cope with life in prison and/or secure care, they need to feel as though their needs are being met to avoid further strain and pressure, ultimately paving the way for effective reformation.

The Current Review

In acknowledgement of the needs of this population it would seem beneficial to explore what helps them to psychologically cope, to provide an emerging evidence-base to guide the allocation of resources and advise service provision. This paper therefore asked: What has helped older individuals to cope with life in prison and secure forensic mental health services, in the context of ageing and the additional complications that ensue? The age cut-off was set at the lowest end of the age-range at 39 years. Reason being, the evidence-base for the target population in answering the research questions was sparse; it was therefore deemed advantageous to include a wider scope of available articles.

Method

Search Strategy

The following databases were searched on 26th June 2022 for articles published up until that date: PsycINFO, Web of Science, PubMed, ASSIA, EMBASE, ProQuest and SCOPUS, dated from 1967-2022. To capture the target population and research question, a combination of search terms was entered, using the Boolean operator "and", as found in Table 2.

Table 2

Search Terms Used in the Searches (Headings, Title, Abstract, Keywords, and Topic)

Age demographic	**Target group**	**Phenomenon under study**	**Environment**
old* OR eld* OR geriatric OR age OR ageing	offend* OR inmate OR criminal* OR crim* OR prisoner OR inpatient	Cope OR coping AND wellbeing OR well-being OR well being	hospital OR mental OR psychiat* OR institution OR prison OR incacerat*

Inclusion/Exclusion

Inclusion and exclusion criteria (See Table 3) were applied to identified articles. Original studies published from inception until June 2022 involving participants aged 39 years and over, who had a history of offending, were included. As the review focused on forensic (offending) and clinical (coping/wellbeing) elements, studies were required to have been conducted in either secure mental health or forensic settings.

Table 3

Inclusion and Exclusion Criteria

Variable	Inclusion criteria	Exclusion criteria
Type of publication	Original studies, grey literature	Literature reviews, letters, books, conference articles
Date of publication	Up until June 2022	-
Setting	Inpatient mental health hospital, prison	Settings that do not have a forensic and/or mental health element
Peer-reviewed?	Yes (including unpublished theses that would have had a form of peer review)	-
Participants	Older adults aged 39 years and above, with an offending history	Under the age of 39, no forensic background
Language	English	-

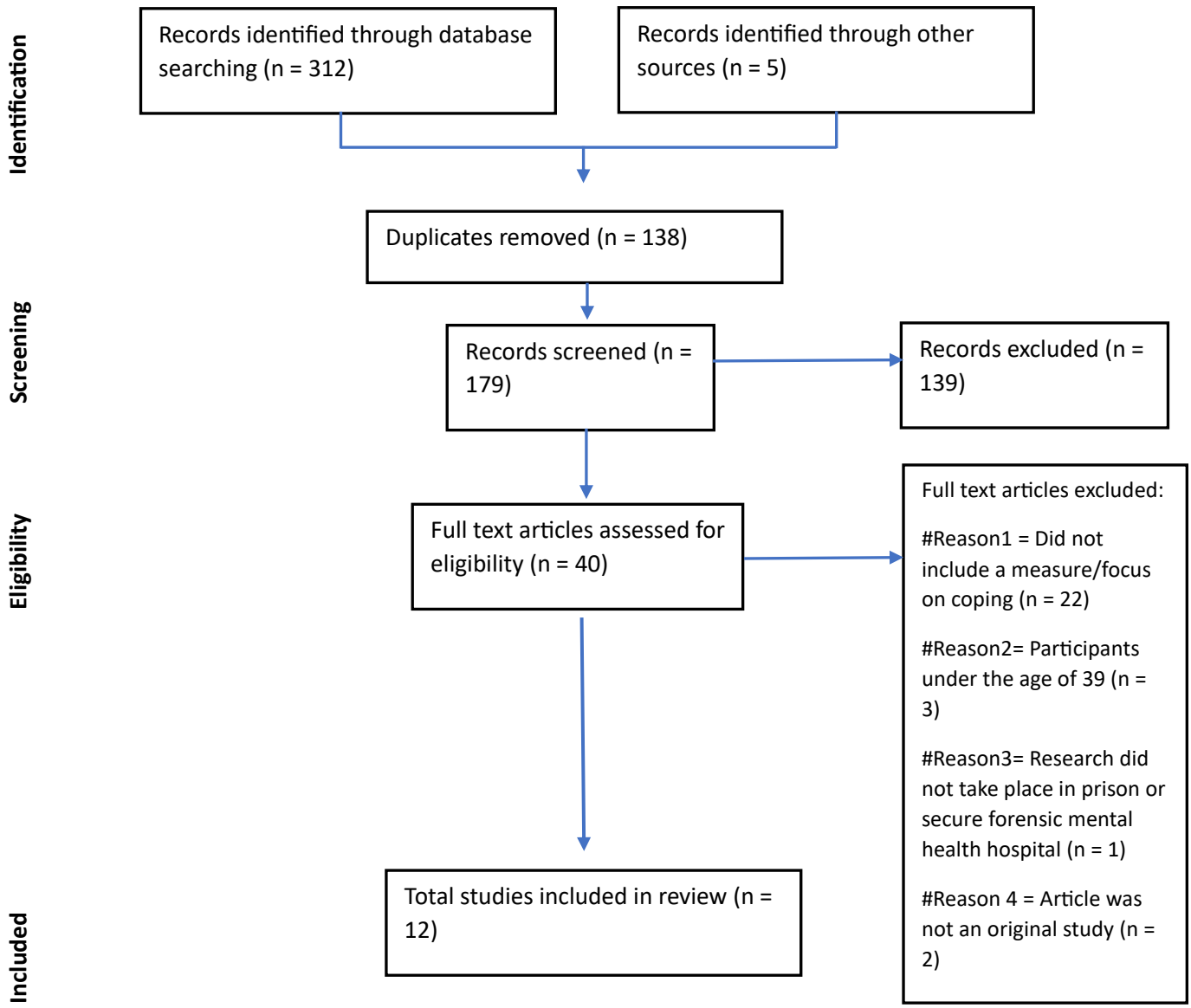
Exposure	Participants to have experienced incarceration either currently or historically and/or time as an inpatient in a secure mental health environment	No support with mental health or criminogenic needs.
Measure	The concept of 'coping' is explored (qualitatively or quantitatively) in direct relation to the research question	No exploration of coping included

Search Results

Searches returned 312 articles, and a review of reference lists identified a further 5 articles. All references were exported to Endnote, a referencing software, and once 138 duplicates were removed, 179 articles remained. From screening titles and abstracts, 40 were identified as relevant to the research question. After screening, 40 articles were reviewed for eligibility assessment and 12 articles were included in the review. Figure 1 depicts an overview of the search process. Information regarding the excluded articles can be found in Appendix J.

Figure 1

PRISMA Diagram of the Search Process



The 12 remaining articles were subject to quality assessments. Three different frameworks were used to accommodate for the qualitative, quantitative, and mixed-method designs of the articles (see Downes et al., 2016; NICE, 2012; Pluye et al., 2009). All articles were considered to be of an acceptable standard and consequently confirmed as the final set.

Overview of Study Characteristics

Table 4 represents the data extraction table providing an overview of each study.

Places Of Study.

Studies were carried out in the United States of America (*n* = 6), United Kingdom (*n* = 3), Philippines (*n* = 1), Israel (*n* = 1), and Australia (*n* = 1). The populations were mostly western, meaning the experiences of those detained in non-western legal systems were omitted. Nine studies were conducted within medium and high secure prison environments and three studies were in secure mental health hospitals.

Methodology of Studies.

Most studies explored this topic via qualitative (*n* = 9) research designs, and a minority employed quantitative (*n* =2) or mixed methods (*n* = 1). The qualitative articles utilised semi-structured or unstructured interviews for data collection, where interviews lasted between 10 minutes and three hours. For data analysis in the qualitative studies, thematic analysis (*n* = 8) was the most common approach (Aday 1994; Aday et al., 2014; Di Lorito et al., 2018; Kozlov, 2008; Lucas et al., 2018; Smoyer et al., 2019; Visser et al., 2021; Yorston & Taylor, 2009) with one study utilising Interpretative Phenomenological Analysis (IPA; Avieli, 2022). Of note, six qualitative studies provided a clear and structured account of the data analysis (Aday et al., 2014; Avieli, 2022; Di Lorito et al., 2018; Lucas et al., 2018; Smoyer et al., 2019; Visser et al., 2021; Yorston & Taylor, 2009) whereas two studies provided little information (Aday, 1994; Kozlov, 2008). Both quantitative studies (Baidawi et al., 2016; Allen et al., 2013) involved structured face-to-face meetings to administer a variety of validated psychometric measures, and utilised descriptive analysis to interpret the results through parametric (regression analysis, *n* = 1) or non-parametric (Independent samples *t*-

test, *n* = 1) statistical testing. The mixed-methods article included both semi-structured interviews and descriptive analysis (Leigey & Ryder, 2015).

Participant Samples.

A total of 458 participants were recruited across studies. The age range was 40-91, although two studies did not specify the exact ages of participants due to anonymity concerns (Di Lorito et al., 2018; Kozlov, 2008). The sample was mostly made up of prisoners (*n* = 396), though some patients were recruited from secure forensic mental health hospitals (SFMHH; *n* = 41), and in one study, staff members in a SFMHH (*n* = 21; Yorston & Taylor, 2009). Some studies had only male participants (*n* = 5; Aday,1994; Allen et al., 2013; Avieli, 2022; Kozlov, 2018; Leigey & Ryder, 2015) or only female participants (*n* = 2; Aday et al., 2014, Lucas et al., 2018), however there were also studies that had a mix of genders in their sample (*n* = 5; Baidawi et al., 2016; Di Lorito et al., 2018; Smoyer et al., 2019; Visser et al., 2021; Yorston & Taylor, 2009).

The offences committed by participants were sentenced through different legal systems and therefore categories were not consistent across countries. The offences have been categorised here into murder, attempted murder, sexual offences against children, robbery/theft, breaking and entering, domestic violence, possession of a firearm, fraud, and drug offences. Five studies did not report on offences (Baidawi et al., 2016; Di Lorito et al., 2018; Kozlov, 2008; Smoyer et al., 2019; Visser et al., 2021).

In the qualitative studies, coping was assessed exploratively through semi-structured or unstructured interviews. In the quantitative and mixed-methods articles, validated measures were used: Brief Multidimensional Measure of Religiousness and Spirituality (Fetzer Institute/National Institute on Aging Work Group, 1999), and the Duke University Religion

Index (Koenig et al., 1997). The following validated measures were also used to compare outcomes for different participants engaging in different coping methods: Mini-mental status examination (Folstein et al., 1975), Wide Range Achievement Test (Wilkinson, 1993), Functional status items from the Medical Outcomes Survey (MOS) 36-item short-form health survey 1.0 (MOS SF-36; Ware and Sherbourne, 1992), Hastened Death Scale-Modified (Rosenfeld et al., 1999), Centre for Epidemiological Studies Depression Scale (Radloff, 1977), and the Kessler Psychological Distress (K10; Kessler et al., 2002).

Table 4

Data Extraction Table

Publication		Sample	Method	Measures used	Data analysis	Setting	Main findings
Author	**Country**						
					Qualitative		
Aday (1994)	USA	25 older male prison inmates (aged 55+)	Case study approach – interviews	Open-ended interview questions about coping with the prison experience	Thematic analysis	Maximum security prison	Themes: prison shock, psychological reactions, family relationships, peer relationships, declining health and death, religion, and prison environment.
Aday et al. (2014)	USA	21 older religious female prison inmates (aged 50+)	Semi-structured interviews	Open-ended interview questions about the role of religion in coping	Constant comparative method (Dorfman, Mendez, & Osterhaus, 2009) to identify themes Thematic analysis used	Prison	Themes: prison and early discontentment, religious activities and support, living with loss and declining health, faith, hope and redemption.
Avieli (2022)	Israel	18 older male inmates (aged 60+)	Semi-structured phenomenological interviews	Questions focused on crime, life in prison and views of successful ageing in prisons	Interpretative Phenomenological Analysis (IPA)	Medium and high security prisons	Themes: comparing ageing in prison with ageing within the community, prison as an escape from a life of loneliness, poverty and delinquency, the older prisoner as a mentor, and experiences of growth and self-discovery as a means for successful ageing in prison
Di Lorito et al. (2018)	UK	15 older adult patients (aged 50+)	Semi-structured interviews	Questions focused on the experience of secure services	Thematic analysis	High, medium and low secure mental	Themes: self-agency, activities, social life, practical matters, recovery, physical health, and service improvement

						health hospitals	
Kozlov 2008	USA	9 older male prisoners (aged 60+)	Unstructured interviews	Questions around coping with ageing in prison	Content analysis	Prison	Themes: hope, regret and loss, transformations in self.
Lucas et al. (2018)	Philippines	15 older female inmates (aged 60+)	Semi-structured interviews	Questions focusing on successful ageing whilst incarcerated	Four stages of analysis: open coding, constant comparison of apriori codes, development of an axial coding paradigm (Strauss & Corbin, 1990), and selective coding into core categories.	Penal institution (prison)	Themes emerged involving a set of phases that participants felt they had to pass through: Struggling, remotivating, reforming, reintegrating, and sustaining.
Smoyer et al. (2019)	USA	23 older adult inmates (aged 40+)	Part of a larger mixed-methods project. Semi-structured interviews	Questions around prison and re-entry experiences	Thematic analysis	Prison and probation	Themes: positive prison experiences, avoiding trouble, accessing services, and rest.
Yorston and Taylor (2009)	UK	11 older patients (aged 60+) Plus, 21 members of staff	Unstructured interviews	One question: 'Can you tell me about your experiences, as an older person, of the care you have received in Broadmoor Hospital.'	Thematic analysis	High secure mental health hospital	Themes: quality of life, vulnerability, risk to others, and external resources.

Visser et al. (2021)	UK	15 older adult patients (50+) Male and female	Semi-structured interviews	Questions focused on the 'user experience' of life in secure forensic mental health care	Thematic analysis	Low and medium secure mental health hospital	Themes: age-related identities, ward environment and age balance, participation in activities, and aspirations for the future.
				Quantitative			
Allen et al. (2013)	USA	94 older male prisoner (aged 45+)	Structured interviews to administer validated measures	Mini-mental status examination (Folstein et al., 1975) Wide Range Achievement Test (Wilkinson, 1993) Functional status items from the Medical Outcomes Survey (MOS) 36-item short-form health survey 1.0 (MOS SF-36; Ware and Sherbourne, 1992) Brief Multidimensional Measure of Religiousness and Spirituality (Fetzer Institute/National Institute on Aging Work Group, 1999) Duke University Religion Index (Koenig et al., 1997)	Multiple regression analysis	Medium-security prison	Older inmates and those who reported greater levels of positive religious coping endorsed fewer symptoms of depression, whereas those who reported greater levels of negative religious coping endorsed more symptoms of depression (F[8, 82] = 5.32, p= 0.001, R^2 = 0.34, adjusted R^2 = 0.28) Inmates who reported higher levels of depression endorsed a greater desire for hastened death. The interaction of functional status and negative religious coping was significant, indicating that the effect of physical functioning on desire for hastened death is

				Hastened Death Scale-Modified (Rosenfeld et al., 1999) Centre for Epidemiological Studies Depression Scale (Radloff, 1977)			moderated by negative religious coping (F[9, 79] = 2.76, p= 0.007, R^2= 0.24, adjusted R^2= 0.15.
Baidawi et al. (2016)	Australia	173 older adults (83 = aged 65+)	Structured interviews including yes/no, scaled, and short-answer questions	Focused questions on a variety of topics relating to the prison experience Kessler Psychological Distress (K10; Kessler et al., 2002) Sense of safety	Descriptive statistics Independent samples t-test Bivariate correlations Linear regression	8 prisons with mixed security levels, both public and private	Reduced distress scores associated with: having another prisoner with whom they could speak about their problems (M = 15.97 vs. 21.06, t = 3.85, p < .001).; having a staff member to whom they could speak regarding their problems (M = 16.73 vs. 20.58, t = 2.6575, p < .01); maintaining employment in prison (M = 16.32 vs. 19.21, t = 2.32, p < .05); Exercise (r = –.265, n = 171, p < .001).
Mixed methods							
Leigey and Ryder (2015)	USA	18 older male inmate (aged 50+)	One component of a larger longitudinal research project.	Qualitative: questions focused on the experience of long-term imprisonment	Qualitative: thematic analysis Quantitative: Spearmans rank order correlational test, Kendall Coefficient of Concordance and the Mann–Whitney U test	Prison	Quantitative results: Results indicate that problems most frequently experienced were also those considered to be most difficult to cope with,

	Qualitative methods: interviews Quantitative methods: descriptive analysis	Quantitative: The Pains of Long-Term Imprisonment survey (Richards, 1978)		and the most severe. Such problems included: missing luxuries, missing social life, missing somebody, feeling that life has been wasted, and wishing for more privacy. Qualitative: Themes: coping with "missing little luxuries", "missing somebody/ social life", "feeling that your life is being wasted", and "wishing you had more privacy". Themes of the least serious problems all related to mental health: "being afraid of going mad," "feeling sorry for yourself," "losing your self-confidence," "feeling angry with the world," and "feeling suicidal."

Quality Assessment

Individual quality assessments were completed on all articles included in the final set. A qualified psychologist associated with the University of Birmingham then rated three articles (one qualitative, one quantitative, one mixed-methods) and inter-rater reliability was found at an agreement rate of 87.5%.

Quantitative.

Downs & Black's (1998) checklist involved reviewing the study's reporting, external validity, and biases (see Table 5). The two quantitative studies scored highly in the reporting section for clearly stating the aims and objectives, providing coherent information on measures used, clear descriptions of the main findings, and reporting actual probability values. Neither studies incorporated specific measures of coping, despite many validated trait and state coping measures available (such as the Coping Strategy Indicator, Amirkhan, 1990; the Ways of Coping – Revised, Folkman & Lazarus, 1985; and the COPE scale, Carver et al., 1989). In Allen et al. (2013), the Brief Multidimensional Measure of Religiousness and Spirituality (Fetzer Institute/National Institute on Aging Work Group, 1999) was used to measure positive and negative religious coping, which is a measure found to be especially useful with older adults, has good convergent and internal validity, and is commonly used in health research (Bodling et al., 2013; Bush et al., 2012).

Table 5

Quantitative Quality Assessment

Study identification	**Allen et al. (2012)**	**Baidawi et al (2016)**
Reporting		

Is the hypothesis/aim/objective of the study clearly described?	Yes No Unclear	Yes No Unclear
Are the main outcomes to be measured clearly described in the Introduction or Methods section?	Yes No Unclear	Yes No Unclear
Are the characteristics of the patients included in the study clearly described?	Yes No Unclear	Yes No Unclear
Are the interventions of interest clearly described?	*-Not applicable- (no intervention used)*	*-Not applicable- (no intervention used)*
Are the distributions of principal confounders in each group of subjects to be compared clearly described?	Yes No Unclear	Yes No Unclear
Are the main findings of the study clearly described?	Yes No Unclear	Yes No Unclear
Does the study provide estimates of the random variability in the data for the main outcomes?	Yes No Unclear	Yes No Unclear
Have all important adverse events that may be a consequence of the intervention been reported?	*-Not applicable- (no intervention used)*	*-Not applicable- (no intervention used)*
Have the characteristics of patients lost to follow-up been described?	*-Not applicable- (no follow up required)*	*-Not applicable- (no follow up required)*
Have actual probability values been reported (eg 0.035 rather than <0.05) for the main outcomes except where the probability value is less than 0.001?	Yes No Unclear	Yes No Unclear
External validity		
Were the subjects asked to participate in the study representative of the entire population from which they were recruited?	Yes No Unclear	Yes No Unclear
Were those subjects who were prepared to participate representative of the entire population from which they were recruited?	Yes No Unclear	Yes No Unclear
Were the staff, places, and facilities where the patients were treated, representative of the treatment the majority of the patients receive?	Yes No Unclear	Yes No Unclear
Internal validity - bias		
Was an attempt made to blind study subjects to the intervention they have received?	*-Not applicable- (no intervention used)*	*-Not applicable- (no intervention used)*
Was an attempt made to blind those measuring he main outcomes of the intervention?	Yes No Unclear	Yes No Unclear

If any of the results of the study were based on "data dredging", was this made clear?	Yes No Unclear	Yes No Unclear
In trials and cohort studies, do the analyses adjust for different lengths of follow-up of patients, or in case-control studies, is the time period between the intervention and outcome the same for cases and controls?	*-Not applicable-*	*-Not applicable-*
Were the statistical tests used to assess the main outcomes appropriate?	Yes No Unclear	Yes No Unclear

Qualitative.

To assess the nine qualitative studies, the Quality Appraisal Checklist for Qualitative Studies developed by the National Institute for Health and Care Excellence (NICE, 2012) was utilised (See Table 6). Four papers were rated as high quality (Avieli, 2022; Di Lorito et al., 2018; Lucas et al., 2018), whereas the rest were rated as medium quality. The papers rated as high quality boasted particularly defensible methodologies, high levels of trustworthiness, and rigorous data analysis methods.

The data collection appeared to be carried out well in six studies. However, only two articles clearly described the role of the researcher (Kozlov, 2018; Visser et al., 2021); surprising given the importance of researcher reflexivity in enhancing trustworthiness and reducing bias in qualitative research (May & Perry, 2014). The data for all qualitative articles were considered rich, although in Yorston and Taylor (2009) there were limited extracts included to evidence the proposed themes.

Table 6

Qualitative Quality Assessment

Study identification	Aday (1994)	Aday et al. (2014)	Avieli (2022)	Di Lorito et al. (2018)	Kozlov (2008)	Lucas et al. (2018)	Smoyer et al. (2019)	Yorston and Taylor (2009)	Visser et al (2021)
Theoretical approach									
1. Is the qualitative approach appropriate?	Appropriate Inappropriate Not sure	Appropriate Inappropriate Not sure	Appropriate Inappropriate Not sure	Appropriate Inappropriate Not sure	Appropriate Inappropriate Not sure	Appropriate Inappropriate Not sure	Appropriate Inappropriate Not sure	Appropriate Inappropriate Not sure	Appropriate Inappropriate Not sure
2. Is the study clear in what it seeks to do?	Clear Unclear Mixed	Clear Unclear Mixed	Clear Unclear Mixed	Clear Unclear Mixed	Clear Unclear Mixed	Clear Unclear Mixed	Clear Unclear Mixed	Clear Unclear Mixed	Clear Unclear Mixed
Study design									
3. How defensible/rigorous is the design/methodology?	Defensible Indefensible Not sure	Defensible Indefensible Not sure	Defensible Indefensible Not sure	Defensible Indefensible Not sure	Defensible Indefensible Not sure	Defensible Indefensible Not sure	Defensible Indefensible Not sure	Defensible Indefensible Not sure	Defensible Indefensible Not sure
Data collection									
4. How well was the data collection carried out?	Appropriately	Appropriately	Appropriately	Appropriately	Appropriately	Appropriately	Appropriately	Appropriately	Appropriately

	Inappropriately Not sure/inadequately reported	Inappropriately Not sure/inadequately reported	Inappropriately Not sure/inadequately reported	Inappropriately Not sure/inadequately reported	Inappropriately Not sure/inadequately reported	Inappropriately Not sure/inadequately reported	Inappropriately Not sure/inadequately reported	Inappropriately Not sure/inadequately reported	Inappropriately Not sure/inadequately reported
Trustworthiness									
5. Is the role of the researcher clearly described?	Clearly described Unclear Not described	Clearly described Unclear Not described	Clearly described Unclear Not described	Clearly described Unclear Not described	Clearly described Unclear Not described	Clearly described Unclear Not described	Clearly described Unclear Not described	Clearly described Unclear Not described	Clearly described Unclear Not described
6. Is the context clearly described?	Clear Unclear Not sure	Clear Unclear Not sure	Clear Unclear Not sure	Clear Unclear Not sure	Clear Unclear Not sure	Clear Unclear Not sure	Clear Unclear Not sure	Clear Unclear Not sure	Clear Unclear Not sure
7. Were the methods reliable?	Reliable Unreliable Not sure	Reliable Unreliable Not sure	Reliable Unreliable Not sure	Reliable Unreliable Not sure	Reliable Unreliable Not sure	Reliable Unreliable Not sure	Reliable Unreliable Not sure	Reliable Unreliable Not sure	Reliable Unreliable Not sure
Analysis									

8. Is the data analysis sufficiently rigorous?	Rigorous Not rigorous Not sure/not reported	Rigorous Not rigorous Not sure/not reported	Rigorous Not rigorous Not sure/not reported	Rigorous Not rigorous Not sure/not reported	Rigorous Not rigorous Not sure/not reported	Rigorous Not rigorous Not sure/not reported	Rigorous Not rigorous Not sure/not reported	Rigorous Not rigorous Not sure/not reported	Rigorous Not rigorous Not sure/not reported
9. Is the data rich?	Rich Poor Not sure/not reported	Rich Poor Not sure/not reported	Rich Poor Not sure/not reported	Rich Poor Not sure/not reported	Rich Poor Not sure/not reported	Rich Poor Not sure/not reported	Rich Poor Not sure/not reported	Rich Poor Not sure/not reported	Rich Poor Not sure/not reported
10. Is the analysis reliable?	Reliable Unreliable Not sure/not reported	Reliable Unreliable Not sure/not reported	Reliable Unreliable Not sure/not reported	Reliable Unreliable Not sure/not reported	Reliable Unreliable Not sure/not reported	Reliable Unreliable Not sure/not reported	Reliable Unreliable Not sure/not reported	Reliable Unreliable Not sure/not reported	Reliable Unreliable Not sure/not reported
11. Are the findings convincing?	Convincing Not convincing Not sure	Convincing Not convincing Not sure	Convincing Not convincing Not sure	Convincing Not convincing Not sure	Convincing Not convincing Not sure	Convincing Not convincing Not sure	Convincing Not convincing Not sure	Convincing Not convincing Not sure	Convincing Not convincing Not sure

12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Relevant Irrelevant Partially relevant	Relevant Irrelevant Partially relevant	Relevant Irrelevant Partially relevant	Relevant Irrelevant Partially relevant	Relevant Irrelevant Partially relevant	Relevant Irrelevant Partially relevant	Relevant Irrelevant Partially relevant	Relevant Irrelevant Partially relevant
Conclusions									
13. Conclusions	Adequate Inadequate Not sure	Adequate Inadequate Not sure	Adequate Inadequate Not sure	Adequate Inadequate Not sure	Adequate Inadequate Not sure	Adequate Inadequate Not sure	Adequate Inadequate Not sure	Adequate Inadequate Not sure	Adequate Inadequate Not sure
Ethics									
14. How clear and coherent is the reporting of ethics?	Appropriate Inappropriate Not sure/not reported	Appropriate Inappropriate Not sure/not reported	Appropriate Inappropriate Not sure/not reported	Appropriate Inappropriate Not sure/not reported	Appropriate Inappropriate Not sure/not reported	Appropriate Inappropriate Not sure/not reported	Appropriate Inappropriate Not sure/not reported	Appropriate Inappropriate Not sure/not reported	Appropriate Inappropriate Not sure/not reported
Overall assessment									
15. How well was the study conducted?	++ + –	++ + –	++ + –	++ + –	++ + –	++ + –	++ + –	++ + –	++ + –

Mixed methods.

The Pluye et al. (2009) scoring system was employed for the only mixed-methods paper in the review (Leigey & Ryder, 2015; see Table 7). In the scoring system, one point is awarded for each criterion present, zero points where they were not. The total number of points are divided by the number of potential criterion, and then multiplied by 100. The total quality score that Leigey & Ryder (2015) received was 78.5%.

The article scored highly for providing justification of using mixed-methods and how the different methods were integrated. The study adequately described the context of the research, the sampling, and the processes of data collection and analysis.

Table 7

Mixed-methods Quality Assessment

Study identification	**Leigey and Ryder (2015)**
Qualitative	
Was an appropriate qualitative approach/design/method used?	1
Was the description of the context adequate?	1
Was an adequate description of participants and justification of sampling provided?	1
Was the description of data collection and analysis adequate?	1
Was there a discussion of the researcher's reflexivity?	0
Quantitative experimental	
Was there appropriate sequence generation and/or randomisation?	0
Was allocation concealment/blinding used?	0
Was complete outcome data reported and/or low withdrawal/dropout?	1
Quantitative observational	
Were appropriate sampling methods and sample sizes used?	1
Was a justification of measurements (validity and standards) provided?	1
Were confounding variables controlled for?	1
Mixed methods	
Was a justification of the mixed methods design provided?	1
Was a combination of qualitative and quantitative data collection and analysis procedures used?	1
Was there an integration of the qualitative and quantitative data discussed?	1

Data Analysis

A narrative synthesis approach was used due to the outcome of studies being presented in a non-comparable format. Narrative synthesis allows for different types of questions, research designs, and contexts amongst studies (Booth et al., 2016) which was favourable given the heterogeneity of the articles included. The process in this review was that of 'developing a preliminary synthesis' (Popay et al., 2006); using the findings in the existing literature to identify patterns as a means of 'telling the story'of the phenomenon in question.

To complete the narrative synthesis, findings from each study were reviewed. For quantitative methods, outcomes were analysed and key findings related to coping were noted. In the qualitative methods articles, themes were reviewed across studies and grouped together based on similarities and differences. Quantitative and qualitative findings were organised by the settings in which the research was conducted to present an account of how older adults coped in such environments.

Epistemological stance

The epistemological stance for the analysis was that of interpretivism-constructivism. With the theoretical roots of interpretivism being held in hermeneutics (Van Der Walt, 2020), a subjective understanding of human experience could be gained through the available data. The interpretivism epistemology accommodated the influences of the author such as their demographics, background, and personal world views when interpreting participant accounts of their lived experiences of secure forensic services; the perspective aligned with the view that true understanding is to be obtained through deep, subjective interpretation of a subject (Rahi, 2017). The constructivism stance supported the analysis through an understanding that

reality is socially constructed and therefore findings are constructed through a subjective lens, through which patterns of meaning can be inductively developed (Chen et al., 2011).

Results

The literature review identified 12 articles exploring how older adults who have offended coped with life in prison and/or secure forensic mental health hospitals (SFMHH). Perspectives from the participants highlighted similarities and differences in living in different secure environments, and, provided insight into areas services could focus on providing better access to.

Prison Environments

Religious Activities as a 'Vehicle' for Constructing Meaning, Supporting Adjustment, and Finding Connections with Others as an Older Adult.

Religion was commonly referenced as a medium for coping with life in prison services and was reported by participants across various papers (e.g Aday 1994; Aday et al., 2014; Allen et al., 2013; Kozlov, 2008; Leigey & Ryder, 2015; Lucas et al., 2018). In Aday et al. (2014), the focus was specifically on exploring the role of religion in facilitating coping. Individuals reported that maintaining a religious identity felt important for coping with life in prison; all participants in the study described religion as 'crucial' in their adjustment: "*my relationship with God is as important to me as the air that I breathe*" (p. 244). Across various other studies, some participants regarded religion as a 'vehicle' for constructing meaning of individual's life stories, which appeared to derive from the focus on reflection and introspection, ultimately leading to positive change (Aday et al., 2014, Lucas et al., 2018). Some participants spoke of finding strength in their faith to develop a sense of morality and foster hope for the future (Aday et al., 2014; Kozlov, 2008; Lucas et al., 2018).

Aday et al. (2014) noted that the community aspect of religiosity afforded additional benefits that supported coping; mostly, having meaningful social support and daily activities to engage with. Participants expressed how in the absence of familial contact, having close connections with religious peers reduced loneliness and isolation – "*My Christian sisters and I are like family"* (p. 246). Such relationships were considered especially positive for omitting judgement and fostering respect and empathy – experiences not readily made available to those who have committed crimes. Kozlov (2008) and Lucas et al. (2018) reported narratives around such accepting relationships ("*religion..friends..they keep me going*"; Kozlov, 2008, p.34) and finding comfort in faith (" *..I relied on God for comfort";* Lucas et al., 2018, p.99*).* Receiving mentorship from the prison chaplains was also highly valued, especially as the chaplains were seen as relatable in terms of age, meaning that participants felt they had someone to turn to for support on managing age-related stressors in prison (Aday et al., 2014; *"The older prison chaplains have been so dedicated to us, sharing much wisdom and insight",* p.245). Regarding religious activities, individuals reported daily bible study, prayer, mass, and church services as providing structure, moral values, a sense of purpose, and as strengthening their perceived connection to God (Aday, 1994; Aday et al., 2014; Lucas et al., 2018) – *"My faith helps me see the difference between what is right and wrong. God pushes me to do the right thing at times when I am tempted"* (Lucas et al., 2018, p.99).

In the sad reality of ageing, family members and other acquaintances pass away. In times of bereavement, some individuals in prison drew upon their faith for support and guidance to navigate grief (Aday et al., 2014), especially to protect against any consequential depression, anxiety, guilt and rumination: *"I cannot do the normal things that free citizens do to honour*

the deceased …since we must grieve alone, many of us turn to religion to fill a critical void" (p. 248). Similarly, in situations where fellow prisoners passed away following age-related illnesses, participants spoke of embracing religion to cope with concerns around their own potential fate – "*When they do die in here, I always hoped they were saved and are now in heaven"* (p. 248).

Allen et al. (2013) found that the individuals who reported greater levels of 'positive religious coping' (having a sense of connection with god; Hebert et al., 2009) presented with significantly fewer symptoms of depression (p = < 0.001). Allen et al. (2013) were the only authors to explore the negative aspects to religious coping for older adult prisoners, which they described as, '*spiritual discontentment..passive religious deferral..re-appraisal of God's powers..a punishing God re-appraisal..feeling abandoned by God'* (p. 771). Participants who exhibited higher levels of these had more symptoms of depression and stronger desires for hastened death (p = < 0.001). One participant in Aday's (1994) study blamed God for putting them in prison, and in Aday et al. (2014) one individual described feeling bitter and angry with God for 'taking her children, church friends and pastor away' (p. 243). These excerpts may illustrate the potential interplay between personality and the use of religiosity as a coping mechanism, in that individuals' perceived relationships with God would generally be interpreted through pre-existing patterns of thinking, feeling, and relating. For example, these individuals believed that God was omnipotent and punishing, whilst seemingly omitting their contributions to their offending behaviour. In other words, when making sense of how they came to be imprisoned, they seemingly turned towards resentment of the 'higher power', and by extension, exonerated themselves of responsibility. The role of personality was likely relevant with other approaches to coping however this discussion was largely absent from the studies in this review.

Age is significantly associated with religiosity whereby younger prisoners in general report less engagement with religion, and for those younger prisoners who would consider themselves religious, spent less time expressing their faith through religious activities (Meade, 2023). For older prisoners, religion can often support coping with age-related problems such as declining physical health, concerns around death, and reduced social opportunities (Meade, 2023).

The Importance of Maintaining a Social Network in Older Age.

Social support, outside of a religious context, was also identified as a factor important for coping as an older adult in prison. This was experienced by maintaining contact with family and friends outside of prison (Aday, 1994; Kozlov, 2008; Lucas et al., 2018), and by building relationships with fellow prisoners and/or prison staff (Aday, 1994; Aday et al., 2014; Avieli, 2022; Baidawi et al., 2016; Kozlov, 2008; Lucas et al., 2018; Smoyer et al., 2019). Participants praised relationships with family for helping maintain their resilience to prison life and building hope for a future of freedom (Kozlov, 2008; "*[my family are] waiting for me*", p.39). Indirect contact (e.g., by letter or telephone) helped to alleviate the distress of being physically separated from loved ones– "*I missed them so much but that went away because I almost always find ways of talking to them*" (Lucas et al., 2018, p. 100). Not all older adult prisoners were able to have contact with family, due to either death, divorce, or rejection because of crimes committed (Aday, 1994). Whilst social support has been found to be effective for prisoners regardless of age (Van Harreveld et al., 2007), older adult prisoners were more likely to have older adult family members and their declining health limited the ability to travel for visits (Aday, 1994).

Also impacting on the experience of older adult prisoners was the relational dynamics with peers. The wider literature highlights how older adult prisoners often seek emotional support and advice from peers, whereas younger prisoners avoid doing so which is hypothesised as being due to anxieties around victimisation and a lack of 'emotional maturity' amongst younger peers (Luke et al., 2020). One participant in Kozlov (2008) described how their age-related health impairments created a vulnerability to abuse from younger prisoners resulting in being targeted by their cellmate. With 'snitching' being considered 'the ultimate sin' in prison, the participant felt helpless to defend themselves and accepted the abuse they received. In the same article, another participant reported feeling 'continuously scared' as their health impairments rendered them unable to walk without the aid of a wheelchair: "*I'm scared I'm gonna get robbed, beat, threatened. I'm scared that when you lay down to take a nap I'll get beat up…I don't sleep. I only cat nap. I'm scared something's gonna happen when I'm asleep. I'm afraid of getting a beating…I won't shower alone"* (p. 22). To prevent this type of victimisation, some participants spoke of building strong connections with other prisoners to 'watch their back' and 'keep [their] stuff safe' (Kozlov, 2008; Smoyer et al., 2019): "*most of us older guys all hang together. We all feel it*" (Kozlov, 2008, p. 23). In Kozlov (2008), older adult inmates reflected on their age as increasing their status in prison as opposed to reducing it; feeling as though being a 'seasoned prison veteran' carried power, as a result of knowing contacts who would enact retribution: *"If you picked on an older guy back in the day, and he'd been around for a while and had connections, he went for the shank"* (p. 24). In a more general sense, Baidawi et al. (2016) found that older prisoners who felt that they had another older prisoner to talk to about their problems were significantly less distressed ($p = < 0.001$). The same was true for those who felt they could confide in staff members, as they were significantly less distressed than those who did not ($p = < 0.01$). In some cases, having friendships in prison supported the feeling of social acceptance and

retaining respect as an individual, a welcomed grace from the wider societal rejection and punishment for their crimes (Avieli, 2022); *"I'm a sex offender…considered the 'scum of the earth' on the outside… in here…people got to know me…now I am the most distinguished man in this prison. Here I get some respect"* (p. 9). This account may again highlight the interplay of personality and coping as for this individual, we can see the use of social contacts for acceptance. Baidawi et al. (2016) summarised that from a social perspective in prison, age and life experience 'compensated' for crimes and were key to being accepted in the incarcerated community.

The Experience of Personal Growth Through Age, Reflection, and Acceptance.

Interestingly, nearly all articles noted how older adults described a process of growth and self-discovery as being an important part of their rehabilitation journey and coping with prison life (Aday, 1994; Aday et al., 2014; Avieli, 2022; Leigey & Ryder, 2015; Lucas et al., 2018; Kozlov, 2008; Smoyer et al., 2019). Kozlov (2008) reported that nearly all their participants reflected on the difference they had noticed in themselves from the time they had committed their offence to their present selves. Aday (1994) found mirroring views: *"When I first came to prison I was a complete stranger to myself… it took me a long time to get back to myself"* (p. 84). In Lucas et al. (2018), participants spoke of their initial negative emotions in response to incarceration encouraging 'realisations' that helped them move forward. Accepting what cannot be changed appeared central to this process, as well as taking responsibility for actions: *"I realized that crying will not solve anything. So I decided that it was time for me to just move on and be productive"* (Lucas et al., 2018, p. 99), *"[prison] was probably good for me. Because I was wild…if it hadn't been for sitting here and coming into the reality that that wasn't the way to do….I may have never woke up to that"* (Kozlov, 2008, p. 31*), "It's my fault. I put myself in this place. And I accept responsibility…I think that's*

what's helped me" (Leigey & Ryder, 2015, p. 737), "*We're human beings, we sometimes make bad choices. The important thing is that we learn from these mistakes and avoid repeating them"* (Lucas et al., 2018, p. 99). References were made regarding incarceration as a time of reflection, a healing process, and a means for understanding oneself (Aday, 1994; Aday et al., 2014; Kozlov, 2008; Smoyer et al., 2019). In Kozlov (2008), several individuals inferred feeling pride in being reformed and found value in themselves in the absence of material items and freedom. A participant in Aday et al. (2014) described, *"I have been able to replace feelings of darkness or emptiness with inner peace and contentment in my heart"* (p. 250). Another explained that even 'low points' served a function: *"Taking the time to search for answers has been very healing to my mind, heart, will, and emotions"* (p. 244). Having the time and space to 'rest and heal' was also deemed important (Leigey & Ryder, 2015; Smoyer et al., 2019).

Many older adult prisoners reported that spending time engaging in productive activities helped them to cope. Whilst younger prisoners also engage in activities to cope with prison life, the motivational stance tends to be different; older adults focus on their development and self-growth, whereas younger prisoners tend to utilise activities as a means of passing the time or to have a break from the prison regime (Behan, 2014). One older individual in Smoyer et al. (2019) described prison as an opportunity to 'refocus what you are doing' and shared, *"I did every program they allowed me to do up there"* (p. 234). In Avieli (2022), 10 participants shared their experiences of this. One person in particular spoke of learning to cook and how this provided new opportunities for feelings of accomplishment: *"I love it and people line up at my door to get my meals. That feels great!...It is something I never thought I could do; now that I am old, I can do whatever I want"* (p. 10). Another inmate expressed their appreciation for improving their design and engineering skills: *"I couldn't believe it –*

here I was, interested in something else, other than my drugs" (p. 10). The process of learning something new provided a sense of self-worth in some cases: *"You feel better about yourself… even if I do stay here until I die, I'll still have been a better person, and that's a self thing, I guess"* (Kozlov, 2018, p. 31), *"I do positive things. You feel better. It brings you some joy, some self-worth or something."* (Leigey & Ryder, 2015, p. 738).

Some individuals expressed the view that maturation facilitated self-growth and the ability to engage positively with activities around them (Avieli, 2022; Kozlov, 2008; Lucas et al., 2018; Smoyer et al., 2019). A prisoner explained how as a younger adult they had often felt in 'survival mode' which was inconducive to learning, but, as an older adult they had been able to take a different perspective: "*I learned to read and write here, at 65… I just want to be able to read a book to my grandson when I go home or be able to read the newspaper. It gives me a sense of purpose and the will to keep going"* (Avieli, 2022, p. 11). Maturity also brought a perceived reduction in impulsivity and increase in prosocial attitudes: *"I'm more settled down than when I was 25, 30 years old. I've learned an awful lot about life in general and what it takes to survive and what it takes to make a go of it…learned how to live here take care of myself, respect others and how they feel…I used to think it was all about me and what I wanted to do, and I don't think that anymore"* (Kozlov, 2008, p. 32).

For many inmates, substance misuse played a role in their lifestyle prior to incarceration. What became evident throughout the articles is how remaining abstinent in prison supported proactive changes to behaviours and lifestyle choices (Kozlov, 2008; Lucas et al., 2018; Smoyer et al., 2019); *"My sobriety started the day they locked that gate … I could've got high as I want in jail, and I just said it's—I'm too old, I'm done, I was tired"* (Smoyer et al., 2019, p. 233), *"[alcohol] wasn't getting me anywhere, didn't get me anywhere but right here.*

I've changed my life a lot, a whole lot since then." (Kozlov, 2008, p. 32). Some expressed views that prison provided an opportunity to get sober that they may not have otherwise had *"If I hadn't wound up in prison…I would probably never have settled down and quit drinking…I probably would have winded up dead somewhere…"* (Kozlov, 2008, p. 33). Shared experiences on the use of substances to cope with prison life were notably absent across articles, even though it is captured in abundance in the literature; higher rates of substance misuse are often observed in the younger prison population (Wu et al., 2011).

Becoming A Role Model to Younger Prisoners; Building Purpose by 'Giving Back'.

Many prisoners echoed the importance of social acceptance and respect, describing how being a mentor/positive role model for others facilitated this (Avieli, 2022; Kozlov, 2008; Lucas et al., 2018; Leigey & Ryder, 2015). Nine individuals in Avieli (2022) discussed being in a position of role model to younger prisoners: *"I advise them because I've got so much experience, so many things in my past. So, I mentor them, especially the young people who are alone here, and they say to me: 'you are like a father to us"* (p. 9). Setting good examples through prosocial behaviour was also frequently raised: *"I started a charity, I collect clothes, bedsheets, deodorant, shoes . . . from prisoners who leave or who have extra, and I give these things to prisoners who don't have any. Over the years, my charity has become sort of famous around the prison, and people started to join in, youngsters who wanted to do some good. So they spread the word, collect stuff from every prisoner who leaves the prison and they look up to me"* (p. 10). These examples of morality may have supported individuals to achieve a positive status through virtue, fitting with the work of Will Storr (2021) on the evolution of human status.

Age and maturity naturally positioned some older adults as promoters for change: *"[older prisoners] set an example for these younger guys. These younger guys look at 'em and think, well if he changed I guess I can too"* (Kozlov, 2008, p. 28), *"A lot of the younger guys that are around a lot of older convicts, and they see the role setting that the older convicts have, not doing some stupid things and not getting involved in nothing stupid, and they follow that"* (Kozlov, 2008, p. 28), *"I don't normally talk to people but whenever someone talks to me, I try to be the positive person for once so that my new found self would affect them as well"* (Lucas et al., 2018, p. 99). Some prisoners described efforts to 'give back' to their communities. For example, one individual shared how he monitored the local newspaper to find those who had been arrested for driving whilst under the influence; he wrote letters to the arrestees detailing his own life story around alcohol and crime in an effort to deter others from 'making the same mistakes'. The individual found it 'rewarding' to make a difference in other people's lives, which inadvertently helped them to feel more fulfilled in their own. Similar accounts were shared of helping others, such as in Leigey & Ryder (2015) where participants volunteered in activities designed to help others (prison ministry, peer education, and legal advocacy). Such activities were regarded as a means of building purpose: *"Even in jail, you have purpose, but you got to define it"* (Leigey & Ryder, 2015, p. 737).

The Comfort of Having Needs Met in the 'Safe Haven' of Prison.

On the contrary to the negative views of incarceration often publicised, it was found in numerous articles that older adult prisoners adopted positive perspectives on their situation to make their realities of life behind bars more bearable (Aday, 1994; Aday et al., 2014; Avieli, 2022; Kozlov, 2008; Lucas et al., 2018; Leigey & Ryder, 2015). In fact, this was found in all but two of the articles on the prison environment. Two major themes that emerged in Avieli (2022) revolved around making positive comparisons of prison to the outside world.

Participants spoke of having better quality of lives in prison where they socialised more, engaged in more activities, attended church, had more free time, and overall likened the situation to retirement: "*I choose to be positive and look optimistically at this whole experience of being here [in prison] at my age. I try to picture my ward as a retirement home. I read a lot of books, and I go to the prison library twice a week. I keep busy. I have a very organized sports regime and I learned how to cook. So I ask – what's the difference? If you look at it the right way, it's just like a retirement home"* (p. 8). Others viewed prison as a 'relief' from the outside world; not having to worry about bills, homelessness, or being alone: *"These aren't dark times; people live a full life here. For me, this is more than fine. I've already been to hell and this isn't it. I lived in a car park for a while, with no water and no electricity… this is better than what I have outside. The meals are served on time, there's a shower, warm blankets in the winter. At my age, these are important things"* (p. 8). Such comments demonstrated cognitive reframing of the situation and highlighted the harsh reality of individual's lives before prison where basic needs were left unmet. Aday (1994) found similar; for some prison was considered to be a 'safe haven' from the 'dangerous elements' of the outside world:*"If I was on the outside, I'd probably be dead by now"* (p. 89). Participants appeared to find comfort in knowing their needs were taken care of inside prison: *"I couldn't work outside, and I certainly wouldn't like having nothing to do. I'm better off here than I would be anywhere… I have friends in here… my medications and everything are there when I need them… if they'd let me take off a week and spend it with my family, I'd come back happy as a lark"* (Aday, 1994, p. 89). This was also observed in Smoyer et al. (2019): *"I think overall it worked out positive… jail can be a sanctuary"* (p. 234). Adopting such perspectives appeared helpful for the older prisoners, more so than in younger individuals who negatively appraise their situation, more frequently report feelings of their lives being wasted and express strong desires to return to the 'outside' (Crewe et al., 2019).

Taking a positive perspective also coincided with maintaining hope for the future. Kozlov (2008) narrated observations of how older adult prisoners occupied their minds with 'idealised future realities'. They noticed individuals appeared to spend time focusing on goals and aspirations for life upon release, even in cases where release was unlikely. Psychologically, this may have offered hope for a positive life trajectory, decreasing distress in relation to the likely outlook for the future. One participant in the article made a distinction between hope and 'useless hope' but explained that they only survived because of their hope regardless of how realistic it was. Hope was also mentioned in the context of religion in Aday et al. (2014) whereby participants referred to it as a way to 'simplify life' and focus on a 'brighter tomorrow'.

Secure Forensic Mental Health Hospitals (SFMHH)

Whilst offering rehabilitative services to those who have offended, SFMHH provide a different type of environment for individuals to serve their time in. Such hospitals detain individuals whilst maintaining a focus on care and treatment as opposed to punishment (Rutherford & Duggan, 2008).

Treatment/Rehabilitation – Recognising the Need and Accepting the Help.

Similar to in prison environments, participants in SFMHH reflected on their growth, addressing personal difficulties, and focusing on rehabilitation (Di Lorito et al., 2018; Visser et al., 2021; Yorston & Taylor, 2009); however in prisons, the focus turned to accepting responsibility for one's behaviour and working towards desistance from crime. In Di Lorito et al. (2018) and Visser et al. (2021), engagement with therapeutic programmes were considered key to having a better quality of life whilst residing on the unit, with some using the sessions

as a distraction and means of passing the time, akin to younger patients: *"This to me is a means to an end and I've got to get through this to be where I want to be"* (Di Lorito et al., 2018, p. 940), *"I like filling my days… As long as you go to the groups you're fine, if you don't go to the groups you're a bit, just sitting down watching telly all day or falling asleep…"* (Visser et al., 2021, p. 54). A variety of different programmes were discussed (such as groups focusing on drugs, alcohol, violence, and relationships) and some felt there was '*always a group for each individual's needs'* (Di Lorito et al., 2018, p. 947); important given the additional needs of older adults. The opportunity to meet weekly with the ward psychiatrist was also referenced as being gratefully received (Di Lorito et al., 2018), although not an opportunity that was consistently available (Yorston & Taylor, 2009). The participants in Visser et al. (2021) also spoke of how they considered their age to afford them with a sense of maturity and experience that allowed them better emotional regulation and the ability to steer clear of conflict; individuals felt empowered in having learned their own triggers. This reflected the accounts of individuals in prison, whereby maturity was viewed as a protective factor in reducing impulsivity and strengthening the ability to take a different perspective, allowing positive engagement with opportunities around them.

Being able to accept the reality of their situation was raised by several patients (Di Lorito et al., 2018; Yorston & Taylor, 2009) as well as taking ownerships over one's mental health (Visser et al., 2021). Whilst reflection and acceptance were raised by participants in prisons, acknowledgement of the role of mental health, interestingly, was omitted. One individual in a SFMHH (Di Lorito et al., 2018) spoke of acceptance through relinquishing control which supporting coping: *"we have to realise that we are in a secure unit and there are parts of our lives that we can't change"* (p. 940). As a result, the commitment to recovery appeared to be more prominent (Di Lorito et al., 2018). Yorston and Taylor (2009) noted how very few

patients spoke about returning to their community, instead the focus being on 'progressing' to a lower security environment. Patients in SFMHH discussed their lack of readiness for discharge: *"the future scares me a bit… that's why I am not in a hurry to leave"* (Di Lorito et al., 2018, p. 941). Interestingly, staff member participants in Yorston and Taylor (2009) shared how older adult patients would often oppose leaving hospital and require encouragement to move on. This view was reflected in Visser et al.'s (2021) observations that moving on appeared to be a 'great source of anxiety' for the oldest patients in the service who seemed to show reluctance due to their valued relationships with staff and peers, and, finding comfort in the familiarity of their current situation. Similar to the way in which participants from the prison studies spoke of the 'harsh realities' of the outside world, individuals in Visser et al.'s (2021) study may have wanted to avoid returning to it. In comparison, adolescents in secure mental health services can find their perceptions tainted by difficult relationships with authority (Gowers & Kushlik, 1992), meaning an increase of negative appraisals of time in services and leaving them feeling as though they are living in an 'alternative reality' (Haynes et al., 2011).

Keeping Busy with Daily Activities.

Having a variety of activities to engage with was highly regarded across several studies (Di Lorito et al., 2018; Visser et al., 2021; Yorston & Taylor, 2009) as was the case in prison. In Di Lorito et al. (2018), activities were seen to protect against social isolation: *"In this place you need to occupy your mind and it's not very helpful if you're sitting there alone with a book on your lap"* (p. 942). Patients spoke of attending the library, horticulture, art, gardening, distance learning courses (education), and IT (Di Lorito et al., 2018), mostly with positive feedback: *"horticulture…being at one with nature…it is the best thing I have here"* (p. 942), *"my artwork, it's a chill out for me. It takes me to another place"* (p. 942), *"I got*

gardening projects coming up. I got plenty to do" (p. 942). Although some patients felt that the activities offered were 'targeted to all ages', it was raised that mobility issues as an older adult could restrict access to them: *"I find it hard walking sometimes"* (Visser et al., 2021, p. 54). Moreover, motivation was difficult to maintain when activities were experienced as repetitive: *"Because I've been here an unprecedented amount of time, I've done most of the groups and have lost all my enthusiasm*" (Di Lorito et al., 2019, p. 942); some even found them to be 'childish' and 'boring': *"It's childish [the groups]. I don't learn nothing from it. I've done 9 groups"* (Visser et al., 2021, p. 54), highlighting the impact of age on interpretations of the suitability of groups. In Yorston & Taylor (2009), activities were considered important as they allowed for time away from the ward such as the activities centre, canteen, gardening sessions, workshops, and the chapel. However, opportunities to get off the ward were dependent upon systemic factors such as staffing levels: *"There are never enough staff to go to the canteen because, whenever staff are needed for the hotspots, they are taken away"* (p. 260*)*. In prison settings, participants reflected on activities as having a positive influence on their own development; having activities to 'refocus', improve their skills and self-worth. In SFMHH, activities appeared to serve a more practical function of socialising and spending time leisurely. In some cases, activities were regarded negatively. The lack of available leisurely opportunities in a prison compared to a SFMHH may influence how valued such opportunities were; therapeutic sessions focused on recovery from mental illness were described as more influential in SFMHH.

Seeking Social Support in the Absence of Family.

Professional and social support was considered a protective coping factor in all three mental health unit studies (Di Lorito et al., 2018; Visser et al., 2021; Yorston & Taylor, 2009). Older adult patients in Di Lorito et al. (2018) valued when staff members could see

beyond the patients' outwards presentations and identify their needs: "*they are very caring*" (p. 943), *"Some of the patients haven't got the confidence to ask for support, but they [staff] recognise that and they sit down with them"* (p. 943), *"It is important to know that my clinical team are all behind me"* (p. 943). Staff members in secure services can support the attachment needs of patients by being responsive, available and sensitive to when intervention is needed (Bucci et al., 2014). In a context that is unfamiliar and unpredictable, this is vital for any age group, regardless of gender (Barber et al., 2006; Schuengel & van Ijzendoorn, 2001). In this review, Yorston and Taylor (2009) found that older adult patients spoke highly of their relationships with staff members, particularly nurses whom they spent the most time with. Staff members in the same article noted that older adult patients spoke to staff more often than they did peers. A different perspective was given of peer relationships in Di Lorito et al. (2018); they were instead seen as being based on a mutual understanding of one another's difficulties: *"it is a recovery ward… everybody relates well"* (p. 944).

Unlike the prison settings where maintenance of family contact was deemed important in coping, in both Di Lorito et al. (2018) and Yorston and Taylor (2009), older adult patients described little input from family members: *"Family contact dwindles away for those patients who have been in hospital for a long time"* (Yorston & Taylor, 2009, p. 260); a stark difference to younger patients in services where family interventions would be prioritised (Hoagwood et al., 2001). In Di Lorito et al. (2018) and Yorston and Taylor (2009), a lack of input from family may have added to the value attributed to the aforementioned support from staff members. In some cases, individuals did not receive visits due to travel being problematic for family members: *"My mom is very old and she's had an operation, so she cannot come very often"* (Di Lorito et al., 2018, p. 944). Befriending schemes were available that helped patients to maintain their connections to life outside of hospital: *"A volunteer*

visitor visits me every month to talk about things that happen outside" (Di Lorito et al., 2018, p. 944). This was welcomed, especially in the aforementioned absence of family contact.

A Sense of Belonging and Acceptance Through Faith.

Spirituality was only raised in detail by participants in Di Lorito et al. (2018) but has been included here as it was described as a meaningful experience. Comparable to the prison accounts, faith supported needs around connection, optimism for the future, and being accepted. For example, an individual described religion as offering peace: *"Being in the church, makes you feel contented and relaxed. No punishing there*" (p. 946), hope: "*It gives me a feeling that I will get free one day*" (p. 946), and a sense of community: *"You sit with the staff, other patients and the padre. . .you're all equal in the eyes of God"* (p. 946). One individual likened pastoral care to psychotherapy, seemingly referring to the emotional support/containment aspect that is typically provided: *"The chaplain came today. I told him the full story of the psychotic incident and he gave me support"* (p. 947). In prisons though, deeper reflections were offered around the sense of morality that was gained through religion, the meaning that it helped to construct of situations, and the structure it provided. Whilst religion and spirituality are consistently evidenced as being positively associated with wellbeing among adults (Koenig, 2001), for adolescents, the results are often more conflicting (Dew et al., 2010), highlighting the increased importance it can have amongst older populations, concurrent to the findings here. In the prison papers, religion was raised by the majority of participants as being an important part of their experience, whereas only two participants in SFMHH raised this.

Discussion

Summary Of Findings

Faith and religion were frequently referenced for coping with life in detainment. Several common threads emerged: hope, being part of a community, constructing meaning, and feeling supported; consistent with research on positive links between religion and wellbeing (Krause & Hayward, 2012; Krause et al., 2019; Steger & Frazier, 2005). Finding meaning in life is not only an essential foundation for personal growth and psychological wellbeing (Steger et al., 2006), it can also serve as an important coping mechanism (Park, 2005; Silberman, 2005). For those in prison, meaning of life can be lost, perhaps due to the pains of indeterminacy and uncertainty as Crewe (2011) pointed out. This can increase levels of distress and the potential for an existential crisis (Vanhooren et al., 2015), especially during long periods of time alone to think. In this review, religion helped guide reflection and introspection in those times and provided contexts for social support, which served as a buffer against isolation and loneliness; significant perpetuating factors for mental health problems amongst the older population (Blazer, 2020). Accessing religious activities with like-minded people supported feelings of acceptance and guidance when some individuals otherwise felt lost. Being part of a community and having social connections revealed interesting examples of fulfilling certain human needs (such as love/belonging and esteem needs; Maslow, 1943); individuals spoke of feeling accepted without judgement, connected to others, respected, and cared for by staff. Feeling cared for, particularly from an attachment perspective (Bowlby, 1969; Blood & Guthrie, 2018) is important for older adults at their developmental stage given the increased vulnerability to poor physical health (Bradley and Cafferty, 2001). Secure attachments are said to be crucial for older adults when adapting to change and can often materialise through a greater variety of attachment figures than is seen in younger adults (Cicirelli, 2020).Such attachments appeared to be much more present within SFMHH settings whereby patients felt more connected to staff than peers, almost

prioritising the nurture received through caregiving; an opportunity not always available in prison environments.

Social support is consistently evidenced to be a protective power against stressful situations (Calhoun et al., 2022; Martino et al., 2015) so it was understandable this was identified as a valuable coping resource in the absence of family, especially in prison. Social support can influence appraisals and provide additional resources to meet the needs generated by a stressor (i.e General Strain Theory; Agnew, 1991). For example, to minimise reactive emotional states to a challenging environment, one may seek social support as a means to re-direct problem-solving attempts, receive emotional support, and have physical assistance (Stewart, 1989). A marked difference was observed in how support was viewed across prison and SFMHH. In prisons, individuals consistently spoke of unity amongst peers and benefitting from having a peer to talk to; there were few considerations given to interactions with staff members. However, in the SFMHH, participants' views varied and it was the relationships with staff members that were most highly valued. The social structure within mental health units has received little academic attention, although Katz and Kirkland (1990) found that violent incidents amongst patients were more frequent on wards that did not operate with standardised, stable and predictable procedures. Peer relationships were not identified as a particular coping mechanism in secure mental health units; perhaps, fuelled by long-standing public perceptions of violence, irrational behaviour, and unpredictability in those with mental health difficulties (Stuart, 2006). Or, impacted by objective features like witnessing distressing events on the ward or having little opportunity to befriend patients on account of dissociative/dysregulated qualities of certain mental health conditions. The social structure in prison is more understood. The prison community tends to operate a collective culture (Hashimi & Schaefer, 2022), possibly influenced by the 'convict code': a collection of values and beliefs providing unwritten rules on behaviour (Mitchell, 2008; Mitchell et al.,

2020) making the actions of others more predictable. Positive interactions with prison officers are usually frowned upon through suspicions of 'snitching' behaviour and not wanting to appear emotionally vulnerable in front of other prisoners (Mitchell, 2008; Mitchell et al., 2020; Molleman & van Ginneken, 2014).

Reflection and introspection were considered useful for individuals across settings to cope with their situations, focus on recovery and desistance from crime. In prison, participants explained the shock of incarceration prompted organic 'realisations' that allowed them to accept reality and take responsibility for their actions; some saw themselves as different from their younger selves who committed the crime or lived in chaos. Individuals in secure mental health hospitals referred to accepting reality and taking ownership over their mental health, although the reflective processes were often fostered through therapeutic interventions. Acceptance is an effective strategy for emotion regulation, adapting to situations, reducing suffering and increasing well-being (Nakamura & Orth, 2005; Wojnarowska et al., 2020). As David and Suls (1999) reported, individuals tend to rely on acceptance to cope when perceived control is low, which could explain why this was raised as an important coping mechanism in the restricted environments under study. Acceptance is a particularly emotion-focused coping strategy (Lazarus & Folkman, 1984) and fits with the Coping Circumplex Model (Stanislawski, 2019); positive emotional coping is seen as more effective longer-term than negative emotional coping such as denial, dissociation, externalising blame, and emotional discharge (De La Fuente et al., 2017).

The idea that personal growth was important to older adults in their journeys was consistent with the literature on the strive for self-actualisation (Maslow, 1943); for older adults, self-actualisation needs can be met through having choice, a feeling of being in

control, being productive, autonomous, and able to express oneself (Cook et al., 2014). These concepts were evident in the participants' narratives around engagement with available activities, learning new skills, and improving their self-esteem; but, mobility issues and staffing sometimes acted as barriers to accessing provisions offered. Some individuals in prison spoke of being role models/mentors to younger inmates which further bolstered their self-esteem and provided means of maintaining purpose. Interestingly, this was not the case in mental health units, which could be the difference in the burden of responsibility. Those in prison, as they naturally age and mature, approach a developmental time where desistance from crime is more likely (see the 'Integrated Maturation Theory'; Rocque, 2015). Participants referred to maturity as affording them with reduced impulsivity and increased social/moral development; taking responsibility for one's actions encouraged the desire to mentor others as a way of making amends for past behaviours. In SFMHH on the other hand, the 'diminished responsibility' defence allows for individuals to be held, in some respects, less accountable for their crimes due to an apparent loss of control as a result of a mental health condition (Nathan & Medland, 2016). In respect of this, the desire to 'make amends' or 'give back' may not have been as strong, instead prioritising recovery to maintain desistance from crime.

Raised frequently across articles on the prison environment was the use of positive perspectives in supporting coping, although rarely in the SFMHH. Older adults in prison used re-appraisal to liken the experience to retirement, having better access to practical and social amenities. Prison was referred to as a 'safe haven', a 'relief from the outside world' where individuals did not have to worry about bills, homelessness or being alone. With a high proportion of older adult crimes being connected to alcohol, drugs, dementia, depression, and homelessness (Gross, 2007; Putkonen et al., 2010; Wong et al., 1995), being in a predictable

prison environment may have been favourable compared to previous chaotic and disadvantaged lifestyles in the community. Of note, such positive appraisals were not explicitly identified in SFMHH however it was noted that the older adults under a mental health section in the papers opposed moving on from services, indicating a level of positive regard for the service. Negative/ distorted cognitions are often associated with poor mental health which may account for why those suffering from mental illness in SFMHH were not able to reflect on their circumstances in a positive or more balanced way (Colvin et al., 2021). The use of re-appraisal for coping has been evidenced in abundance in the literature over the years. Lazarus and Folkman (1984) put forward that it is not the event that causes distress, it is how the event is interpreted that makes an impact. In this review, maintaining a positive perspective was highly protective for the mental wellbeing of older adult prisoners, with some participants considering themselves fortunate to be there. The use here of positive reappraisal for coping links with existing knowledge around positive emotional coping and the increased ability that older adults can have for maintaining a balanced perspective (Frydenberg, 2014; Lazarus & Folkman, 1984).

Quality Assessments

Most studies were qualitative, appropriately using interviews for data collection (Aday, 1994; Aday et al., 2014; Avieli, 2022; Di Lorito et al., 2018; Kozlov, 2008; Lucas et al., 2018; Smoyer et al., 2019; Visser et al., 2021; Yorston & Taylor, 2009). Four of the qualitative papers were deemed high quality through their reliable methods, rigorous data analysis and clearly presented findings (Avieli, 2022; Di Lorito et al., 2018; Lucas et al., 2018; Visser et al., 2021). Both of the quantitative papers (Allen et al., 2012; Baidawi et al., 2016) favourably administered psychometrics face to face which, minimising confusion or

misunderstanding during completion; appropriate statistical tests were also used. However, neither utilised existing validated measures of coping.

Given the differing outcomes of quality assessments, it is important to consider here the findings in relation to them. Whilst all papers were considered to be of a standard suitable for inclusion, Aday (1994), Aday et al. (2014), Kozlov (2008), Leigey & Ryder (2015), Smoyer et al. (2019), and Yorston & Taylor (2009) were rated as having a lower methodological quality. Of note, some of these papers were heavily influential in the development of the following themes: '*Religious Activities as a 'Vehicle' for Constructing Meaning, Supporting Adjustment, and Finding Connections with Others as an Older Adult', 'The Experience of Personal Growth Through Age, Reflection, and Acceptance', and 'The Comfort of Having Needs Met in the 'Safe Haven' of Prison'.* The remaining themes ('*The Importance of Maintaining a Social Network in Older Age', 'Becoming A Role Model to Younger Prisoners; Building Purpose by 'Giving Back', 'Treatment/Rehabilitation – Recognising the Need and Accepting the Help', 'Keeping Busy with Daily Activities'*, and *'Seeking Social Support in the Absence of Family'*) contained a mixture of high and medium quality papers. The final theme, *'A Sense of Belonging and Acceptance Through Faith'*, had only one contributing paper (Di Lorito et al., 2018) although this was considered as high quality. From the lower quality papers, Aday (1994) and Kozlov (2008) were both marked down for how rigorous and reliable the data analysis was due to inadequate reporting, and therefore themes using extracts from these papers must be viewed with this is mind. Moreover, in Smoyer et al. (2019), the data collected was part of a larger study investigating a different phenomenon – the authors analysed the existing transcripts to answer their own research question which felt somewhat inappropriate as the original interview questions did not specifically target the research

question. Despite this, the findings appeared relevant and informative, offering further insight into the phenomenon and thus still deemed useful to evidence the developed themes.

Implications Of Findings

The findings of this review support wider evidence on what older adults consider helpful in coping whilst in forensic services. Although the socio-political context of crime and punishment may not overtly support the facilitation of coping in prisons, it is important to understand the benefits that this can have on personal growth and recidivism; once needs are met, better rehabilitation and recovery can be expected (Bullock & Bunce, 2020; LaCourse et al., 2019), ultimately reducing the cost of longer stays in secure services. Given that research consistently evidences the utility of coping factors in these settings, the availability and access to them could be improved to break the 'revolving door' process often seen in offending populations and provide individuals with the skills needed to pro-socially re-settle into the community (LaCourse et al., 2019; Maruna, 2001; Padfield & Maruna, 2006; Weaver et al., 2012).

To facilitate the processes raised such as reflection, introspection, and cognitive re-appraisal, increased recruitment of trained professionals to deliver therapeutic interventions focusing on these could be useful, especially in the Criminal Justice System. Reflection could be supported in other ways too, for example through religion, self-help programmes, or educational courses that encourage learning and taking different perspectives. In UK prisons, many peer-mentoring and befriender schemes exist which should be prioritised for those wishing to engage. Moreover, services could revise the level and frequency of staff training to ensure staff are upskilled with knowledge around older adult mental health and offending to better support those struggling to cope; in-house psychological services are usually best

placed to provide mental health training. Although the results of this review did not outline instances where participants were struggling to cope, it is suggested here that training in emotion regulation techniques and trauma-informed care would provide a sound understanding in offering help when distress is heightened; thus facilitating better coping and encouraging some of the effective processes outlined by individuals such as reflection, accepting help and increasing social connections. Staff members should have access to a variety of self-help resources that can be distributed amongst services-users when needed.

Secure settings should build connections with supportive mental health and social care services in the local area to increase individuals' access to them, to remain part of the community and increase collaborative support for coping with stress and transitioning in or out of services (Maguire & Raynor, 2017). Increased provision for Liaison and Diversion services across the UK would support this need.

Limitations And Recommendations For Future Research

Only three papers looked at SFMHH. The qualitative approaches yielded rich data, but a further variety of articles would have provided more evidence had they been available. From the quality assessment of the qualitative papers, a frequent concern was that of inadequate reporting making it difficult to assess the reliability of the data collection and analytic processes, and having little understanding of the role of the researcher. To improve trustworthiness and credibility, future researchers should make effort to report these factors clearly, particularly as the environments are complex with many variables at play. In the quantitative papers, the use of blinding was not employed which moving forward could be useful to include as a measure against biases. Also, there is a need for better quality measures exploring coping strategies to further inform the understanding around what works.

Attachment styles and personality patterns were not accounted for in any of the studies. Further, individuals were either sentenced or sectioned but the lengths and types of these were not accounted for. These factors would have likely influenced the perspectives of individuals on their ability and means of coping, as well as their levels of motivation to engage with opportunities; important to bear in mind when interpreting the results. Given the complexities of mental health difficulties in older adults, this group may have been subject to biases interpretations of their experiences. Therefore, quantitative approaches would be useful to evaluate the effectiveness of the approaches described herein in enhancing coping. It could be beneficial to have an understanding of the individual differences (for example attachment styles or personality traits) that may contribute to coping. The existing evidence is based on what people say about their coping and so future research could explore this alternative approach.

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Chapter Two: The experience of living and ageing on a secure mental health ward as an older adult with an offending history

Abstract

Background: The needs of older adults in secure services are complex and unique. With the high cost of inpatient services, it is important to understand the most effective facilitators of recovery. Research into the experience of older adults in secure care is lacking, despite increasing numbers of such individuals in services. Existing evidence has highlighted the complex needs of this population yet has failed to explore what it is like to age in secure forensic mental health settings.

Aim: To better understand the lived experience of older adults ageing in forensic mental health services, in order to inform service provision on effective means of supporting stabilisation and rehabilitation.

Method: Eight participants aged between 50-83 were recruited through purposive sampling across a mental health charity in the UK. Individual face-to-face, semi-structured interviews were conducted generating detailed transcripts for analysis. Interpretative Phenomenological Analysis (IPA) was then employed to systematically analyse the data.

Results: Through a comprehensive analytic process, four 'Group Experiential Themes' (GETs) were created to capture the essence of the participant's experiences: '*Relational power of staff members in secure care'*, '*the experience of living with other patients with forensic and mental health needs*', '*the additional stressors of being an older adult in secure care*', and *'coping'.*

Conclusions: The perceptions of staff member approaches played an instrumental role in experiences, linked to the attachment needs of participants. Feelings of oppression and control were prominent, indicating the ongoing need for minimising restrictive practices. Individuals valued access to activities and maintaining connections with the outside world to cope; important considerations for services moving forward.

Introduction

Chapter one described the nature of older populations in secure services and the special considerations required, highlighting the rationale for research in this area. The literature review identified factors supporting older individuals in coping with life in detainment. In this chapter, the focus turns to secure forensic mental health hospitals (SFMHH) in particular, exploring the whole experience as opposed to solely coping.

Mental health services in the UK are counted upon to uphold high standards of care, but in the current economic climate seems to be proving difficult (WHO, 2022). The demand for services continues to rise (Care Quality Commission, 2022), and now a decade on from publication of the 'Francis Report' (Mid Staffordshire NHS Foundation Trust Public Inquiry, 2013) questions continue to be raised regarding the quality of care provided throughout mental health inpatient services in the UK (Smith, 2023). The report recommended the importance of adequate training for staff members, transparency across services, and regulation of those in charge.

Inpatient services are the most costly and intense means of mental health provision, even more so for older adults given their complex needs (Glasby & Lester, 2005; McKillop & Boucher, 2018). It therefore seems beneficial for organisations to understand effective practices that support recovery alongside the barriers preventing it (Eldal et al., 2019). Inpatient admissions, whilst serving the purpose of assessment and treatment, can be a stressful, frustrating, and even traumatic experience; one characterised by a loss of freedom, privacy, control, and an infringement upon dignity (Bowers, 2005; Chambers et al., 2014; Chumbler et al., 2016). A forensic context can influence the experience further, given the physical and relational security measures in place (Mann et al., 2014). A consistent finding for the general inpatient population is the importance of safety and relationships with

professionals in the overall experience (Gilburt et al., 2008; Larsen & Terkelson, 2014; Thibeault, 2011). This corresponds with Maslow's (1943) hierarchy of needs model and the significance of establishing basic needs before any growth can be expected. The mental health charity 'MIND' (2004) produced a report arguing safe and comfortable conditions were fundamental to maximise recovery potential and minimise longer inpatient stays at further costs to services. From an interpersonal perspective, research suggests compassionate, person-centred approaches, empathic understanding, empowerment, unconditional positive regard, and sensitivity to individual needs are imperative (Gilburt et al., 2008; Phillips et al., 2023; Rogers, 1957; Rosenheck et al., 1997).

Many psychological theories exist that shed light on the above findings. For example, it has long been understood that resilience to stressful experiences can be enhanced by having a secure attachment style (Ramussen et al., 2018), and behavioural and emotional reactions can be mediated more effectively (Olgivie et al., 2014). In the offender population, there is a greater prevalence of insecure attachment patterns compared to the general population, with less emotional attachments to others and increased desires for autonomy observed (Ross & Pfafflin, 2007). The 'Social Control Theory' (Hirschi, 1969) explains crime and delinquency as a consequence of poor attachments; when an individual's attachment to caregivers and wider society are compromised, the likelihood of offending behaviour increases (Hirschi, 1969). The Social Control Theory has contributed greatly to the field of criminology but has not been without controversy; many argue that the theory can be 'victim blaming', neglect 'pull factors' to crime such as peer pressure, and also biological elements (i.e impulsivity, serotonin/dopamine levels; Paul, 2020). Crimes committed by individuals who maintain strong connections with others are also overlooked (i.e corporate crime; Lilly et al., 2019). A more contemporary psychological theory on attachment in a criminal justice context is the Dynamic-Maturational Model (DMM) of Attachment and Adaptation (Crittenden, 2006).

Crittenden (2006) conceptualised attachment within the DMM as a biopsychosocial understanding of how one psychologically protects themselves from danger; the attachment serves as a means of processing interpersonal information in order to effectively respond to threat (Baim, 2020). The focus is on the function of the attachment behaviours. In an offender population there is an increased prevalence of unsafe relationships, for example, higher rates of Adverse Childhood Experiences (Ansbro, 2008; Graf et al., 2021), meaning that individuals enter services with complex, self-protective adaptations, which ultimately implicate coping efforts (Ansbro, 2008).

Regardless of a forensic context, attachment relationships matter (Bowlby, 1973), supported by decades of research. In ageing, attachment relationships are varied; older adults often have fewer attachment relationships in their lives (due to the loss of loved ones), increased symbolic attachments (such as to God), and can become increasingly reliant on caregivers (akin to early childhood) due to declining physical and mental health (Van Assche et al., 2013). Attachment styles can determine how an individual copes (Buelow et al., 2002) with evidence suggesting that secure attachments are positively linked to 'positive coping methods' (for example problem-solving; Lazarus & Folkman, 1984), and insecure attachments linked to 'negative, emotionally-avoidant coping' (for example, substance misuse, and disengagement with others; Howard & Medway, 2004). As dependency on caregivers develops in later life, there is an increased vulnerability to abuse and exploitation, with reduced functioning impeding the ability to cope and/or defend oneself (Shaw & Kaur, 2015). Sadly, elder abuse is often observed in institutional settings designed to care and protect the older adults in their service (Shaw & Kaur, 2015). Blood and Guthrie (2019) created a 'strengths-based' approach to working with older adults, using the Dynamic Maturational Model (DMM; Crittenden, 1995) as a foundation. In the approach, Blood and

Guthrie (2019) proposed the importance of collaboration with family members, and empowering older adults through joint decision-making regarding care and treatment.

Secure mental health hospitals present a unique challenge for older adults. Intertwining goals of both health and criminal justice systems, the care environment becomes complex; implicating the quality of life for older adults with intricate needs (Walker et al., 2023). Quality of life can be difficult to define, but for older adults in the general population, the key domains have been suggested as: "autonomy, role and activity, health perception, relationships, attitude and adaptation, emotional comfort, spirituality, home and neighbourhood, and financial security" (Van Leeuwen et al., 2019, p.6). Considering a forensic context in addition, treatment (of mental and physical health), opportunities for activities, and improving social skills and self-esteem have also been deemed important (Glorney et al., 2010). In Walker et al.'s (2023) qualitative exploration of older adult recovery journeys in SFMHH, it was interpreted that relational factors were important for promoting recovery and wellbeing, requiring a person-centred, individualised approach to care. Environmental aspects such as available facilities were also relevant (Walker et al., 2023). National policies and legislation have, over the years, attempted to address meeting the unique needs of older adults in SFMHH (for example, the National Service Framework (NSF) for older people; Department of Health, 2001); but evidence suggests that ideas have rarely materialised into practice (Anderson et al., 2013). One particular area of interest is the development of age-specific services. Despite evidence suggesting that such services produce more effective outcomes than mixed-aged services (Draper, 2000), they have received minimal backing from governing bodies due to concerns around age discrimination and lack of clear rationales (Anderson et al., 2009; Anderson et al., 2013).

Little work has been done to explore the various factors important in the experience of older adults with a forensic history. Interest *is* picking up traction in the literature though due

to the growing prevalence of such individuals in secure settings (Aday, 1994; Girardi et al., 2018; Parrott et al., 2019; Yorston, 1999). The literature to date has focused on the older adult experience of prison (Di Lorito, Völlm, & Dening, 2019), with SFMHH being overlooked. Several quantitative studies have outlined characteristics of older adult offenders in secure services (Di Lorito et al., 2018; Girardi et al, 2018); mostly white-British males with a personality disorder and comorbid chronic physical health problems. There have been several qualitative studies exploring the 'user experience' of ageing in these settings, and older adult needs in forensic psychiatric care (e.g., Di Loriti, Vollm, & Dening, 2019; Visser et al., 2021); that is; self-agency, leisurely activities, socialising, physical health management, and recovery. Lacking in the literature is an exploration of this population's experiences of living in these services and the considerations of being an ageing adult; an important understanding to assist service development and promote effective stabilisation ahead of rehabilitation, tailored to the individualised needs. A clear perspective on the lived experience of age-specific SFMHH remains unreached.

This study therefore asks:

- *What is it like for older adults to live and age in a forensic mental health hospital?*
- *What sense do such individuals make of their experience?*
- *How did these individuals cope with the experience?*

The qualitative design of this novel study provided an opportunity to focus on older adults' personal reflections and sense-making of their unique experiences.

Method

Design

The qualitative study utilised 1:1 semi-structured interviews for data collection and Interpretative Phenomenological Analysis (IPA) for analysis, to explore participant's meaning making of their lived experiences (Smith et al., 2022). The use of IPA felt necessary given the context of this study; a novel, under-researched area where an understanding from the individual's perspectives was important in order to answer the proposed research questions. Given the infancy of the research area, gaining an insight into the inner workings of the participants sense-making was highly valued and sought-after. From an academic stance, IPA offers theoretical underpinnings that suitably link experiential and psychological constructs (Shinebourne, 2011) which are useful in translating findings into meaningful recommendations for services. The phenomenological, hermeneutic, and idiographic foundations of the knowledge in IPA support the drive in psychological research to explore individual conscious experiences in a way that can be interpreted and disseminated purposefully (Shinebourne, 2011).

Sampling

Sampling took place within a third-sector mental health organisation. The organisation comprised three hospitals on three different sites across the Midlands and North-East of England. The organisation delivered specialist mental health services, both inpatient and community, in partnership with the NHS, academic, and voluntary organisations.

Purposive sampling was used to identify individuals best placed to support the development of understanding around the research topic. A consultant clinical psychologist within the organisation, who held expertise in older adult mental health, identified wards across the organisation's three sites where potential participants were resident. The main researcher was put in contact with the psychologists for those wards. Four separate wards

were identified; two wards had an age-mix of 18+ and two wards were for those aged 50+ only.

Participants

As explained in chapter one, the literature has a varied age range for defining who is 'older', but generally a cut-off age of 50 and above is used (Merkt et al., 2020). A cut-off of 50 years was decided in line with the most frequently referenced in the literature and it was acknowledged that this was different to the cut-off used in chapter one; chapter one utilised a cut-off of 39 years to provide the widest scope of research given the limited published articles available on the topic. In this chapter, narrowing the age cut-off to 50 aligned appropriately with the service criteria within the organisation for being admitted under the categorisation of 'older adult'.

Participants were required to be aged 50 years or above, have a forensic history, and be a current forensic mental health inpatient. The following exclusion criteria were also applied:

- Individuals with a Deprivation of Liberty Safeguards (DoLS) in place.
- Individuals with cognitive problems preventing meaningful participation in the interview.
- Individuals whose discharge is anticipated to be imminent (within 3 months of first approach).
- Individuals who are assessed as posing an imminent risk to themselves or others, including risks that would compromise the safety of the participant and the main researcher before, during or after the interview.
- Individuals being nursed on the following enhanced observations: constant observations (individual has a member of staff with them at all times), or long-term

segregation (individual is cared for in a separate area of the ward accompanied by a minimum of two members or staff).

- Individuals who require an interpreter to communicate with the main researcher during interview, including individuals who are hard of hearing and require the use of British Sign Language.

A total of eight individuals consented to participate: all male with an age range of 50-83. Given the qualitative nature of the study and the desire to protect the anonymity of vulnerable individuals under a forensic mental health section, detailed individual demographic information was not obtained. Participants were residing on various low and medium secure wards within the organisation. The journey into secure care was either through a prison transfer post-conviction, via a hospital order direct from court, or via a hospital transfer from another secure unit. All had been in secure hospitals for at least five years, with around half of the sample being in secure services for most of their adult lives. Participants chose their own pseudonyms: Adam, Jahscater, John, Johnathan, Mark, Mary-Jane, Nicholas, and Sid.

Procedure

Recruitment followed several systematic steps in line with the organisation's guidance. Firstly, the wards were identified through the advising clinical psychologist with expertise in older adult mental health. The responsible clinician for each ward was informed of the study and then the ward The Multi-Disciplinary Teams (MDT) were provided with a summary of the study (see Appendix A) and the inclusion and exclusion criteria. Each MDT were asked to discuss the appropriateness of the study for the patients on their ward and identify suitable candidates for inclusion. Candidates identified as suitable were then approached by a member

of the psychology team to gauge the potential participant's interest and provide a summary of the study (See Appendix B). Consenting individuals were contacted by the main researcher through the ward assistant psychologist who scheduled meetings for the potential participant and main researcher to take place on the ward. Once the meeting had been arranged, the main researcher met with the individuals on their ward and talked through the Participant Information Sheet (see Appendix C) with them in private. The opportunity for any questions was provided, and the individuals were given a paper copy to take away with them (subject to an MDT risk assessment) to process the information in their own time. A second meeting was then arranged for at least one week later to reflect on the Participant Information Sheet, answer any further questions, and talk through the consent form (See Appendix D) with a view to getting it signed, if they were still interested. At this point, participants assigned themselves pseudonyms. The recruitment process continued for all suitable candidates until eight participants had consented and completed the study interviews.

An informal discussion was held with the target population on one of the earlier identified wards to obtain feedback on the proposed interview schedule. The interview schedule (see Appendix E) was developed based on topic areas of 'adjustment', 'coping', and 'support', inspired by points of interest in the wider literature and the objectives of the research question. It was reported that the questions felt relevant, appropriate, and adequately covered the phenomena under study. Age-specific questions were omitted to provide space for authentic meaning-making and explore whether age was naturally offered as a relevant factor in the experience.

Interviews were planned in advance with participants and their clinical teams to avoid disruption to therapeutic timetables. Participants were given a 'question topics' summary prior to the interview to allow a reasonable timeframe to reflect on experiences. Interviews took place face-to-face and on individual's respective wards in rooms identified as having the

least possibility for interruptions. On the day of interview, participants were re-assessed by the main researcher and ward staff to clarify consent, capacity to engage, mental state, and the level of risk that may have been present. Interviews were recorded using an encrypted Dictaphone and lasted between 15-54 minutes, with the average interview time being around 38 minutes. The same questions were used across interviews, however the main researcher was responsive to the direction of dialogue and followed up with questions related to those lines of enquiry. Audio recordings of interviews were securely stored and transcribed into word documents in preparation for analysis. All files were encrypted and password protected.

Analysis

A comprehensive guide to completing a quality IPA analysis by Smith et al. (2022) supported the sequence of analysis. This involved initial readings of the transcript to familiarise oneself with the data, exploratory noting (initial thoughts, reactions and questions to the data), and creating experiential statements that conceptualise the material, before exploring any connections amongst them. As part of the idiographic process, each transcript was subject to the same levels of coding in turn. Personal Experiential Themes (PETs) were identified to reflect participant's experience of sense-making at a broader level, describing the characteristics of the clusters of experiential statements. A PET table was assembled for each individual highlighting the different levels of analysis (See Table 1).

Table 1

Example section taken from a participant's PETs table.

PET B	SECURE CARE AS A JOURNEY
Sub-theme	***Moving through security levels***
Experiential statements	281. Moving on creates mixed feelings

	"Good experience and that and I was excited but nervous at the same time and that. So it's not a bad mix" 98. Being admitted to a less secure environment signalled the end of suffering *"When it ends…its like my body just breathed a big massive sigh of relief and that it's over, you know that horrible journey is over"* 12. Having more freedom is an achievement that is worked towards *"I knew it was a positive thing. I think i'd finally got out of that high secure setting and you know achieved or accomplished whatever you want to call it, you know freedom"* 64. Being admitted to a less secure environment felt like the end of a long and difficult journey to freedom *"I'd come to the end of that journey. I didn't need to fight anymore. It was a massive thing of relief…it was over, the ordeal or whatever you wanna call it"* 270. After so many years, it is hard to imagine what a less secure environment would be like *"I've been locked up in high secure units for you know, places for the last 38 years so…I can't imagine what is gonna happen in these places because before I came here i'd never been here so you know so…i'm not gonna get it right. I can have a guess"*

The main organisational principle for PETs was similarity as the experiential statements depicted clear associations with one another in terms of meaning, despite polarisation in negative or positive stances. Once PET tables were completed for each transcript, sample sections were peer reviewed to assess appropriateness of the clustering of experiential statements and correlating sub-themes. To begin the cross-case analysis, PET tables were printed and colour coded for each participant to support traceability of data once working at a group analysis level. Honouring the hermeneutic cycle observed within IPA (Nizza et al., 2021; Smith et al., 2022), iterative recontextualization of the data followed ready for group analysis; PET tables were explored as a collective with instances of convergence and divergence across participants noted. Some individual PET tables were broken down to allow for the merging of individual participant sub-themes and experiential statements as most commonalities were shared at this level. The PETs were then used to highlight the shared features of the experience across cases and labelled with Group Experiential Themes (GETs).

After the GETs and correlating sub-themes were finalised, all information was collated in a table and evidenced with the relevant quotes from participants (see Appendix G). A final peer review ensured that themes remained grounded in the data. The GETs were arranged to present a coherent narrative of entering services and the subsequent experiences that unfolded. Appendix F contains an example of the coding in action on a transcript.

Epistemological stance

Consistent with chapter one of the thesis, the epistemological stance for the empirical project was an interpretivism-constructivism approach. The characteristics and perceptions of the researcher were able to be explored through an interpretivist epistemology which supported the hermeneutic cycle within IPA (Nizza et al., 2021) and shone light on the role of the researcher during analysis. The constructivist perspective helped deepen analysis through an understanding that multiple meanings can be made of experiences and that such meanings will be influenced by the social world of the individual making them (Guba & Lincoln, 1994). The reflective diary was used as a means of maintaining the epistemological stance.

Reflexivity

The researcher was a trainee clinical and forensic psychologist in their final year of study. The researcher's doctoral training was funded by the organisation where the study took place, however the researcher did not work within services participants were recruited from. The research was supervised by an Assistant Professor in Psychology at the University of Birmingham, who was also an Honorary Research Fellow. Both the researcher and research supervisor held extensive experience in forensic mental health. The researcher and the participants had not had any previous contact prior to the recruitment for the study. The

participants were made aware of the researcher's credentials and the rational for the research/why they had been approached. A reflective diary was maintained throughout the process to bracket any researcher biases and minimise their influence, ensuring participant accounts were reflected fairly. It was acknowledged that the researcher was a female interpreting the experiences of older adult males and in identifying this, it became possible to highlight and separate from the preconceptions made (Creswell and Miller, 2000). The position the researcher held within the power hierarchy of the research itself was also considered; the researcher was a staff member and had previous experience of working in a nursing role. This generated various reflections from personal reactions to data discussing staff members as punitive and/or uncaring. These reactions were noted and reviewed each time a new interpretation was made, to uncover any subjective influences and check for contradictory information. Further, the researcher had never experienced life in detainment and it was therefore important to maintain openness to any meaning that participant's made rather than regarding some aspects as more relevant than others.

Ethics

Approval for the study was granted by the Research Centre at the hospital and by the Ethical Review Committee at the University of Birmingham. Confirmations of approvals can be found in Appendix H.

Results

The qualitative analysis yielded four Group Experiential Themes (GETs). A summarised version of the final GETs table can be found in Table 2 (full version in Appendix G).

Table 2

Summary of final GETs table

		Number of participants contributing to the GET
GET	**A. RELATIONAL POWER OF STAFF MEMBERS IN SECURE CARE**	**8**
Sub-themes	• "We are staff, you're patients…Never the two shall meet" – Tolerating the power differentials in attachment relationships with staff members • "Lack of trust, they don't trust you" – Conflicts in insecure attachments • "I just felt human" – Humane approaches meeting attachment needs • "It is difficult to know people's names" – Staffing issues as a barrier to building meaningful relationships • "Do as you are told and listen" – Feelings of oppression in the wider system	
GET	**B. THE EXPERIENCE OF LIVING WITH OTHER PATIENTS WITH FORENSIC AND MENTAL HEALTH NEEDS**	**8**
Sub-themes	• "At the end of the day it is our home" – The value of a calm ward environment • "You have to be aware all of the time" – Living in threat mode • "I have nothing in common with any of them" – Making it work with unrelatable peers	
GET	**C. THE STRESSORS OF BEING AN OLDER ADULT IN SECURE CARE**	**7**
GET	**D. COPING**	**8**
Sub-themes	• "That is the way that it is" - Acceptance of the situation • "Doing something positive…gives you a lifeline" - The importance of valued activities • "Part of the world again" - Feeling connected to life outside of hospital	

The GETs are presented in order of presentation in Table 2 with each sub-theme being described in turn, evidenced with verbatim extracts and correlating transcript line numbers.

GET A – Relational Power Of Staff Members In Secure Care.

This group theme reflected the importance participants placed on staff presence and behaviour in shaping how their time in a secure hospital was experienced as an older adult. Interpersonal styles of staff affected individual senses of safety, comfort, value, and self-worth, highlighting the power held in relationships and wider system. Identified sub-themes were: *"We are staff, you're patients…Never the two shall meet" – Tolerating the power differentials in attachment relationships with staff members; "Lack of trust, they don't trust you" – Conflicts in insecure attachments; "I just felt human" – Humane approaches meeting attachment needs; "It is difficult to know people's names" – Staffing issues as a barrier to building meaningful relationships; and "Do as you are told and listen" – Feelings of oppression in the wider system.*

"We Are Staff, You're Patients and…Never the Two Shall Meet" – Tolerating the Power Differentials in Attachment Relationships with Staff Members.

This subordinate theme explored dynamics between staff and patients and the dialectic experience of seeking connection whilst also feeling oppressed in the relationship. Mark highlighted that between staff and patients, '*That line is there you know, I know that line is there. There's a line there (Mark, 217)*'. Mark's reiteration of 'the line is there' created an imagery of separation, adding prominence to the belief that, '*we are staff, you're patients and…never the two shall meet (Mark, 216)*'. Acknowledging the boundary between patients and staff, Mark noted that effective working relationships were still needed:

In the other places you don't make a bond and that like I said because it's easier. Here… you-You gotta make a bond, some sort of bond and that to get some sort of working relationship you know in order to get leave and go out and stuff like that, progress. (Mark, 719)

Introduced in this extract is the notion of dependency on staff to achieve valued goals. Adam shared this view, finding it difficult to tolerate the reliance on staff due to the restrictions of the environment, '*Life could be so easy but they make it tough for us because we can't do anything for ourselves (Adam, 431)'*. In such situations, frustrations were likely to arise and as Jahscater said, '*We do get a little hassle between the staff and patients (Jahscater, 280)*'.

In adjusting to living alongside staff members of various ages, Sid, Adam, and John all spoke of forming attachments and finding it difficult, *'a shame really (John, 80)',* when valued members left the service:

It is a shame really when you build a rapport with somebody and they are helpful and friendly and then you lose them. (Sid, 164)

Whilst both conveyed sadness when they spoke of finding it 'a shame', Sid gave indications of experiencing a sense of loss. He alluded to feeling deprived of a useful source of support:

When you become used to staff … you know who they are and you know you can talk to them. (Sid, 182)

For Adam, the loss of transitional attachment figures (staff) appeared to trigger feelings of abandonment which made it difficult for him to accept; perhaps stemming from the experience of pre-existing losses. He expressed feelings of desperation and attempts to convince staff members to stay:

Something happened in his life, or he-he resigned. And I said to him, 'Oh don't resign come on it's not the done thing'…he just walked away and I was like, 'What are you doing? Don't do it, don't do it. (Adam, 83)

Adam was the only participant to recognise the difficult dynamics from a staff member point of view which seemed to help him depersonalise the reasons behind increasing rates of staff turnover:

The staff are good. They get a lot of abuse from patients…It makes me feel horrible because I think the staff should be treated with respect. They are not here to take that kind of stupidness from patients. (Adam, 310)

Adam almost felt protective of staff and repeatedly referenced a strive for reciprocal respect amongst the staff and patient community. As an older adult on an age-specific ward, Adam inferred higher expectations of behaviour of the patient group. Mary-Jane on the other hand, also residing on an age-specific ward, reported little sense of connection with staff, perceiving them as *'deliberately trying to wind you up (Mary-Jane, 283)'*. Mary-Jane found it difficult to predict staff members' interactions at times, and noted this prevented them from forming any meaningful bonds:

They can be quite friendly if you are talking to them but they can turn, they can deliberately try to wind you up and it's not nice. (Mary-Jane, 290)

Mary-Jane omitted examples of how staff members would 'wind them up'. This could reflect perceived maltreatment or could be indicative of pre-existing suspicious and negative beliefs about others. For the most part, there were clear desires for closeness and connection with staff members: *'I want a named nurse who I can talk to. It's not fair (John, 338)'.* But, these relationships ultimately created vulnerabilities to further distress when staff members left.

"Lack of Trust, They Don't Trust You" – Conflicts in Insecure Attachments.

Some participants shared perceptions of receiving unfair treatment which appeared to affect their sense of control, agency and how they viewed themselves; depicting patterns of insecure attachment styles. Initiating this sub-theme was Mary-Janes' continued account of feeling as though staff were antagonistic, evident in how they perceived communication styles when asking for help:

> *It makes me feel like they are trying to wind me up…Gently tap on the door and the nurse -the charge nurse will probably turn round and scowl at me, 'what the hell do you want' as though, making it uneasy for me rather than easy (…) They are not soft enough (…) Still get the same people now saying, 'you wait!'. It is not a very nice thing to say. (Mary-Jane, 29)*

Mary-Jane repeatedly referenced staff as being ill-intended during their interview, which was interesting given that the service aimed to tailor the care to the needs of older adults specifically. In this extract, Mary-Jane described 'gently' initiating contact highlighting the disproportionate response received, depicting staff as callous through emotive language such as 'scowl' and 'what the hell do you want'. Adam held a more optimistic view on the intentions of staff, but similarly reported that staff insensitivities when responding to patients:

> *If you are on the PC then just pause it and say, 'yes what can I do for you?', not 'what do you want?'. What kind of a question is that? (Adam, 427)*

In the struggle for control, Adam adopted a position of defiance when discussing his interactions with staff, asserting that he refused to be '*dictated to (Adam, 142)*', perhaps because of his age, and shared his disapproval of staff when they, '*turn around and say to me, 'hey, this is it you do it, you do it'. I don't take that man, ordering my behaviour (Adam, 144)'*. Adam stated he was, *'threatened to be taken to seclusion on my first day, I thought*

which is well out of order (Adam, 135)'. Adam explained that this response came from his refusal to comply with instructions when they were delivered in what he considered to be a 'dictating' manner and felt that the punitive reaction was not warranted, showing the disconnect between the views of staff and patients but that ultimately staff maintained the power. Mary-Jane spoke of how when they challenged staff members, they were described as being, '*too pushy!... You are pushing all of the time and if things don't go to plan, you are pushing (Mary-Jane, 19)'.* This was particularly difficult for Mary-Jane to accept due to the significance that reports held on assessments of progress.

The sense of staff members having too much power continued to develop; '*If you give a certain person the power to do something, they abuse that power, they're abusing that power and er this is what I thought of it (Adam, 156)'*. For Mary-Jane, that power came in the form of stigmatising reports that they felt would be believed by the wider clinical team with little scope for patient input.

John (age-specific ward) provided a short account of his beliefs around poor patient treatment:

> *You'd need evidence to believe me wouldn't ya…I wish I had the evidence of it. Channel 5 (laugh) I wonder if I could get on the tele on Channel 5. (John, 359)*

John spoke of poor treatment in a light-hearted manner although he did express a somewhat suspicious view of the priorities of the service and governmental initiatives:

> *There just don't seem no wins I reckon it's just making the country more money making the pills. (John, 287)*

The treatment by staff in some instances appeared to impact on participants' sense of self. For Johnathan, he spoke of, '*the lack of trust, they don't trust you…people think you are deceiving*

them all the time" (Johnathan, 121)' which converged with Adam's reaction to being perceived as dangerous when threatened with seclusion:

> *It wasn't very nice anyway. She didn't even know me, that was the first time we spoke. (Adam, 135/153)*

Mary-Jane viewed staff behaviour as a means of validating that patients were not fit to be in society:

> *I don't know whether it's that if they wind you up and you break down then they can discipline you and they put you in a room, seclusion, and it helps to say to the patient that is why you are here because you broke down…it is cruel. (Mary-Jane, 329)*

Although considerations of risk and legal sanctions may have meant that Mary-Jane was not in fact considered well enough to be in the community, they described staff here as the opposing force responsible for their oppression; the relationship was not based on collaboration, staff were seen as against patients: *'don't be surprised if they try to wind you up but er don't let them (Mary-Jane, 328)'.* Perhaps, it was psychologically safer for Mary-Jane to interpret the problem as within the staff, as opposed to acknowledging their own contributions to risk.

From this sub-theme we see the unravelling narrative of helplessness amongst patients with insecure attachment styles; staff held the power in the relationship and any challenges to this were met with negative consequences. Participants that perceived uncaring communication styles on age-specific wards felt more distant from those caring for them.

"I Just Felt Human" –Humane Approaches Meeting Attachment Needs.

Contrarily, what developed through this sub-theme was the powerful impact of experiencing compassion and warmth when living in secure care. With different participants contributing to it, we see a difference in how relationships in the service were experienced, in part, influenced by the lived experiences of different environments previously. Mark articulated the concept of a human approach nicely, describing how staff members on their age-specific ward had interacted with him in a way that made him feel valued as a human being:

> *I just felt human, I felt human [laugh] I felt people were being human to me and that erm it felt more personal (Mark, 649)*

Compared to his previous admission to a high secure mixed-age unit, Mark said that arriving into a less secure age-specific environment felt like his *'body just breathed a massive sigh of relief…that horrible journey is over (Mark, 98)'*. When asked what made the difference to him, he shared:

> *Humanity! It's just all humanity here…the way people talk to ya…the way people treat you…the level of trust that you get is massively different. (Mark, 115)*

For Mark, it was the little things that made a difference to him such as being '*called by my name here…in the other places it can be dehumanising (Mark, 153)'* which helped him to, '*let them barriers down…you just know you've been accepted back into society (Mark, 185)*' and form healthy attachments with others. This feeling of acceptance as a person marked a huge difference in how Mark viewed himself, as he previously acknowledged he was '*a danger or you were classed as a danger when you were where you were because, you had to for survival and that (Mark, 380)'.* Feeling treated with respect as an older adult was important for Sid living on a mixed-age ward:

If you are treated with a degree of respect it just changes the dynamics entirely. (Sid, 140)

For some participants arriving in the service from more punitive mixed-age environments, receiving such care and warmth was a new experience that challenged their pessimistic view of others. Sid explained that the prosocial attitude of some staff members served as a positive influence in his life:

A lot of the people…have lived experience… just had a really positive attitude and it was infectious to a degree. It was nice to meet people who wanted to do something positive and make some kind of a difference. (Sid, 79)

Jahscater (age-specific ward) felt comforted by the care of staff: *'they tend to ya…all the patients feel err comfortable (Jahscater, 95)*' and Johnathan (mixed-age ward) repeated three times that feeling listened to made his experience feel more positive, showing the importance it held :

They are listening to me (Johnathan, 84)

From an attachment perspective, being treated humanely, regardless of the age-mix of peers, supporting some individuals to feel cared for and allowed them to engage more effectively in the relationships.

"It is Difficult to Know People's Names" – Staffing Issues as a Barrier to Building Meaningful Relationships.

Unfortunately, issues with obtaining and retaining staff members often impacted on opportunities for relationship building:

Particularly on the night shift you realise you don't know the names of half the staff because they have bounced off or whatever and they've just come in…but you won't see them again for weeks… so it is difficult to know people's names. (Sid, 167)

Sid held staff members in a positive regard but found it burdensome to repeatedly *'go through the process of getting to know people over and over again (Sid, 184)'*. Having a shortage of staff also posed operational issues which caused frustrations in having to wait long periods of time for needs to be met; a dilemma for a patient group with higher demands:

Takes such a long time for anything to get done. (Johnathan, 36)

The response from the office is really slow, people are just really slow and i'm just waiting, waiting, waiting, waiting, and it really is so frustrating. (Adam, 422)

There were additional risk concerns where both Mark and Adam asserted that they took charge of situations to maintain order on the ward; possibly utilising their age as a means of authority:

There is a massive shortage of staff so when things go off and things happen, you find yourself sometimes getting involved (Mark, 483)

The only thing I don't like is if staff are in the office not doing anything or making themselves scarce leaving me to run this show if you like (Adam, 123)

Whilst it became clear in other sub-themes that the power dynamics influenced the patient experience, here we saw the influence of a lack of staff and how patients felt responsible for dealing with consequential situations beyond their control such as risk management.

"Do As You Are Told And Listen" - Feelings Of Oppression In The Wider System.

For five of the participants, underlying feelings of oppression dominated their perception of the service and the sense they made of it. Several individuals spoke of restrictive practices that led to the environment feeling '*like being in a prison (Johnathan, 113)*' and that *'it is not such a happy place (Mary-Jane, 198)'.* Sid suggested that he felt as though he had no control over his life:

> *You feel as though everything happens to you and you don't really have a say in it and…you know that is quite disheartening I think. (Sid, 62)*

Johnathan also spoke to this sense, stating, *'your movements are restricted…you are always like a dog on a lead (Johnathan, 115)'* giving a strong image of dehumanisation and being treated as though one should '*do as you're told and listen (Johnathan, 322)*'.

Out of all of the patients, John (age-specific ward) spoke most of feeling as though he was being treated against his will:

> *Hopefully they'll stop using me, stop making me take drugs all me life. (John, 438)*
>
> *I don't like those drugs…I've had enough of it! It really is doing my head in. (John, 441)*
>
> *One day they might let me go. Surely they know nothing is wrong with me. (John, 169)*

Despite disagreeing with his treatment plan, John compared his time on the ward to when he was in prison, *'I call it [prison] grumpy castle…Force of authority…It's alright here [hospital], it's alright (John, 332)*', which seemed to remind him that he was better off where he was now; a contradictory view to that of Johnathan and Mary-Jane. Nicholas, also living on an age-specific ward, expressed resentment at the *'length of time spent in these places (Nicholas, 263)*', and appeared to hold deep-rooted feelings of injustice by psychiatry:

There is a lot of injustices in these places…psychiatry is based on 5 things: opinions, guesswork, bullshit, favouritism, and injustice…psychiatry is based on guesswork…it is not factual. (Nicholas, 162)

A sense of futility was evident in several individuals following the ongoing experience of oppressive authority. Sid felt '*demoralised and er the fight had gone out of me (Sid, 56)'*, and Johnathan believed *'there is nothing I can change it is all militant…There's note I can change (Johnathan, 287).*

By nature of forensic mental health, some decisions are out of the hands of both patients and staff members. Whilst the purpose of admission revolves around risk management and rehabilitation, it is acknowledged that patients do not always agree that this is warranted which can translate to feelings of oppression, giving rise to resentment and futility as observed.

GET B – The Experience Of Living With Other Patients with Forensic and Mental Health Needs.

This GET was characterised by reflections on life on a secure mental health hospital ward as an older adult, how participants encountered living with other people considered to be 'unsafe' to remain in society alongside how they managed such. The sub-themes included were: *"At the End Of the Day it is Our Home" - The Value Of A Calm Ward Environment; "You Have to Be Aware All of the Time" – Living in Threat Mode; and "I Have Nothing in Common with any of Them" - Making It Work With Unrelatable Peers.*

"At the End Of the Day it is Our Home" - The Value Of A Calm Ward Environment.

There were indications that the majority of participants did not wish to be in the service. However, some described the ward as *'home…At the end of the day, it is our home (Adam, 247)'*. Appraising the environment in this way appeared to be containing for some, taking ownership over their space:

> *While I am here the thing I value most is my room. That is my room. And I like my privacy there. (Mary-Jane, 75)*

> *They're rooms. You make them-you personalise them…Your room, your bedroom, you make it how you wanna make it. (Mark, 87)*

The idea of having a home and one's own space may have provided a level of psychological safety for Adam, Mary-Jane, and Mark. Regarding the ward as home also appeared to have provoked a protectiveness in Mark over the general atmosphere: *'I see it as my home and I don't want my home being uncomfortable and people fighting and people arguing and it just being unrestful (Mark, 487)*'. John echoed this view when talking about advice to other patients coming to the ward:

> *Keep your head down. Stay calm. Settle in. Settle in decently. Quietly. Calmly. (John, 436)*

Here transpired an institutionalised view of compliance, inferring that being submissive, well-behaved, and 'keeping your head down' would help survive the experience. Jahscater regarded calmness as favourable which made the ward seem *'like a real good place…Nice and comfortable…not erm hectic (Jahscater, 8/35)'.* He added that *'the patients were all quiet which was acceptable (Jahscater, 73)*' suggesting an unwritten rule of what is acceptable or not in a communal environment. For John, when he was first admitted to the service his first impressions were good because *'the patients, it was quiet, it was alright (John, 392)*'.

What stood out in this theme was a collective desire to live in a peaceful environment and the need for working together to make that a reality; the paradox being it was the behaviour of each individual that could compromise it.

"You Have to Be Aware All of the Time" – Living in Threat Mode.

Participants spoke of how they perceived other patients on the ward, and what it was like for them living with a sense risk in the environment as an older adult. Participants, despite finding it uncomfortable and oppressive to be acknowledged as risky by staff, appeared to readily identify risk in their peers. Jahscater explained that for him *'patients seem erm sick…it wasn't very-a very good atmosphere for a hospital (Jahscater, 120)'*. Mark commented, *'the potential for what could happen in that room is massive (Mark, 132)'* and referred to being *'aware of who you are with and what type of people you are with (Mark, 130).* Sid similarly noted, *'everybody has the potential to be quite violent…people are triggered (Sid, 285)'.* Knowing who to be mindful of could be a challenge sometimes due to the unpredictable nature of peers:

> *One of the lads here attacked another patient…he wouldn't strike you as a particularly violent person as he was usually well natured, but there you go. (Sid, 296)*

Such unpredictability appeared to be unnerving, as Mark described a hypervigilance to threat:

> *You have to be aware all the time, very aware all the time because there is always mind games and things going on…always something under the light. (Mark, 149)*

The sense of threat appeared evident regardless of the age-mix on the wards; mental health patients were viewed as dangerous at any age. Threat seemed to create a lack of trust amongst

the patient community, particularly highlighted by Adam who felt *'scared to have my [family] telephone numbers on there in case they fall into the wrong hands (Adam, 211)'*. Mark said, *'you don't form any bonds and that because then nobody can hurt ya (Mark, 710)'* which was a position also held by Johnathan:

> *I don't wanna get into any relationships with any of the patients because…er some of them aren't very well and…I don't want to give them any excuse to have a confrontation with me…In the other hospitals…people turned against me that I thought were my friends. Been violent on me. (Johnathan, 226)*

Although individuals avoided forming relationships with peers as a self-protective strategy, conflict still occurred often in which Mary-Jane said, *'I hate it…it spoils the peace on the ward (Mary-Jane, 125)*'. Adam showed agreement, *'there are so many arguments here it is unbelievable. That upsets me sometimes (Adam, 295)'*. A clear link is observed here in the conflict on the ward and the emotional impact it had on individuals; especially with evocative language such as 'hated it'. Undoubtedly, living in such an unpredictable setting would have left individuals primed in 'threat mode' which may have contributed to the challenging behaviours seen on the ward:

> *Like a porcupine or hedgehog…your pines stick out like you know, 'don't talk to me don't come near me I'm dangerous [laugh], and really…you're not fucking dangerous, you're like a scared little kid, that's what it is. So you have to put a front on. (Mark, 301)*

Anxieties around safety were shared amongst patients, but instead of this commonality providing comfort, such negative past experiences had prevented individual's openness to the possibilities of forming meaningful friendships on the ward; it did not feel psychologically or physically safe to do so. Ultimately, communal harmony was seen as fragile and that '*one*

person can infect the whole environment (Sid, 357)' with it generally being accepted that problems were inevitable:

> *In any group of people you might get some of that I suppose but that is to be expected. (Sid, 91)*
>
> *If you put a load of odd people together, they are gonna fall out. (Johnathan, 297)*

The use of language by both Sid and Johnathan ('infect', 'odd people') indicated a negative view held of peers and ominous perceptions of people who have been removed from society for public protection or their own safety.

"I Have Nothing in Common with any of Them" - Making It Work With Unrelatable Peers.

This sub-theme presented how participants made communal living work in the hospital setting with those that they felt were unrelatable. Johnathan (mixed-age ward) remarked, *'I don't like it. Cause I have nothing in common with any of them (Johnathan, 178)'*, and explained that he *'spent most of my time in my room (Johnathan, 212)'*. Nicholas (age-specific ward) also, '*kept out the way quite a lot (Nicholas, 259)'*, and Sid (mixed-age ward) said he tended to '*withdraw (Sid, 145)'*. Seeing peers as 'other' may have felt protective for some participants.

Adam (age-specific ward) spoke of his expectations of reciprocity in relationships where he strived for *'being friendly and I expect to be treated friendly back (Adam, 289)*'. Sid shared how although himself and his peers had not chosen to be there, they *'make the best of it (Sid, 88)*'. In some cases, there was evidence of the forming of social hierarchies: *'he's a convict, a patient…he does all the talking for us (John, 268)'.* Mark (age-specific ward)

identified that in the absence of staff, patients would come together to help each other out: *'other patients will chip in and try and do things for other patients as well (Mark, 509)'*, and found that understanding the difficulties people were experiencing with their mental health helped him to manage his reactions to being a victim of assault:

> *I've been smacked a couple of times since I've been here but…I didn't take it personally. They're ill. (Mark, 165)*

Patients seemed to spend time away from other peers where possible but would work together to maintain peace and function on the ward; taking collective responsibility to maintain the milieu, which Adam reported should be a consideration for staff when admitting new patients:

> *You've got to find out the person you've selected to come here and whether he or she is entitled to fit in properly and you know because you don't want them upsetting the whole thingy. You gotta look and think you know this person is going to be ideal to come there, let's get this person there as they'll be an asset to that environment. (Adam, 388).*

The 'entitlement' and 'being an asset' that Adam spoke of surprisingly made visible some sense of belonging within the patient community despite it being unfavourable; finding security in having a shared understanding of making the best of a bad situation.

GET C – The Stressors Of Being An Older Adult In Secure Care.

Throughout interviews, anecdotes were volunteered shining light on the experience of being an older adult in the service. Requiring no sub-themes, this group theme told the participant's stories of how they directly experienced the age-mix on the wards and the

additional complications that ageing added to their lives. Only Adam and Sid found living with other older adults to be a positive factor in their hospital lives. For Adam, he '*appreciated these guys because they are older persons (Adam, 9)',* reflecting on his previous experiences where younger peers would cause trouble on the ward. Johnathan also reported that younger patients had previously exploited him for '*money, tobacco…anything i'd got (Johnathan, 216)'*. On the other hand, Mary-Jane found living with only older adults created an '*artificial world (Mary-Jane, 148)*'; being unable to mix with different age groups. Nicholas held a particularly negative view of elderly peers stating that he was *'not that keen on the elderly on mass (Nicholas, 51)'*, and that they *'don't really fulfil any [social] criteria (Nicholas, 117)'*. He went further to disassociate himself by claiming, *'I don't have anything in common with them. Well I hope not anyway (Nicholas, 117)',* claiming that he did not *'have a great deal to do with them because of age an infirmity (Nicholas, 97)'.* It was evident that Nicholas did not identify as an older adult, referring to being older as a weakness, inferior. Others were more accepting of the course of ageing, acknowledging that it is *'not nice when you are old, you feel like you aint got that far to go (John, 401)',* and feeling as though death is *'just a matter of time now (John, 467)'*. In light of the ticking biological clock, Mark reflected the importance of being true to oneself:

> *Do it and if it goes wrong you can always pull back…don't just sit there…because before you know it [clicks fingers], your fucking life has passed you it's gone…do it you know what I mean, while you've got time to do it. (Mark, 811)*

It was observed that Mark's words created a sense of urgency, and his use of explicit language reflected potential underlying anger which may have stemmed from a feeling of missing out on life whilst being detained. Links then became evident with other patients in line with 'making the most of the rest of your life', where individuals expressed their future desires for living in peace:

As people get older…I've just suddenly realised but you actually become less tolerant of that kind of behaviour as you get older because you've seen it too many times…When you get to a certain age, you don't want to deal with tantrums and throwing things about do you. (Sid, 371/376)

An aspiration for calmness was correspondingly shared with Johnathan: *'I'm not gonna live forever am I? I'm not gonna live much longer…I just want to be somewhere in an old people's home, settled. Where I can have visits (Johnathan, 158)'.* One may perceive here that the reality of chaotic and changeable environments in inpatient care can be difficult to tolerate for older adults.

An additional complication that arose for several participants was declining physical health as their age progressed. Nicholas recognised that he was *'limited in what I can do…because of my disability (Nicholas, 35/43)'*. For John, his physical ailments were the cause of most of his distress:

This hernia does me head in…it sticks up when I'm trying to go to bed…that is what is bugging me the most this hernia. (John, 172)

It's like when you are laying in bed an all, lying in bed, and my knee starts jerking…Got the bloody hips. (John, 461)

Fortunately, participants felt that their physical health problems were accommodated well as *'that is that the ward is geared up for (Nicholas, 227)'*. Johnathan expressed appreciation for staff members making allowances for how he was feeling physically:

I get a lot of pain relief so that helps…they don't pressure me into doing anything that I don't want to do or if I don't feel up to it. (Johnathan, 340)

Overall though, he felt saddened by the reality of ageing:

I wish I was a bit younger…can't fight old age can you…parts wear out as you get older, it catches up with you. (Johnathan, 329)

GET D – Coping.

The final GET was that of coping. This group theme highlighted the different factors that helped participants to cope in light of the various difficulties outlined in other themes. The coping factors were categorised into the following sub-themes: *"That is the way that it is" - Acceptance of the situation*; *"Doing something positive…Gives you a lifeline" - The importance of valued activities; and "Part of the world again" – Feeling connected to life outside of hospital.*

"That is the Way that it Is" - Acceptance Of The Situation.

Despite many finding the service difficult for various reasons, accepting aspects of the situation that cannot be changed served several participants positively. When discussing the perceived flaws of the system, Nicholas commented that *'it is just an acceptance of things (Nicholas, 197)*' and that *'you just try to put it to one side… (Nicholas, 181)*'. Nicholas realised that non-acceptance would likely cause further psychological pressure stating it is *'…No good dwelling on it (Nicholas, 181)'*. Johnathan spoke of acceptance being the only option to progress: *'That is the way that it is, you just have to cope with it (Johnathan, 175)'*, and felt that being compliant made his time on the ward easier:

I just get on with it. Just do as I'm told, behave myself, don't get into no fights. Don't use bad language err…go to the groups I am supposed to go to er…just do as I'm told really. (Johnathan, 132)

In John's extract, the notion of acceptance appeared to shift to compliance – relinquishing control and conforming to expectations placed on him. Here a sense of 'giving up the fight' was noticed; an acceptance that rebellion was not an effective means of progression in his context. For others, acceptance came in the form of recognising their need for treatment:

> *Recently I've been taking my medication on time… I have accepted the fact that medication is erm, it's good for you. I was trying to fight my medication, stay off it and live a normal life but I can't do it, it's impossible. (Adam, 180)*

Likewise, Mary-Jane said, ' *I know why I am here. I am accepting treatment…I know why I am in a secure hospital because of what I did (Mary-Jane, 87/206)'.* Mary-Jane also created the impression that understanding rationales behind certain rules helped to accept them:

> *I realise why it is so secure and er so I can accept it. (Mary-Jane, 215)*

The view of acceptance shared by many led to a feeling of 'just getting on with it': *'Just get on with every day as it comes…they come and then you just have to get to the end of it (John, 366)'* and in some cases helped to re-appraise the situation:

> *It is as well as it can be considering…For an institution. (Nicholas, 239)*

> *[Anything that you would change?] No! In this environment it is good, very good. (Jahscater, 227)*

"Doing Something Positive…Gives You a Lifeline" - The Importance Of Valued Activities.

Being able to fill the time was found to be a positive coping mechanism within this sub-theme. It is worth noting that several participants raised the difficulty in managing when having nothing to do *'because if you are just sat in your room staring at the walls 24/7 it does*

drive you a bit mad (Sid, 123)', making their lives feel like *'groundhog day, every day is the same (Johnathan, 235)'.* Sid noted that a paucity of meaningful activities was harmful for people's mental health:

> *The dangers of not doing anything is you start dwelling on negative thoughts and feelings and that can be a…vicious cycle. (Sid, 251)*

Recognising this as a 'danger' was thought-provoking in considering the use of therapeutic timetables in secure services. Johnathan felt this too: *'Doing something positive…gives you a lifeline (Johnathan, 249)'.* Nicholas found that activities were useful for *'passing the time (Nicholas, 158)*' and that they '*take your mind off things (Nicholas, 39)*'.

Participants spoke of finding some activities *'therapeutic (Johnathan, 183)*', focusing on something in order to *'stay out of trouble (Adam, 255)*', and developing skills: *'I have improved my swimming and er me sewing (Nicholas, 69)'*. The skills building aspect supported individuals in building their self-worth and sense of accomplishment:

> *Focus on something I enjoy that is productive…it gives me a sense of worth as well that I feel I have done something worthwhile. (Sid, 232)*

> *I suppose it gives you a certain satisfaction. (Nicholas, 73)*

Not all activities were deemed helpful in such ways, instead it was those classed as *'extra-curricular (Nicholas, 158)*', such as: *'arts and crafts…I like doing that (Johnathan, 190)*', *'psychology sessions (Mary-Jane, 256)'*, *'unescorted leave…I like walking because I do exercise (Mary-Jane, 235)*', *'gym…computing…session with the music man (Nicholas, 34)*', and delivering wellbeing courses to peers through the support of a patient college team:

I've been doing the [wellbeing course]…could just be a distraction but I also think… you do more positive things it just improves your quality of mind full stop because you are developing a positive mindset as oppose to dwelling on negative things. (Sid, 255)

Sid spoke of finding benefit in prosocial activities and helping others altruistically, *'I've not gone into this for any reward (Sid, 242)*'. Adam shared that he too would *'try to help people more…I like helping people (Adam, 255)'* which showed that helping others felt good and improved wellbeing in those that chose to do so.

"Part of the World Again" – Feeling Connected To Life Outside Of Hospital.

In the context of previous feelings of unsafety amongst peers, oppression and lack of control, this sub-theme spoke to the psychological benefit of maintaining a sense of connection to the outside world. For Sid, he found the connection through utilising community leave:

I was feeling at the time that I had very little control over my life…you are in a position where your liberty has been taken away from you, your freedom has been taken away from you, it is not great…But I suppose the thing is that we are indulged to quite a degree here I think as opposed to the prison system. At least we do get to go out for walks…I get to go out into the community now aswell. (Sid, 114)

Coming from the prison as Sid mentioned, he described being able to go for a walk as an 'indulgence' which served as a reminder of just how restrictive secure environments can be, and how individuals within those environments come to normalise the experience. Mark's most recent admission followed a transfer from a higher secure environment and for him, seeing the outside world again felt overwhelming:

Just overload…Where I come from I don't have a beautiful view of trees and-and traffic going by and-and birds and animals and squirrels, squirrels!... Seeing squirrels hopping around everywhere and rabbits and everything just running around…It's almost like Alice in Wonderland…that's what it felt like… Just like being in never never land honestly. (Mark, 403/408)

The picture Mark painted here was that when deprived of his liberty, he had felt cut off from the world for so long that after he regained it, he developed newfound wonder for occurrences that others might usually take for granted. Being able to observe outside life appeared to have a profound impact on Mark and his feeling of belonging in society:

All of a sudden I just knew I was back in society…I've been accepted back into society and that I'm you know part of the world again. (Mark, 28)

Feeling a part of the world also brought a sense of freedom and societal connection to Johnathan:

I like going out shopping in the community and seeing the people outside…being in touch with the er world again for a few hours. (Johnathan, 270)

As we have seen throughout the findings, Mary-Jane had a mostly pessimistic view of their time in hospital, but, here they expressed how they found their ability to cope improved once leave off of the ward was granted, regarding it as a 'priviledge', congruent to Sid's earlier statement:

It did get better when you start to get privileges like er, having in particular having leave and then having home leave or having visits… Bit by bit you get further more privilege…those sorts of things help to make it nice. (Mary-Jane, 310)

Some found connection to the world through staying in touch with their lives outside of hospital. For example, Adam valued utilising skills from his previous employment:

> *I've been doing a lot of cooking…What I did is I used to work in restaurants and takeaways and so forth…When I came into hospital I taught [staff member] how to cook, I taught her how to cook. (Adam, 228/232)*

Mary-Jane, although they were able to leave the ward, also valued maintaining a sense of independence through managing their 'life admin':

> *I have decided to sell my house. That has kept me busy kept my mind active on practical things in the world. (Mary-Jane, 269)*

Some of the extracts displayed in this sub-theme show the importance of supporting older individuals to maintain or rekindle their relationship with society and their position within it. In time, this may help to de-institutionalise long-stay patients in secure services.

Discussion

The study aimed to provide rich accounts of the lived experience of ageing in secure services for older adults, and considerations of the age-mix on wards. Eight participants engaged with 1:1 semi-structured interviews, generating data that was systematically analysed through IPA. In total, four group experiential themes (GETs) were found through a double hermeneutic process (Smith et al., 2022): Relational power of staff members in secure care, the experience of living with other patients with forensic and mental health needs, the stressors of being an older adult in secure care, and coping.

Relational Power of Staff Members

The relational encounters with staff members appeared to hold the most significance for participants in determining how they experienced their time in the service, regardless of the age-mix on the ward. One key factor in determining a positive impact of therapeutic relationships on patient outcomes is the use of communication and how patients feel treated by professionals (Priebe & McCabe, 2008); in this study we saw the negative impact of poor staff communication styles, feeling disrespected, and a disempowered sense of self ('untrustworthy'). Although not looking at older adults specifically, Gilburt et al. (2008) investigated patient perspectives on relationships in mental health care and found communication, coercion, and safety to be amongst their main themes. From the findings in this study, participants linked the communication styles of staff to their feelings of care or coercion, and thus the therapeutic relationships were clearly key. Congruous to Carl Rogers (1957) core conditions it was unconditional positive regard, or empathic understanding of individuals, that was significant in how participants made sense of their experiences and themselves. When these approaches were perceived, participants felt human, they felt safer, and they felt valued; in line with decades of research on therapeutic relationships (Kornhaber et al., 2016; McCabe & Priebe, 2004; Olgivie et al., 2014; Ramussen et al., 2018), and what is known to support recovery in older adults (Blood and Guthrie, 2018; Walker et al., 2023). Of interest, there was a clear divide in how participants perceived the staff members and it should be noted that this correlated with the journeys that led the participants into their current service. For those that arrived from another hospital, feelings of ill-intended or unhelpful staff were shared, whereas those that arrived from a prison found staff members to be less authoritative, more compassionate, and invested in their wellbeing. Comparisons of prison and secure mental health environments would highlight the recovery oriented versus punitive focus of work (Amidov, 2015) and may shed light on the stark differences in perceptions of staff. SFMHH focus on assessment and treatment (Bowers, 2005) as opposed

to punishment and public protection as in prison. As Glorney et al. (2010) pointed out, having opportunities for activities and interventions to build social skills and self-esteem were deemed important in forensic mental health settings for older adults, so it could be that in prison, access to such elements were limited. Thus, arriving into a SFMHH with increased opportunities for these valued functions supported the development of positive appraisals of the environment and staff within it, perhaps on account of having more autonomy and role, and activity (Van Leeuwen et al., 2019). For those that arrived from another SFMHH, the indeterminacy of time in services may have led to negative appraisals emanating from feelings of negativity and hopelessness. Of interest, ill-intended staff were perceived on age specific wards, a cause for concern given the nature of the service being designed to specifically accommodate older adult needs. As Shaw and Kaur (2015) pointed out, institutional elder-abuse does happen, and it is important to review the care and treatment provided to maintain compassionate, high-level care to a vulnerable population, and avoid the breach of legal and ethical obligations.

The notion of safety, outlined in the introduction as forming the basis of Maslow's (1943) 'hierarchy of needs', certainly held relevance. Participants strived for a calm and safe environment, feeling unnerved and distressed when this was not the case. According to Maslow (1943), addressing further needs such as belonging, self-esteem, or self-actualisation is futile if safety needs are unmet; indicating the importance of ensuring individuals feel safe to maximise recovery potential. Some participants felt their safety needs were unmet, living with an ongoing sense of threat in the environment. However, the effects of such were mitigated by positive staff relationships which appeared to evolve into functional attachments. Similar to the findings in Chapter 1, feeling cared for increased such attachments, which made it difficult for participants to accept when staff members inevitably moved on. Despite the power dynamics between staff and patients being referred to as overtly

evident and oppressive in some instances, participants sought connections regardless, which Blood and Guthrie (2018) would argue as a survival strategy to secure safety, comfort, proximity, and predictability in situations deemed dangerous. Secure attachments build resilience, and as attachment opportunities decrease in older age, it is no surprise that caregivers were looked to, to fulfil such a role – consistent with the current understanding in the literature (Crittenden, 2006; Olgivie et al., 2014; Ramussen et al., 2018; Shaw & Kaur, 2015).

Living with Other Patients

Another key theme discovered was around communal living in secure mental health. Quirk et al. (2004) found that mental health wards can be considered 'volatile environments' in which the presence of risk is concentrated; mostly, the threat being potential violence from other patients (Castledine, 1993; McGeorge et al., 2000). The findings here suggested that participants perceived their peers as dangerous, regardless of their age. Aggression within secure mental health is an ongoing problem and can exacerbate feelings of anger, stress, anxiety, and depression in those involved (Cohen, 2000; Ilkiw-Lavalle & Grenyer, 2003). From service-user perspectives, mental health wards have been regarded as unsafe places, especially as aggression in the environment is unpredictable (Wood & Pistrang, 2004). Whilst (unwarranted) stigmatising perspectives of mentally ill individuals posing risk to others persist (Riles et al., 2021), the reality is that those in inpatient services are often detained because of risk. This may have contributed to participants' accounts in this study of being hyper vigilant around other patients, feeling a strong sense of mistrust, and avoiding forming relationships as a self-protective measure. As is known for older adults, vulnerability increases as physical and mental health declines, perhaps leaving the participants feeling

exposed to high levels of danger without a means of protection (Shaw & Kaur, 2015); compromising the basic safety needs as outlined in Maslow's hierarchy (Maslow, 1943).

Being An Older Adult In Secure Services

Participants raised a variety of pertinent factors in relation to being an older adult. What stood out within the theme around being an older adult in secure care was the diverging opinions regarding the age-mix on the wards. For several participants, being placed with other older adults was deemed beneficial to reduce vulnerabilities and the unsettled atmosphere that younger inpatients can bring; concurrent to the findings of Visser et al. (2021). For several participants on age-specific wards, a greater sense of community was discussed, with patients coming together in moments of need when staff were unavailable. Age was not considered a key part of identity for several participants, which may have psychologically protected them from any shame or stigma that can surround older age groups due to levels of dependency on others and decreased physical functioning (Crossley & Rockett, 2005).

Older adults persistently perceive deficits in the care they receive from mental health providers (Fortuna et al., 2017) which is discouraging as positive patient experiences translate into better compliance with treatment and improved outcomes (Haskard Zolnierek & DiMatteo, 2009; Isaac et al., 2010).

Coping

Participants often manufactured their own positive experiences through their coping efforts. For example, engaging with valued activities or maintaining contact to the outside

world. Maintaining connection to the outside world revealed a desire for belonging within the wider community, an essential human need fulfilled through frequent, ongoing pleasant interactions with the community in question (Baumeister & Leary, 1995). The finding also linked to the 'Social Control Theory' (Hirschi, 1969); individuals need to feel connected to the wider society to function effectively within it (and lawfully).

Lazarus and DeLongis (1983) described two approaches to coping in older age: problem-solving and the regulation of emotion related to the stressor. The participants in this study appeared to divert their attention from the realities of their situations by focusing on activities that brought them pleasure; changing their relationship with their environment (problem-solving; Lazarus & DeLongis, 1983). For others, the cognitive reappraisal of their situation through acceptance reduced their emotional distress in regards to feeling helpless and oppressed in the system. A particular means of coping for some participants appeared to be through their relationships with staff members, which as previously acknowledged, secure attachments can determine the way in which an individual copes (Baim, 2020; Buelow et al., 2002). This may have explained the different accounts shared by participants in that those who felt securely attached, were better able to positive appraise their situation and reflect on their experience, whereas those who were insecurely attached held overtly negative views on most aspects of their time in services (see Baim, 2020; Buelow et al., 2003; Crittenden, 2006; Howard & Medway, 2004).

Reflexive Evaluation

This study provided a voice to a niche population where little academic interest had been before. This provided an opportunity for individuals to influence service development through recommendations based on their first-hand experiences. Participants were selected

across different services within the organisation to represent various perspectives and minimise influences of a single environment.

The use of IPA requires a homogenous population (Smith et al., 2022) and whilst the older adult population within the hospital were considered as such, it must be acknowledged that individuals were at different stages of their recovery journeys which would have likely impacted on their perspectives. For example, Section 17 leave from the ward was deemed beneficial in coping, however not all participants had access to this due to risk management policies. Moreover, some participants had improved mental states and thus an increased capacity to engage with the interviews, providing in-depth accounts of their experiences. In some cases, this led to their extracts being used more frequently in the results compared to those who were perhaps less articulate in their descriptions. Because of the nature of participants fluctuating capacity, it was not possible within the timeframe of the project to triangulate the results.

The focus of the study was on living and ageing on a secure mental health ward, and the experience of living with similar-aged or younger peers. For some participants, secure care had been a regular feature of their lives and therefore their ageing experience was through an institutionalised lens. For others, their length of admission may have been relatively small, and thus their experience of ageing in the service would not have been as prominent. It was acknowledged that the participants had varied previous life experiences but the 'questions topic' summary prepared individuals for reflecting on their most recent secure care experience, regardless of timeframe. Future research could benefit from capturing a sample of participants whom they could separate into groups based on previous experiences of secure mental health care.

Reviewing the validity and quality of this study, Yardley's (2000) four criteria were considered; Table 3 outlines how they were accounted for in this study.

Table 3

Yardley's (2000) four criteria for assessing qualitative research, applied to this study.

Criteria	Current study
Sensitivity to context	Participants were residing in a secure setting and therefore the lack of freedom and independence was acknowledged. In making interpretations during analysis, care was taken through the reflective diary to monitor judgements around restrictive practices and the actions of staff members; considering the authors position as a staff member within the organisation and experience of working with inpatients. Strict ethical requirements were adhered to, ensuring participants had sufficient information to provide informed consent and an understanding of the right to withdraw.
Commitment and rigour	The focus on older adults within secure forensic mental health was maintained throughout both chapters of the thesis. The author committed to immersing themselves into research around the topic, and the literature review in chapter one supported the understanding required prior to the empirical investigation undertaken in this study. The analytic process span across several weeks to allow a thorough and rigorous exploration of the material and regular attendance at qualitative research support groups were maintained. Frequent research supervision took place to support the development of the study over time and confirm that this was done to a high standard.

Transparency and coherence	All stages of the study were documented and organised in a manner that would support an independent audit if required from initial documentation to the final report (Smith et al., 2022). The use of a reflective diary would also support an audit trail allowing transparency in how interpretations were made, enhancing the bracketing process (Chan et al., 2015).
Impact and importance	The findings highlight the importance of human needs for connection and safety, in line with existing theoretical constructs. Moreover, the requirement to minimise feelings of oppression and increase opportunities for connections with life outside of hospital. For services, lessons can be learned from patient experiences of helpful and unhelpful practices in secure forensic mental health. Appendix I depicts the official research recommendations.

Implications Of Findings And Future Research

The findings provided a useful insight into older adult forensic inpatient experiences. A number of key recommendations were prepared to disseminate to the organisation in which the study took place (see Appendix I). The recommendations made are suitable for any secure mental health service caring for older adults.

With an idiographic perspective gained, future research could focus on the impact of some of the factors described in the results on patient outcomes, to further evidence their utility. For example an analysis of the effects of mixed-aged wards on patient's quality of life, or the effects of section 17 leave on satisfaction with the service. As it was not possible to triangulate the results, future qualitative explorations into older adult's experiences could

utilise this methodology to enhance validity. Given the importance participants placed on their experiences of staff members, researchers may consider investigating more specifically the barriers for staff members in caring for older adults and how these could be addressed.

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Press Release One

Old and incarcerated: Latest research evidences how the older population in secure services cope with detainment.

A new review has collated the ways in which elderly offenders in prisons or secure mental health hospitals cope with incarceration. Secure services are designed with younger offenders in mind, which causes extra challenges for older individuals with both mental and physical health complications. With the aim of secure services being to rehabilitate individuals to refrain from crime or to recover from mental illness, it seems important to maximise this possibility by improving the resources available to individuals to cope and engage effectively.

The review collated existing studies that explored how older adults coped in secure settings and identified 12 appropriate papers. The data from the articles were analysed and patterns in the findings were discovered. The review identified that some older adults place high value on religion, describing it as 'crucial' to their adjustment to incarcerated life. One individual commented, "*my relationship with God is as important to me as the air that I breathe".* Individuals found benefit in being part of a religious community which helped them find meaning in their lives and develop moral values. Outside of religion, individuals also found great benefit in social support either through peers, staff members, or by maintaining contact with family members; this fostered a sense of acceptance and belonging that supported prosocial future aspirations. When individuals felt accepted, they described prison as having a transformative effect, supporting a process of self-discovery and taking responsibility for one's actions. In some cases, this led to efforts of 'making amends' or giving back to younger prisoners, and the wider community. Having meaningful activities to engage in also promoted individuals' self-worth, fuelling motivation to become a better person.

In secure mental health hospitals, it was the therapeutic interventions that held the most significance in helping older adults to cope. Individuals described a process of coming to accept what cannot be changed and develop insight into the need for recovery from mental illness in order to desist from crime. Individuals in these settings also regarded activities as important to protect against isolation and loneliness, two big factors that affect mental health in the older population. One person shared, "*you need to occupy your mind…it's not very helpful if you're sitting there alone".* Social support was a key factor like in prison, where individuals found that caring professional relationships supported their progression; humans are inherently social and require needs to be met in this area.

The findings of the review shone light on an area not well understood. As an outcome of the research, several clinical recommendations were made to support service development. Firstly, the increase in available psychological therapies that champion the development of reflection and insight into emotions and behaviour, and consequential thinking. Secondly, to increase links to community services to encourage prosocial engagement with society and support individuals in transitioning in or out of services. Finally, increased investment into staff training to upskill professionals with the knowledge of the needs of older adult offenders in order to support better coping skills and encourage engagement with services.

Press Release Two

Supporting recovery and rehabilitation: Lessons learned from the experiences of older offenders with mental health difficulties.

Latest research has uncovered the lived experiences of older adults living and ageing in secure forensic mental health settings. Whilst most research exploring older adult offenders has focused on prisons, this new study has turned the focus to the forgotten group in secure hospitals. It is generally understood that mental health difficulties are rife in the older population. Academics have made links to a subgroup of people who present with psychological features that give rise to further vulnerabilities such as loneliness, substance misuse, homelessness, and poor health management; all of which can contribute to an increased likelihood of criminal behaviour. In secure mental health settings, the focus of the work is on treatment and recovery, a different perspective for offenders than is traditionally upheld in prisons. But what has been missing from the existing research, is what it is like for older adults ageing in these settings, particularly as their physical health, mental health, and criminogenic needs can be more complex than their younger counterparts.

The novel study recruited eight participants from a multi-site mental health hospital and invited them to discuss, and make sense of, their experiences. The study revealed the biggest influencing factor on whether their experience was positive, was the approach undertaken by staff members. For those that perceived positive, caring approaches, they felt human, safe, and benefitted from the role modelling of prosocial behaviour. Feeling safe helped individuals to use their time effectively to work with the psychology interventions offered and improve their coping styles. For those that perceived ill-intentions from staff, their time in services felt oppressive and unjust, implicating their engagement with therapeutic activities. Some individuals felt that staff members dictated to them, and when they voiced

their disagreement with this, received punitive responses and consequently felt helpless in the system.

Being an older adult in the service, some participants spoke of valuing a calm and peaceful environment which reduced their distress. This was important, because an unsettled environment increased anxiety around the threat posed by other patients on the ward; individuals felt unsettled by living with those deemed unsafe to be in the community. To help keep the peace, participants often found ways to 'make it work' living with other patients, whereby they would help each other out when staff members were not available and would strive to understand each other's mental health difficulties. On the whole, participants tended to stay out of the way of other patients, and for some being placed with only older adults felt 'artificial'.

For most participants, maintaining contact with the outside world was vital for their sense of belonging in society and afforded opportunities to gradually re-integrate into the wider community. Having leave off of the ward or access to maintaining links with their lives outside of hospital were considered helpful. Moreover, having opportunities to engage in meaningful activities protected against mental health decline, which one person described: "*Doing something positive…gives you a lifeline"*.

Clinical recommendations were made in light of the findings, which revolved around an increase in enriching activities available on therapeutic timetables, improved patient empowerment, providing increased access to community services to increase prosocial engagement with the local areas, and staff training in compassionate approaches to care.

Appendices

APPENDIX A – Summary of research for the MDT

DOCTORAL THESIS RESEARCH PROJECT

Research Title: Experiences of admission to secure mental health services for older adults who have a forensic history

Researchers: Jade Mitchell (St Andrews Healthcare), Dr Stephanie Wilson (University of Birmingham), and Piet Snyman (St Andrews Healthcare)

Summary of the research:

The research is being run by Jade Mitchell as part of her doctorate degree in Forensic and Clinical Psychology at the University of Birmingham, and is aimed at helping us to better understand the personal experiences of being admitted to a secure forensic mental health service. For the purpose of the research, Jade will conduct a series of interviews with the recruited participants to investigate what sense people make of the admission, and whether there are any changes that could be made to make the experience more supportive of their needs.

Inclusion criteria:

1.) Aged 50+
2.) Currently cared for at St Andrews Healthcare
3.) Have a forensic history

Exclusion criteria:

1.) Individuals with a Deprivation of Liberty Safeguards (DoLS) in place
2.) Individuals who may present with cognitive problems preventing them from meaningful participation in the interview.
3.) Individuals whose discharge is anticipated to be imminent (within 3 months of first approach)
4.) Individuals who are assessed as an ongoing risk to themselves or others including risks that would compromise the safety of the participant and the main researcher before, during or after the interview
5.) Individuals being nursed on the following enhanced observations: constant observations, or long-term segregation. This is due to the level of potential risk to the interviewer, and, the potential impact of having staff members present in the interview whose familiarity with the patient may bias the participant's responses.

6.) Individuals who require an interpreter to communicate with the interviewer including individuals who are hard of hearing and require the use of British Sign Language. This is due to the use of Interpretative Phenomenological Analysis (IPA) which requires a homogenous population.

Potential participants:

Please consider whether there are any patients currently under your care who may be suitable to taking part in this research. We advise that the following considerations are borne in mind when thinking of potential participants:

1.) Is the individual capacitous?
2.) Does the individual have the cognitive ability to meaningfully engage with the interview?
3.) What level of risk does the individual pose? And will they require a third person in the room because of this? (This will be a pre-selected person who the patient is comfortable with and whose presence will not compromise the answers provided by the patient during interview.)
4.) How likely is the individual to remain within St Andrews Healthcare for the necessary time that the research requires for data collection (up until Summer 2022)?

Once potential participants have been identified, Jade will liaise with the ward psychologist to discuss the next steps of recruitment.

APPENDIX B – Summary of research for potential participants

Participants wanted!

- New exciting research taking place at St Andrews Healthcare
- The research is exploring the personal experience of admission from the perspective of the patients
- Individuals aged 50 or above will be invited to take part in an interview to better understand their perspectives of this experience
- The research could help to adapt and further develop the service to better meet the needs of individuals who are being admitted to our services
- Would you like to be contacted by the researchers to know more? Let your ward psychologist know!

APPENDIX C – Participant information sheet

PARTICIPANT INFORMATION SHEET

***Research Title**:* Experiences of admission to secure mental health services for older adults who have a forensic history

Researchers: Jade Mitchell, Dr Stephanie Wilson (University of Birmingham), and Piet Snyman (St Andrews Healthcare)

We would like to invite you to take part in our research study. Before you make a decision, we would like you to understand why the research is being done and what it would involve for you. Please read this information carefully. Reading this information sheet will take up to 10 minutes.

What is the purpose of this research?

The study is being run by Jade Mitchell as part of a psychology doctorate degree at the University of Birmingham. The study is aimed at helping us to understand your experiences of being admitted to a secure forensic mental health service. To find out more about your experiences, the main researcher (Jade) will conduct a series of interviews with you. We are interested to hear from you about any areas for development the service could make in order to better support your needs.

Why have I been invited to take part?

You have been invited to take part in our research study based on a recommendation from your MDT who feel that you would be suitable candidate. Following a conversation with your ward psychologist, you agreed to be contacted by Jade to further discuss the research.

What will happen to me if I agree to take part?

You will be asked to attend an interview with Jade to talk about your personal experiences of admission to the current service. On the day of the interview, Jade will meet you on your ward and accompany you to a quiet room. The interview will last up to/around 60 minutes, and will provide you with an opportunity to discuss your admission in whichever way feels comfortable to you. After the interview, Jade will have a chat with you to see how you found the interview, and direct you to any further support, if needed.

If your MDT feel that it is necessary, a third person may be asked to be present in your interview. This will be agreed and made known to you prior to the interview and you will be

able to choose who this person is. The third person will have to agree to and sign a confidentiality agreement, meaning that they will not be permitted to discuss anything from the interview with anyone else. They are merely there to support you.

What will happen to the information I give?

Prior to the interview, you will be asked to provide an alias (alternative name to your real name) in order to protect your identity. The interview will be recorded on an encrypted Dictaphone (recording device). The audio file will be saved under the alias that you provide and saved in a secure storage space at the University. Jade will then transcribe the interview recording into text and permanently delete the audio file. The interview transcript will also be saved in a secure storage space at the University, using your alias. Only Jade and her supervisors will be able to access these files.

Should you raise anything during interview that is considered to be a risk concern for either yourself or someone else, then this information will need to be shared in order to maintain your safety and the safety of others. In the event of a safeguarding disclosure, you will be supported to raise this issue to the wider team yourself, or Jade can raise this on your behalf.

What will happen if I do not want to carry on with the study?

You do not have to take part in the research study. If you start the interview but decide that you do not wish to continue, then you have the right to stop at any time. You can request for your interview to be withdrawn from the research study up to two weeks after the interview. After this time, it will no longer be possible to withdraw your data as the process of analysis will have began. In order to withdraw from the study, please inform your ward psychologist who will contact the research team to remove all your data.

What will happen to the results of the research study?

The findings of the research study will be written up as part of Jade's thesis. As part of this, we may use direct quotes as a way of demonstrating these findings. We may also submit the findings for publication to scientific journal or present them at a conference. When the analysis has been completed, we will provide you with a summary of the research study's findings. No personally identifying information will be used in any write-up of the findings, and you can therefore not be personally identified from them.

What happens if I have any further concerns?

If you have any concerns about taking part, we encourage you to talk to other people whom you are close to about it, or contact the research team. Remember, you do not have to take part – your care and treatment will stay the same no matter what you decide.

If you would like to discuss any aspect of this research study, please ask your ward psychologist to contact the research team and let them know that you would like to be contacted. Jade will then get in touch with you to discuss your concerns.

APPENDIX D - Consent form

Participant Number/Alias: .....

CONSENT FORM

Research Title: Experiences of admission to secure mental health services for older adults who have a forensic history

Researchers: Jade Mitchell (St Andrews Healthcare), Dr Stephanie Wilson (University of Birmingham), and Piet Snyman (St Andrews Healthcare)

Please tick each box if you agree:

1. I confirm that I have understood the information sheet dated ..... for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I can stop at any time, without giving any reason, without my medical/social care or legal rights being affected. ☐
3. I agree to have the interview audio recorded so that it can be transcribed shortly after the interview, and I understand that the audio recording will be destroyed once the transcription has been completed. ☐
4. I understand that I can withdraw from the research up until two weeks after I have engaged in the interview (DATE TO BE INSERTED HERE), and that after this time it will no longer be possible to withdraw my data. ☐
5. I understand that the data collected during this study will be looked at by the main researcher and her supervisors (listed above) to ensure that the analysis is a fair and reasonable representation of the data. ☐
6. Please indicate whether you are currently involved in another research project or study of any kind: YES/NO
7. I understand that, if required, there may be a third person present during the research interview, which will be discussed and decided on by the MDT prior to the interview, and that I will have a choice in who this person is. The third person will agree to and sign a confidentiality agreement to confirm that they will keep anything that was discussed during the research interview confidential. ☐
8. I agree to take part in the above study. ☐

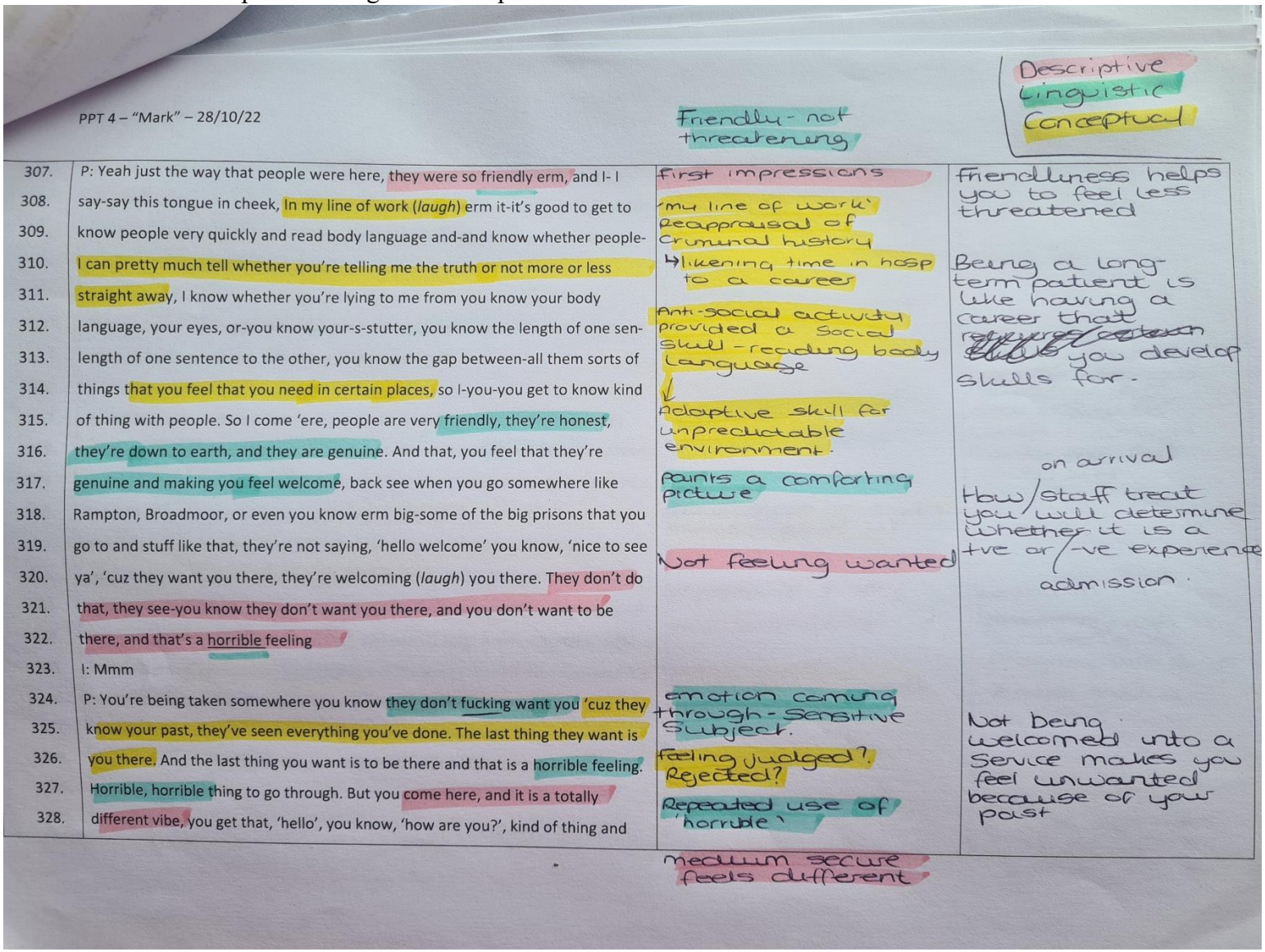
.....	.....	.....
Name of Participant	Date	Signature
.....	.....	.....
Name of Researcher	Date	Signature

Appendix E – Interview Schedule

Interview schedule

1. Can you tell me about what it was like for you when you were admitted to the ward?
   - What was that like for you?
   - How did it make you feel?
   - How long did it take?
   - What was the process like?
2. Do you remember how you felt during the first night on the ward?
   - How did that make you feel?
   - What sense did you make of that?
   - Can you tell me more about that?
   - And what did that mean to you?
3. Throughout your admission, was there anything in particular that stood out to you?
   - eg support from others, level of involvement in the process, level of contact with others
   - What did this mean to you?
   - How did that make you feel?
4. What is it like for you to be in a secure hospital?
   - Compared to where you have been before?
5. Since you have been admitted, what has it been like for you?
   - What do your days consist of?
   - What helps recovery?
6. If you had to go through the process of admission again, what aspects, if any, would you like to be different?
7. What advice would you give to other people who are being admitted to this ward?

APPENDIX F – Example of coding on transcript



PPT 4 – "Mark" – 28/10/22

Friendly - not threatening

Descriptive
Linguistic
Conceptual

307.	P: Yeah just the way that people were here, they were so friendly erm, and I- I	first impressions	Friendliness helps you to feel less threatened
308.	say-say this tongue in cheek, In my line of work (*laugh*) erm it-it's good to get to	'my line of work'	
309.	know people very quickly and read body language and-and know whether people-	Reappraisal of criminal history	
310.	I can pretty much tell whether you're telling me the truth or not more or less	↳likening time in hosp to a career	Being a long-term patient is like having a career that
311.	straight away, I know whether you're lying to me from you know your body		
312.	language, your eyes, or-you know your-s-stutter, you know the length of one sen-	Anti-social activity provided a social skill - reading body language	~~requires certain~~ ~~skills~~ you develop skills for.
313.	length of one sentence to the other, you know the gap between-all them sorts of		
314.	things that you feel that you need in certain places, so I-you-you get to know kind	↓	
315.	of thing with people. So I come 'ere, people are very friendly, they're honest,	Adaptive skill for unpredictable environment.	
316.	they're down to earth, and they are genuine. And that, you feel that they're		on arrival
317.	genuine and making you feel welcome, back see when you go somewhere like	Paints a comforting picture	How staff treat you will determine whether it is a +ve or -ve experience
318.	Rampton, Broadmoor, or even you know erm big-some of the big prisons that you		
319.	go to and stuff like that, they're not saying, 'hello welcome' you know, 'nice to see		
320.	ya', 'cuz they want you there, they're welcoming (*laugh*) you there. They don't do	Not feeling wanted	admission.
321.	that, they see-you know they don't want you there, and you don't want to be		
322.	there, and that's a horrible feeling		
323.	I: Mmm		
324.	P: You're being taken somewhere you know they don't fucking want you 'cuz they	emotion coming through - sensitive subject.	Not being welcomed into a service makes you feel unwanted because of your past
325.	know your past, they've seen everything you've done. The last thing they want is		
326.	you there. And the last thing you want is to be there and that is a horrible feeling.	Feeling judged? Rejected?	
327.	Horrible, horrible thing to go through. But you come here, and it is a totally		
328.	different vibe, you get that, 'hello', you know, 'how are you?', kind of thing and	Repeated use of 'horrible'	

medium secure feels different

Appendix G – Final GET table

A. RELTIONAL POWER OF STAFF MEMBERS IN SECURE CARE

"We Are Staff, You're Patients and…Never the Two Shall Meet" – Tolerating the Power Differentials in Attachment Relationships with Staff Members.

Acknowledgement of the power differential between staff and patients
"Constant reminder that you know that at the end of the day that we are staff, you're patients and that, never-you know, never the two shall meet" (Mark, 216)

Authoritative uniforms can be re-traumatising
"If you are wearing a uniform a lot of us in these places have had bad experiences with people in uniforms i.e police officers, particularly prison officers"
"People in uniforms…you tend not to want to approach them…you don't want to approach them because they remind you of the past and what you know what's got you into trouble or what's, you know, done bad things to you in the past" (Mark, 205)

Staff and patients are different
"That line is there you know, I know that line is there. There's a line there, I know"
(Mark, 217)

Inconsistencies in how staff interact
"They can be quite friendly if you are talking to them but they can turn, they can deliberately try to wind you up and it's not nice" (Mary-Jane, 290)

Some relationships are important for progression
"You gotta make a bond, some sort of bond and that to get some sort of working relationship you know in order to get leave and go out and stuff like that, progress" (Mark, 719)

Transparency and honesty are the foundations of a working relationship
"The biggest thing of all is be honest, don't lie, be honest…if you lie to us we will never trust ya, ever and that. We will never have that working relationship" (Mark, 665)

You have to constantly prove that you are not a threat
"You're constantly working and that all the time to prove to them that you're ok, you're fine, and you're not a threat anymore" (Mark, 371)

Staff winding you up
"I would like it for the staff for not be deliberately trying to wind you up"
(Mary-Jane, 283)

Dynamics between staff members can impact on the patients
"They can give you a hard time about that and that's unacceptable because he asked me first" (Jahscater, 267)

There is a positive impact of staff treating you nicely
"well the staff was, very nice and they treated me nice and comfortable" (Jahscater, 61)

Depending on staff
"Life could be so easy but they make it tough for us because we can't do anything for ourselves"
(Adam, 422/431)

Feeling more comfortable with staff whom I know well
"When you become used to staff and they become part of the furniture if you like and you know who they are and you know you can talk to them" (Sid, 182)

Not being able to have a regular member of staff to talk to is unfair
"I want a named nurse who I can talk to. It's not fair" (John, 338)

Experiencing the loss of a valued staff member
"He was a great man yeah, it is a shame really, I used to really like him being here, he was alright he was. Shame he is gone" (John, 80)

Acknowledgement of the pressure that staff are under in such environments
"Staff are good. They get a lot of abuse from patients…It makes me feel horrible because I think the staff should be treated with respect. They are not here to take that kind of stupidness from patients" (Adam, 310)

Difficult to accept when valued staff member leaves
"I said to him, 'Oh don't resign come on it's not the done thing'…he just walked away and I was like, 'What are you doing? Don't do it, don't do it'" (Adam, 83)

Conflict happens between staff and patients
"We do get a little hassle between the staff and patients" (Jahscater, 280)

Feeling the loss when staff members leave
"It is a shame really when you build a rapport with somebody and they are helpful and friendly and then you lose them" (Sid, 164)

"Lack of Trust, They Don't Trust You" – Conflicts in Insecure Attachments.

Disrespectful communication from staff
"They are not soft enough"
"Still get the same people now saying, 'you wait!'. It is not a very nice thing to say" (Mary-Jane, 33/43)

The use of language is important
"If you are on the PC then just pause it and say, 'yes what can I do for you?', not 'what do you want?'. What kind of a question is that?" (Adam, 427)

Difficult to tolerate a dictating style of communication
"I said I will not be dictated to, right, by a lady. My mother has never told me what to do, neither did my father right"
"gonna turn around and say to me, 'hey, this is it you do it, you do it'. I don't take that man, ordering my behaviour" (Adam, 142/144)

Feeling as though staff want to provoke a reaction
"It makes me feel like they are trying to wind me up…Gently tap on the door and the nurse -the charge nurse will probably turn round and scowl at me, 'what the hell do you want' as though, making it uneasy for me rather than easy" (Mary-Jane, 29)

The stigma of negative reports
"They say in a report..'you are too pushy! And you are autistic. You are pushing all the time if things don't go to plan, you are pushing"
"What was wrong? I was trying to behave normal, not protesting about being here"
"Why am I only fairly settled? Things like that hurt…well say why I am not then, why am I not settled" (Mary-Jane, 19/84/91)

Language barriers between staff and patients increases the risk potential
"Before you come on a ward you should have a decent semblance of the English language and that, otherwise you-you are putting yourself at risk and other people at risk" (Mark, 562)

It is harder to trust staff that you've observed talking behind people's backs
"They can talk behind their back…that's not nice… they can't be trusted can they?"
"When I'm with who they are talking about …that is uncomfortable"
(Jahscater, 184/191)

Staff not supporting you to do well
"I come here peacefully to stay as long as it takes to get well and I don't expect to be wound up" (Mary-Jane, 285)

Staff intentions to prove why you need to be detained
"I don't know whether it's that if they wind you up and you break down then they can discipline you and they put you in a room, seclusion, and it helps to say to the patient that is why you are here because you broke down…it is cruel" (Mary-Jane, 329)

Being assumed to be dangerous before getting to know me
"I was threatened to be taken to seclusion on my first night, I thought which is well out of order"

"Made me feel horrible, first patient, first night, and I was threatened to be taken to seclusion!... It wasn't very nice anyway. She didn't even know me, that was the first time we spoke"
(Adam, 135/153)

Being made to feel untrustworthy
"It's the lack of trust, they don't trust you…people think you are deceiving them all the time" (Johnathan, 121)

Staff misuse their authority
"If you give a certain person the power to do something, they abuse that power, they're abusing that power and er this is what I thought of it" (Adam, 156)

Night staff are negligent in keeping your belongings safe
"There is negligence and malice here…by patients who-who are-and employees, the night shift and that. I wake up in the morning, my things are misplaced" (Adam, 197)

Views of patients will not be listened to
"They said, 'Believe you me sir, they won't listen to ya'…and they do that honestly" (John, 356)

Patients are not treated properly
"You'd need evidence to believe me wouldn't ya…I wish I had the evidence of it. Channel 5 (laugh) I wonder if I could get on the tele on Channel 5" (John, 359)

Best interests of the patients are not a priority
"There just don't seem no wins I reckon it's just making the country more money making the pills" (John, 287)

Night staff are inconsiderate of our sleep
"Some nights they wake you up all bloody night…They must enjoy doing it" (John, 47)

"I Just Felt Human" –Humane Approaches Meeting Attachment Needs.

The powerful impact of feeling cared about
"Someone had actually done something to help me…really done something…that made a huge difference to me" (Sid, 339)

Respect changes how you feel
"If you are treated with a degree of respect it just changes the dynamics entirely" (Sid, 140)

Friendliness is reassuring
"People were friendly and that was quite reassuring" (Sid, 47)

Friendliness helps you to feel less threatened
"[what helped to not be defensive?] Just the way that people were here, they were so friendly" (Mark, 307)

Being treated with respect helps barriers come down and to feel more accepted
"When you come somewhere like here it's not the same…you can let them barriers down…you just know you've been accepted back into society aswell because you can hear those noises and stuff like that, and the way people talk to ya" (Mark, 185)

Being treated respectfully helps you to feel human again
"Humanity! It's just all humanity here…the way people talk to ya…the way people treat you…the level of trust that you get is massively different" (Mark, 115)

Staff taking a person-centred approach makes you feel valued as a human being
"I just felt human, I felt human [laugh] I felt people were being human to me and that erm it felt more personal" (Mark, 649)

Friendly, helpful staff make me feel safe
"The nurses all helped" (Jahscater, 156)

Being treated respectfully is a new experience
"You are treated a lot better by the staff as well and that is really important…[peer] said to me…he has just come from prison, 'You are actually treated like a human being' which is really good" (Sid, 134)

Staff getting to know you personally feels more natural and human
"I'm called by my name here…in the other places they can be dehumanising…they don't get personal with ya…it is a normal, natural, human response" (Mark, 153)

Feeling protected by experienced staff
"The staff are very used to working with people who have problems and might be difficult to deal with and I think that shows in their approach and the way they deal with people. They are patient and they listen. It's good"
"If there is an issue staff tend to be on it really, really quickly and it gets resolved with really, really quickly, usually without any force needed. People are generally talked down quite quickly which is good" (Sid, 109/289)

Positive influence of role models
"Just had a really positive attitude and it was infectious to a degree. It was nice to meet people who wanted to do something positive and make some kind of a difference" (Sid, 79)

Experienced staff members who engage with the patients are valuable
"There's a chap here called [name], he's been here a while, wonderful chap. He used to play football out there" (Adam, 80)

Appreciating staff members who go the extra mile for you
"He used to go up the shop for us…do 'em a favour whenever he used to come around"
(Adam, 89)

Staff support you
"Staff pay you more attention… take you where they can… you sat with them" (Jahscater, 248)

Feeling comfortable because of the care provided by staff
"They tend to ya… all the patients feel err comfortable" (Jahscater, 95)
Staff providing good care because they felt comfortable too
"The doctors and nurses seemed they are comfortable and they-they looked after ya" (Jahscater, 30)

Feeling as though staff genuinely care about you
"They have got your best interests at heart"
"They just have your best interests at heart don't they really"
"I talk to staff quite a bit. They ask me how am I going, have I heard any more about my leave"
(Johnathan, 304/323)

Having somebody to talk to was valued
"He was great he was you could have a talk with him and he was alright" (John, 271)

Feeling listened to by the responsible clinician
"They are listening to me"
"She listens and she tries her best"
"The doctor listens, the doctor does listen"
(Johnathan, 84/87/142)

Staff are generally helpful
"I suppose the staff were quite helpful…we have got one member who is very good at fixing TVs" (Nicholas, 91)

The marker of a good member of staff is honesty
"On the whole yeah people are honest, people are upfront…that is a sign of a good member of staff"
"At least they were honest…and I can trust them again and that whereas if they don't do that then I will never trust them again"
(Mark, 690/699)

"It is Difficult to Know People's Names" – Staffing Issues as a Barrier to Building Meaningful Relationships.

Seeing other people suffering adds to distress
"The staff aren't here for 'em and that-that feels horrible and that er and it looks horrible kind of thing so that hangs on you aswell" (Mark, 506)

Having less staff around validates that I am not dangerous
"Sometimes you don't see staff for like all day!...I see it as a good thing and as a bad thing as you know the good thing is, if they didn't trust me that wouldn't be happening with me" (Mark, 501)

Poor staffing means you have to get involved in risk incidents
"There is a massive shortage of staff so when things go off and things happen, you find yourself sometimes getting involved" (Mark, 483)

Feeling pressured to maintain ward safety in the absence of staff
"The only thing I don't like is if staff are in the office not doing anything or making themselves scarce leaving me to run this show if you like" (Adam, 123)

Takes a long time for requests to be actioned
"Takes such a long time for anything to get done" (Johnathan, 36)

The difficulty of depending on staff for everything when they are so busy
"The response from the office is really slow, people are just really slow and i'm just waiting, waiting, waiting, waiting, and it really is so frustrating"
(Adam, 422)

The frustration in having to wait long periods of time for needs to be met
"I was just getting a bit frustrated that's all. I would shout a bit and make a lot of noise" (Johnathan, 92/102)

Staff approaches to risk are reactive rather than proactive
"They just let it carry on happening. You gotta do summut, they reckon you gotta do summut before they do ote about it" (John, 104)

Staffing issues make it hard to get to know them
"Particularly on the night shift you realise you don't know the names of half the staff because they have bounced off or whatever and they've just come in …but you won't see them again for weeks"
(Sid, 167)

The burden of repeatedly getting to know new people
"You have got to go through the process of getting to know people over and over again" (Sid, 184)

"Do As You Are Told And Listen" - Feelings Of Oppression In The Wider System.

Being treated against my will
"Hopefully they'll stop using me, stop making me take drugs all me life"
"I don't like those drugs…I've had enough of it! It is really doing my head in" (John, 438/441)

Disagreeing with professionals about my experiences of mental health
"Doctor there said about yeah you get voices in your head and all that but I said, 'no I don't have voices in my head', not from mental illnesses. I don't want to be mentally ill and i'm not mentally ill" (John, 131)

Being held in services unnecessarily
"Just pass my days. One day they might let me go. Surely they know nothing is wrong with me" (John, 169)

My views about what I need have not been involved in decision making processes
"They wanted me to take drugs but I didn't want to take drugs so they said, 'right you're gonna go back there [high secure]', and I said I didn't want to go back there" (John, 127)

Not feeling understood by doctors
"He said, 'I haven't seen anybody have as many doctors as you, what's going on with you', I said, 'I don't know sir they keep trying to get me on something… I haven't got a clue why'" (John, 142)

I should be able to be more involved in decisions about my treatment
"Ask me about the drugs and tell me the cons so I can choose the one I want…Choose the one I like best" (John, 417)

Compliance even when disagreeing with treatment
"I took what you asked me to took and now look. I don't know what you are trying to achieve" (John, 286)

Patients need to be managed authoritatively
"When they[patients] play up they[staff] don't seem to do ote with them" (John, 97)

Punishment is needed to keep order

"Punching people? There is no idea of punishment here is there, you shouldn't be going around punching people" (John, 119)

I am used to punishment – it doesn't bother me
"I aint bothered if they segregated me for a long time…Seclusion…and that don't bother me either" (John, 27)

Hospital is less authoritative than prison
"I call it [prison] grumpy castle…Force of authority…It's alright here [hospital], it's alright" (John, 332)

Restrictive practices make it feel like prison
"A bit like being in a prison"
"[secure hospital] It is like being in a prison"
(Johnathan, 21/113)

Constant feeling of being controlled
"Your movements are restricted… I go into the community tomorrow but I've got to go with a member of staff so you are always like a dog on a lead" (Johnathan, 115)

Strict rules mean less freedom
"It just seemed very strict…the other hospital that i used to be in before, you seemed to have a lot more freedom" (Johnathan, 48)

Feeling helpless in the system
"There is nothing I can change it is all militant-like the military…they have all got their rules and regulations and you have to abide by them. There's note I can change" (Johnathan, 287)

Rebellion gets you nowhere
"Do as your told and listen" (Johnathan, 322)

Restrictions remove choice
"They are just locking doors, always locking and unlocking doors. You can't go out your cell…meal times is at a set time and sometimes I don't feel like eating" (Johnathan, 165)

Injustices at the hands of psychiatry
"There is a lot of injustices in these places…psychiatry is based on 5 things: opinions, guesswork, bullshit, favouritism, and injustice…psychiatry is based on guesswork…it is not factual" (Nicholas, 162)

Treatment doesn't work
"folk had been there… well as long as I have done now, 40,50,60 years. Nothing done for them"
(Nicholas, 60)

Resentment at time spent in services
"[feeling as though you've been here longer than needed] You could say that yes"
"Just that i've been-well i've touched on it before, length of time spent in these places"
(Nicholas, 175/263)

Becoming passive through repeated oppression
"I was so-quite demoralised and er the fight had gone out of me I think" (Sid, 56)

Having no control over your life
"You feel as though everything happens to you and you don't really have a say in it and…you know that is quite disheartening I think" (Sid, 62)

Having your things taken away
"Not allowed vapes in our room…having your vape taken off of you when you can have it all the time in prison…it's just something else being taken off of you kind of thing" (Sid, 99)

Not having a choice about going to hospital
"I was not willing haha, erm so but I didn't have a choice so I was bundled into a van and brought here" (Sid, 5)

A restrictive environment is not a happy place to be
"I realise why they are doing it, for security. But as I say, it is not such a happy place"
(Mary-Jane, 198)

Blanket risk management rules
"We are not allowed to go to other wards. At anything. At any stage of your life here" (Mary-Jane, 178)

Risk management policies have gone too far
"I realise why they have stopped it that is because of the suicides and the occasional even murder but they've gone too far, there is not enough relaxed freedom here" (Mary-Jane, 188)

Difficult to put up with blanket rules that shouldn't apply to me
"I realise that er they are trying to stop erm the serious behaviour that went on in Broadmoor er and er but I have to put up with it, I don't like it. I don't need it myself" (Mary-Jane, 227)

It is more comfortable being observed from a distance
"Not stood over, er staff at a distance, sat round just observing which is more comfortable than having staff with you"
"Not with one staff watching three people, no…staff were at points around the edge [of a field] just observing. Makes you feel free. Free and easy"
(Mary-Jane, 185/168)

B. THE EXPERIENCE OF LIVING WITH OTHER PATIENTS WITH FORENSIC AND MENTAL HEALTH NEEDS

"At the End Of the Day it is Our Home" - The Value Of A Calm Ward Environment.

Patients don't want hostility
"People watch more cartoons in mental institutions like this …and they really like it because there is no swearing, no arguing, no bickering, no fighting" (Adam, 298)

Being quiet and calm will help you to settle in
"Keep your head down. Stay calm. Settle in. Settle in decently. Quietly. Calmly" (John, 436)

Settled patients and a calm environment make it alright to be here
"The patients, it was quiet, it was alright" (John, 392)

The ward is my home and I want it to be a calm and settled environment
"I see it as my home and I don't want my home being uncomfortable and people fighting and people arguing and it just being unrestful" (Mark, 487)

Patients presenting as quiet and laid back made it seem like a happy place to be
"Patients were all quiet which was acceptable"
"It seemed like a happy place to be. The patients weren't too bad" (Jahscater, 73/82)

It doesn't take long to settle in when you find the environment to be acceptable
"It didn't take long…to be happy…it was acceptable" (Jahscater, 113)

Feeling happy to be in a place that was laid back and less hectic
"It was nice and comfortable, and not-not erm hectic" (Jahscater, 35)

The calm and settled environment made it seem like a good place
"Seemed like a real good you know, place. Calm" (Jahscater, 8)

Feeling safe and comfortable helps recovery
"[what helps recovery?] Ohhh! More comfortable and more safe"
"[anything that has stood out to you?] Comfort…real comfortable"
(Jahscater, 150)

Having my own space and privacy is important
"While I am here the thing I value the most is my room. That is my room. And I like my privacy there" (Mary-Jane, 75)

Having your own space to retreat to
"They're rooms. You make them-you personalise them…Your room, your bedroom, you make it how you wanna make it…you go back to your room at the end of the day and you are mentally exhausted" (Mark, 87)

Feeling content with having own space and a structured routine
"Day-to-day life is good…I go out…like today i've got one at 2, and then 4 or 5 oclock…go to the loo, go back to bed…I don't like coming out of my bed space because I might disturb people"

(Adam, 242)

Seeing the ward as 'home' is containing
"I'm alright, I'm home"
"At the end of the day, it is our home"
(Adam, 247)

"You Have to Be Aware All of the Time" – Living in Threat Mode.

Anticipation of threat from others
"I don't wanna get into any relationships with any of the patients because…er some of them aren't very well and…I don't want to give them any excuse to have a confrontation with me"
"In the other hospitals…people turned against me that I thought were my friends. Been violent on me" (Johnathan, 226)

Staff are needed to keep patients safe from one another
"There should be staff, one or two members of staff on the actual…with the er patients…Stop any arguing, fighting, arguing, this that, and pause it or whatever and they need each other to put people in seclusion as well" (Adam, 124)

Distrusting those around you
"All sorts of staff coming through and that is a concern really"
"I am even scared to have my telephone numbers on there in case they fall into the wrong hands"
(Adam, 202/211)

The potential for violence is always there
"Everybody has the potential to be quite violent…people are triggered" (Sid, 285)

Patients are unpredictable
"One of the lads here attacked another patient…he wouldn't strike you as a particularly violent person as he was usually well natured, but there you go" (Sid, 296)

There can be a tense atmosphere when people are unwell
"Patients seem erm sick…it wasn't very-a very good atmosphere for a hospital" (Jahscater, 120)

Patients in secure services are dangerous
"The potential for what could happen in that room is massive" (Mark, 132)

People in high secure are intentionally dangerous
"If somebody in Rampton…or Broadmoor or wherever those kind of places and that, they know what they're doing" (Mark, 174)

Being surrounded by forensic patients makes you feel on edge
"People don't get attacked all the time, but! There is the potential…if you are aware of who you are with and what type of people you are with" (Mark, 130)

In high secure environments you cannot trust the people around you
"You have to be aware all the time, very aware all the time because there is always mind games and things going on…always something under the light" (Mark, 149)

After living with high risk people it can take time to learn to trust again
"just don't trust 'em kind of thing…so then when you come 'ere you have to turn that upon it's head, you have to trust people if you wanna get anywhere you have to trust people" (Mark, 704)

There are more incidents in less secure environments
"Things do happen in here more than they do there [high secure] and that-that's the crazy thing about it" (Mark, 158)

Not forming relationships is a learnt means of survival
"You don't form any bonds and that because then nobody can hurt ya…they can't hurt ya and that if they walk away…so what?" (Mark, 710)

Being dangerous is a survival strategy in high secure environments
"You are a danger or you were classed as a danger when you were where you were because, you had to for survival and that" (Mark, 380)

Hiding your true feelings makes you less vulnerable
"Like a porcupine or hedgehog-your-your pines stick out like you know, 'don't talk to me don't come near me i'm dangerous [laugh], and really you're not-you're not fucking dangerous, you're like a scared little kid" (Mark, 301)

Intimidating others is a survival strategy
"You pretend to be something that you are not and that because you think at the time erm it is for your safety and that, you think horrible things are gonna happen to ya…so you know, you sit there and you're kind of like-your chest is a bit out more than it usually is, sat up" (Mark, 294)

To survive in a secure setting you need to be hypervigilant to threat
"You are constantly looking…it comes a habit for life when you do certain things. When you're in these sorts of settings…you scope the whole room…you see who is a possible threat to you, who's no threat" (Mark, 75)

Frequent arguments amongst staff and patients about fairness on the ward
"[conflict on the ward] It does occasionally. Often, not occasionally it happens too often really"
"I don't like it…in fact I hate it…it spoils the peace on the ward" (Mary-Jane, 125)

Living with people who all have the same diagnosis is difficult
"You have a whole ward of PDs and you can imagine what that is like, you know everyone is paranoid about everyone all the time and everyone is playing mind games…you don't get any rest" (Mark, 181)

Conflict is inevitable in large groups
"I'm not a knobhead to anyone or anything like that but like in any big group of people you might get some of that I suppose but that is to be expected" (Sid, 91)

Disruptive behaviour affects everybody
"If you've got one person smashing the place up that means everybody has to go back to their rooms" (Sid, 360)

Communal harmony is fragile
"I think one person can infect the whole environment you know if they are being difficult or disruptive" (Sid, 357)

Not having a say in what entertainment is on in communal areas
"If a certain person wants to watch tele in the morning then it doesn't get changed until the night time which I think is wrong because no-one else can bother with it" (Adam, 12)

Conflict on the ward is distressing
"There are so many arguments here it is unbelievable. That upsets me sometimes" (Adam, 295)

The impact of others on how you feel about the environment
"The environment was a bit off at the time because there were a few violent people on the ward at the time" (Johnathan, 12)

Conflict is inevitable in communal living
"We are all individuals with different wants and needs… If you put a load of odd people together, they are gonna fall out" (Johnathan, 297)

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"I Have Nothing in Common with any of Them" - Making It Work With Unrelatable Peers.

Spending time alone is preferable to spending time with other patients
"I spend most of my time in my room"
"Keep myself to myself most of the time"
"[communal space] I don't stay in it for very long"
"I've been on my own for quite a while actually. You get used to it"
(Johnathan, 212/180/240/242)

Difficult living with people whom you have nothing in common with
"[communal living] I don't like it. Cause I have nothing in common with any of them. I've got no interests that they've got" (Johnathan, 178)

Avoid being around other patients on the ward
"It would get you away from these more wouldn't it"
"I keep out the way quite a lot, I do a lot of off ward activities"
(Nicholas, 121/259)

It is hard when you don't get on with peers
"One or two people here that I didn't get on with at all and that is challenging because erm it is difficult, I just tend to withdraw…I am not the best at dealing with conflict" (Sid, 145)

Feeling different from the other patients because they are 'simpletons'
"*He aint not the full shilling…Simpletons yeah…It's got to be alright because i'm here… but it's a bit simple" (John, 112)*

New patients need to be a good fit so as not to disrupt the established milieu
"You've got to find out the person you've selected to come here and whether he or she is entitled to fit in properly and you know because you don't want them upsetting the whole thingy"
(Adam, 388)

Expectation of reciprocity in relationships
"Being friendly and I expect to be treated friendly back" (Adam, 289)

Efforts to get along
"Yeah it is ok yeah we get along with each other"
"If you've got a problem come see me and likewise if i've got a problem then i'll come see you"
(Adam, 397/400)

Efforts to maintain peace on the ward
"I don't like coming out of my bed space because I might disturb people" (Adam, 244)

Making the most of the situation
"I don't think many people would choose to be here but we make the best of it I think" (Sid, 88)

Feeling safer around patients rather than prisoners
"Prison can be quite-people are a bit funny, this is a lot easier, a lot more relaxed atmosphere…you don't have to worry about people trying to pick on you or silly stuff like that" (Sid, 48)

Social hierarchy on the ward – one person as the spokesperson
"*He's a convict, a patient… He does all the talking for us" (John, 268)*

Maintaining safety on the ward is a priority even if the means of doing so are unorthodox
"Sometimes you've got no choice you've gotta use what you've got erm and that might be unorthodox" (Mark, 541)

It is a duty to look out for peers in need
"Some people if you help them they'll be thankful and that but you're not doing it to be thanked, you're doing it-it's a normal human thing to do…you should be doing it" (Mark, 526)

Physical assault is not personal when the person has a mental illness
"I've been smacked a couple of times since i've been here but…I didn't take it personally. They're ill" (Mark, 165)

In the absence of staff, we help each other out
"Other patients will chip in and try and do things for other patients as well" (Mark, 509)

Being a long-term patient is similar to having a career that you develop skills in
"I say this tongue in cheek, in my line of work [laugh] it is good to get to know people very quickly and read body language" (Mark, 308)

C. STRESSORS OF BEING AN OLDER ADULT IN SECURE CARE

Feeling forgotten about in older age
"As you get older people don't think about you as much as they do themselves and they do younger people" (Johnathan, 223)

Younger patients can exploit older ones
"Once you are the leader of the pack one time when you are in your prime and as you get older you are like the wolf at the back of the pack and have to live on scraps"
"Always stressing me for stuff. Money, tobacco…anything i'd got" (Johnathan, 216)

It is better being around older people as they cause less trouble
"My age group people…where I came from it was youngsters who used to get into all sorts of trouble and mischief…I appreciate these guys because they are older persons" (Adam, 9)

The age mix is positive despite not having many shared interests
"It is good to have a mix" (Sid, 386)

Artificiality of only being surrounded by older people
"I wish it was more like in prison where it is more like the outside world where you are not among old people you are among young people. It is a mixed world, I like it to be more like the world outside rather than an artificial world" (Mary-Jane, 148)

Older adults can't accept change
"The elderly people here got used to this old method can't accept the new method, they can't accept the change even though it is simple" (Mary-Jane, 111)

It would be more comfortable to be living with people who were young at heart
"I would rather have some people who are at least young at heart. They don't have to be young, as long as they are young at heart" (Mary-Jane, 141)

Unable to relate to other older adults on the ward
"The people here, the patients, they are all elderly and erm [pause] I am young at heart…I find that they are old…They are forgetful" (Mary-Jane, 98)

Other older patients on the ward have nothing to offer me socially
"You are limited because of the clientele. I am quite outgoing but they don't really fulfil any criteria" (Nicholas, 117)

Dislike being around old people
"I am not a huge fan of old folks, especially old folks with infirmities" (Nicholas, 101)

Would rather not live with a group of older people
"I am not that keen on the elderly on mass as it were. There are some old folks who are acceptable as individuals but not all bunched together" (Nicholas, 51)

Not feeling able to relate to older peers
"I don't have anything in common with them. Well I hope not anyway"
"I think it is only me that goes off the ward. The rest just vegetate I suppose" (Nicholas, 117/139)

Choosing not to mix with peers because of their age-related problems
"I don't have a great deal to do with them because of age and infirmity" (Nicholas, 97)

Dislike being around people less functional than me
"It is the clientele for the most part. Stuck in wheelchairs all day…It is not very pleasant is it. You just have to put up with it"
"*Well not very good. We've got quite a number in wheelchairs…they are in a worse state than me" (Nicholas, 204)*

Not wanting to be associated with older adults
"It's like if you were in an old folks home or a nursing home…discussing their ailments and their operations and saying how cold they felt and showing their pictures of their grandchildren. It is not for me"
"I suppose you try and distance yourself in so far as you are able to" (Nicholas, 209/211)

Death is not scary
"He had smothered himself in bin liners, phwoar…well done kid"
"I can see him on the other side can't I"
"It [death] won't be all that bad to be honest"
(John, 470/479)

Feeling as though time is running out because I am old
"Not nice when you are old, you feel like you aint got that far to go" (John, 401)

Acceptance of the imminence of death
"Just a matter of time now innit. I won't be long now before I pass over again" (John, 467)

Use the time you have left to finally be yourself
"Do it and if it goes wrong you can always pull back… don't just sit there…because before you know it [clicks fingers], your fucking life has passed you it's gone…do it you know what I mean, while you've got time to do it" (Mark, 811)

With age comes reflection and self-awareness
"It is only later on when you know you get older and you have time to sit and think…you work out for yourself and that you know that's why that happened" (Mark, 792)

Emotional insight comes from experience
"All of a sudden when you least expect it boop! The box comes open…I've stood there talking to somebody and you burst out in tears! And you don't know why…I know why now but you don't know why at the time" (Mark, 781)

Tolerance of negative behaviours decreases with age
"As people get older…i've just suddenly realised but you actually become less tolerant of that kind of behaviour as you get older because you've seen it too many times" (Sid, 371)

Wanting a calmer environment as you get older
"When you get to a certain age, you don't want to deal with tantrums and throwing things about do you, it's more…you expect that from teenagers. I'm showing my age now [laugh]" (Sid, 376)

Wanting to spend the little time left of life in a calm and settled environment
"I'm not gonna live forever am I? I'm not gonna live much longer…I just want to be somewhere in an old people's home, settled. Where I can have visits" (Johnathan, 158)

Mellowing out as you get older
"Don't expect miraculous changes. I suppose I have mellowed though so…" (Nicholas, 154)

Physical health getting in the way of activities

"I do errr there's a mini gym here, which I do the mini gym now and again on the side but my knees are getting old fast now right getting torn and erm something has to be done about that erm injections in both to make the gristle erm make the gristle go back" (Adam, 256)

Physical health problems are accommodated well
"I get a lot of pain relief so that helps… they don't pressure me into doing anything that I don't want to do or if I don't feel up to it" (Johnathan, 340)

The sad reality of ageing
"I wish I was a bit younger…can't fight old age can you…parts wear out as you get older, it catches up with you" (Johnathan, 329)

Feeling limited by physical health conditions
"I'm limited in what I can do of course…because of my disability" (Nicholas, 35/43)

My physical health dictates my routine, but it is manageable
"I've got my activities and everything else revolves around meals and medication. That is for my physical conditions…it is easy enough" (Nicholas, 124)

Appropriate support is available for chronic physical health needs
"That is what the ward is geared up for…for someone who is that way inclined it's alright isn't it" (Nicholas, 227)

Side effects of medication affect quality of life
"I've heard people saying about me following through and that but it weren't funny! This aint funny" (John, 446)

The complexity of having both physical and mental health problems
"Depot they called it. It is supposed to be good because you don't get side effects from it, but the only problem is I would get side effects but I put that down to having a stroke" (John, 277)

The additional burden of physical health problems
"This hernia does me head in…it sticks up when i'm trying to go to bed…That is what is bugging me the most this hernia"
"It's like when you are laying in bed an all, lying in bed, and my knee starts jerking…Got the bloody hips" (John, 172/461)

D. COPING

"That is the Way that it Is" - Acceptance Of The Situation.

Accepting the flaws of the system helps
"Well you just try to put it to one side don't you. No good dwelling on it"
"Well I suppose it is just an acceptance of things"
(Nicholas, 181/197)

It could be worse
"Well I don't have experience of other wards but I don't know what the clientele is like I'm sure. There are some horrors I do know that. Perhaps I am better where I am…there are some undesirables" (Nicholas, 247)

Tolerating the experience
"You have to try and put that to one side don't you"
"You just have to accept it"
"You just try and get by as best you can"
(Nicholas, 138/271/267)

The service is ok but it is not suitable for me
"It is as well as it can be considering…the meals are not too bad considering…well the nature of the place. For an institution" (Nicholas, 239)

Accepting institutional routines
"Well it is a routine. Meals, medication, meals, medication. Medication, meals."
"There's got to be some sort of routine…you've got to have some sort of routine"
(Nicholas, 33)

Being compliant makes your time here easier
"I just get on with it. Just do as I'm told, behave myself, don't get into no fights. Don't use bad language err… go to the groups I am supposed to go to er…just do as i'm told really"

"Co-operate with the staff"
(Johnathan, 132/304)

Acceptance is the only option if you want to progress
"That is the way it is, you just have to cope with it" (Johnathan, 175)

Tolerating the service until you can leave
"You just get on with every day as it comes don't ya, they come and then you just have to get to the end of it" (John, 366)

This is a good place to be compared to where I have been
"I've been to three nut houses now and this is about the best one out the three" (John, 45)

Acceptance of the placement as it is
"[Anything you would change?] No! In this environment it is good, very good"
(Jahscater, 227)

Acceptance of the need for treatment
"I have accepted the fact that medication is erm, it's good for you. I was trying to fight my medication, stay off it and live a normal life but I can't do it, it's impossible" (Adam, 180)

Understanding of the need for risk assessments
"[in regards to leave] they have got to assess you in some way before they do it so I can accept that" (Mary-Jane, 316)

Acceptance of hospitalisation
"I know why I am here. I am accepting treatment"
"I know why I am in a secure hospital because of what I did"
(Mary-Jane, 87/206)

Understanding the rationale for rules helps to cope with them
"I realise why it is so secure and er so I can accept it" (Mary-Jane, 215)

Accepting what can't be helped
"[regarding waiting for a bed] It took a few days and it was delayed and I mean…I can accept that…it is the mechanics of the place…The delays were not upsetting erm disappointing, but I can accept that it can't be helped" (Mary-Jane, 57)

"Doing Something Positive…Gives You a Lifeline" - The Importance Of Valued Activities.

Active role in supporting others
"I delivered a course on Tuesday so they've actually got me down delivering one of the courses [on wellbeing], which is quite good, it's a first apparently so I am quite happy about that" (Sid, 68)

A sense of fulfilment through giving
"It is good so I will be delivering more sessions in the future…I've not gone into this for any reward" (Sid, 242)

Prosocial activity positively impacts your mental health
"I've been doing the REDs [wellbeing course], you do more positive things it just improves your quality of mind full stop because you are developing a positive mindset as oppose to dwelling on negative things" (Sid, 255)

Difficult to cope when there are not enough things to do
"I haven't had a very good week this week, some days I am hardly doing anything" (Sid, 197)

The importance of activities for mental wellbeing
"I've tried to do stuff whilst i've been in and that is really important that you can do things because if you are just sat in your room staring at the walls 24/7 it does drive you a bit mad" (Sid, 123)

Building a sense of worth through creative activity
"Focus on something I enjoy that is productive…it gives me a sense of worth aswell that I feel I have done something worthwhile" (Sid, 232)

Having nothing to do is dangerous for your mental health
"The dangers of not doing anything is you start dwelling on negative thoughts and feelings and that can be a kind of a bit of a vicious cycle" (Sid, 251)

The college gives hope for support and recovery
"The whole point in what they are doing is to give people hope and erm-erm recovery" (Sid, 240)

Limited options for recreational activities
"They don't do ote here, they just pretend they do. Refreshments and gym"
"If you've got no tele then you just sleep"
(John, 348)

The value of having things to do
"Art and craft, I find that therapeutic"
"I do the arts and craft group and I like doing that"
"I just try to fill up my time with things"
(Johnathan, 183/190/246)

Repetition of routine is mundane
"*For the last 3 years its been the same groundhog day"*
"Medicaiton.Food.Vape. That's it"
"Its like groundhog day, every day is the same"
(Johnathan, 150/154/235)

Psychology has helped recovery
"Psychology group helps me" (Johnathan, 83/246)

Meaningful activity is a lifeline
"Doing something positive…gives you a lifeline don't it" (Johnathan, 249)

Helping others keeps me out of trouble
"*Well i've stayed out of trouble by not going in seclusion and I try to help people more now ermm helping, I like helping people" (Adam, 255)*

Having access to activities that I enjoy
"It's ok cuz I go to the sensory room, play on the guitar ermm I do have a few things that are acceptable" (Jahscater, 216)

Self-development through education
"I used to go to college a lot for er IT and er office work and er I did French but it stopped when Covid came" (Mary-Jane, 257/268)

Recovery is supported by psychology input and time passing by
"Psychology sessions. Erm and er time. Erm length-you know time passing by and having psychology" (Mary-Jane, 256)

Valuing time away from the ward
"Unescorted leave …and er I quite enjoy that…I can walk around the garden or go to the courtyard or go to the café and I like walking because I do exercise" (Mary-Jane, 235)

Activities take your mind off things
"It takes your mind off things doesn't it" (Nicholas, 39)

Available activities have allowed me to further develop skills in different areas
"I have improved my swimming and er me sewing" (Nicholas, 69)

Getting satisfaction through selling items that I have made
"I make purses and bags which they are selling in the canteen…I suppose it gives you a certain satisfaction" (Nicholas, 70/73)

Passing the time with activities helps
"Extra-curricular activities. Passing the time" (Nicholas, 158)

Occupying time with various activities
"I do try and occupy myself…I do my sewing in the workshop. Gym…computing…a session with the music man…So I try to keep fairly busy" (Nicholas, 34)

"Part of the World Again" – Feeling Connected To Life Outside Of Hospital.

Having leave helps to deal with your liberty and freedom being taken away
"I was feeling at the time that I had very little control over my life…you are in a position where your liberty has been taken away from you, your freedom has been taken away from you, it is not great…But I suppose the thing is that we are indulged to quite a degree here I think as opposed to the prison system. At least we do get to go out for walks…I get to go out into the community now aswell" (Sid, 114)

The importance of feeling connected to the outside world
"I like going out shopping in the community and seeing the people outside…being in touch with the er world again for a few hours" (Johnathan, 270)

Wanting more time outside
"I'd like to be able to go lie down. When summer comes I like wondering off, sit outside and feed the birds and stuff" (Johnathan, 291)

Staying connected to previous employment
"I've been doing a lot of cooking…What I did I used to work in restaurants and takeaways and so forth"
"When I came into hospital I taught [staff member] how to cook, I taught her how to cook"
(Adam, 228/232)

A new appreciation for nature
"Seeing squirrels hopping around everywhere and rabbits and everything just running around…It's almost like Alice in Wonderland…that's what it felt like… Just like being in never never land honestly" (Mark, 408)

Feeling back in touch with the outside world helped to lessen the internalised belief of being a dangerous person
"Public walk through and I couldn't believe that when I first come here [laugh] I was-was like oh there's some member of public you know just with their dog, oh my goddddd! Walking through here? Do they know where they are? [laugh]…blew my mind that" (Mark, 446)

The view you have from your window is a reminder of where you are
"All the time it is a constant reminder of where you are" (Mark, 422)

Seeing the outside world again was overwhelming after being cut off so long
"Just overload…Where I come from I don't have a beautiful view of trees and-and traffic going by and-and birds and animals and squirrels, squirrels!" (Mark, 403)

Being in high secure is like being removed from society
"Because you are in the middle of nowhere, you don't hear anything, you hear nothing, absolutely nothing…you don't hear any traffic or anything like that" (Mark, 21)

Being able to observe the outside world helped Mark to feel part of society again
"All of a sudden I just knew I was back in society…I've been accepted back into society and that i'm you know part of the world again" (Mark, 28)

Not feeling judged by others allowed Mark to feel accepted back into society
"There's public there, i'm mixing with public! [laugh] Joe public. And they don't know who I am, I don't know who they are. I'm not judging them, they're not judging me" (Mark, 121)

Keeping mind active by staying connected to life on the outside
"Son is recently with his family moved to Wales and I have been a part of that…I have decided to sell my house. That has kept me busy kept my mind active on practical things in the world"
(Mary-Jane, 269)

Value feeling back into the outside world
"[having leave on the grounds] It is like walking around town you know or through the park which is quite nice. ..I value that very much" (Mary-Jane, 244)

Gaining more leave makes it tolerable
"It did get better when you start to get privileges like er, having in particular having leave and then having home leave or having visits…those sorts of things help to make it nice" (Mary-Jane, 310)

Appendix H – Ethical approval

Dear Dr Kloess

Re: "Experiences of admission to secure mental health services of older adults who have a forensic history"

Application for Ethical Review ERN_21-0129

Thank you for your application for ethical review for the above project, which has now been reviewed by the Science, Technology, Engineering and Mathematics Ethical Review Committee.

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for your project, subject to your adherence to the following conditions:

- Please ensure that an appropriate health and safety risk assessment is carried out and signed off in line with the requirements of your College, prior to the work being undertaken.

- Please note that in line with the latest guidance within the College of Life and Environmental Sciences on COVID risks, no face to face work can commence prior to 19th July 2021 at the earliest.

- It is recommended that if possible, the researcher is fully vaccinated against COVID prior to any face to face work with participants.

For clarification, as long as the conditions above are met and the details of the proposed work do not change, your project has ethics approval and no further action is necessary.

I would like to remind you that any substantive changes to the nature of the study as described in the Application for Ethical Review, and/or any adverse events occurring during the study should be promptly bought to the Committee's attention by the Principal Investigator and may necessitate further ethical review.

Please also ensure that the relevant requirements within the University's Code of Practice for Research and the information and guidance provided on the University's ethics webpages (available at https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Links-and-Resources.aspx) are adhered to and referred to in any future applications for ethical review. It is now a requirement on the revised application form (https://intranet.birmingham.ac.uk/finance/accounting/Research-Support-Group/Research-Ethics/Ethical-Review-Forms.aspx) to confirm that this guidance has been consulted and is understood, and that it has been taken into account when completing your application for ethical review.

If you require a hard copy of this correspondence, please let me know.

Kind regards

Susan Cottam
Research Ethics Manager
Research Support Group, C Block Dome
Aston Webb Building, University of Birmingham
Edgbaston B15 2TT

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Appendix I – Service recommendations to be shared with St Andrews

DOCTORAL THESIS RESEARCH PROJECT

Title of Research: Experience of admission to secure mental health services for older adults who have a forensic history

Researchers: Jade Mitchell (St Andrews Healthcare), Dr Stephanie Wilson (University of Birmingham), and Piet Snyman (St Andrews Healthcare)

Summary of the research:

The study was completed by Jade Mitchell as part of a clinical and forensic psychology doctorate degree at the University of Birmingham. The study aimed to increase understanding around the experience of being admitted to a secure forensic mental health service, from the perspective of the individuals who were considered an older adult and with a forensic history. The findings of the research highlighted five key themes: Relational power of staff members in secure care, the experience of living with other mental health patients, being an older adult in secure care, and coping.

Recommendations:

Based on the findings of the research, the following recommendations have been made:

- To empower individuals to be more independent, in line with guidance around least restrictive practice, encourage service users to have responsibility over their own medication (where appropriate), meals, and weekly therapeutic timetables. This would reduce dependency on staff.
- To allow continuity in the support received and to reinforce the development of positive working relationships, where possible allow named nurses to continue professional contact with service users when moving wards through regular check-in sessions.
- Provide each service user with a point of contact in the organisation from a different service to where they are residing. This would offer a safe space for support outside of the service user's clinical team.
- Review staff training and ensure all members of the nursing teams have received both trauma-informed care training as well as RAID. Staff should be offered annual refreshers on both forms of training.
- Upskill nursing staff in basic coping skills such as relaxation, mindfulness, and grounding techniques to support individuals in distress and minimise disruption on the ward.

- Develop ‘compassionate care’ champions on the ward in which service-users could submit nominations for on a monthly basis. A reward system for staff members could be considered in relation to this.
- Identify ‘relaxation spaces’ on the ward for service users to access when seeking calm and quiet. The space could be equipped with a range of resources such as books, music, and sensory activities. The space should be accessible without having to request it.
- To provide ‘patient participation’ information booklets containing up-to-date information on the variety of patient involvement forums available at St Andrews and an easy read version of the complaints procedure.
- To liaise with the patient advocacy service to arrange for regular advocate drop-in clinics accessible to all.
- Increase provision for enriching activities to ensure that therapeutic timetables remain varied, meaningful, and tailored to the needs of the service user group.
- Develop links with community services that could support individuals in accessing work opportunities, learning new skills, and accessing mental health support to encourage individuals to prosocially engage with the local community.
- To provide more choice in whether the individual is placed in an environment that has an age-mix or is for older adults only.
- Offer individuals regular opportunities to discuss their age-related needs and to collaboratively input into their care plans.

APPENDIX J – Information on articles excluded from the literature review

Publication		Sample	Method	Setting	Reason for exclusion
Author	**Country**				
			Qualitative		
Crawley & Sparks (2005)	UK	Male prisoners aged 65+	Observations, prisoner interviews and staff interviews	Four prisons across England	Did not include a measure/focus on coping: Focus on the invisibility and hidden injuries of older prisoners
De Guzman et al. (2021)	Phillipines	25 older prisoners (aged 60+)	Semi-structured interviews	Medium security prison	Did not include a measure/focus on coping: Focus on the development of fear of other inmates
Loeb et al. (2014)	USA	22 male prisoners	Semi-structured interviews	General prison	Included participants under the age of 39: Aged 18+
Seaward et al. (2021)	Switzerland	41 prisoners (aged 56-76) and 63 mental health professional	Semi-structured interviews	Prison and secure mental health facility	Did not include a measure/focus on coping: Focus on therapist qualities that support rehabilitation
Shaw et al. (2019)	AUS	8 prison chaplains	Semi-structured interviews	Four prisons	Did not include a measure/focus on coping: Focus on chaplaincy
			Quantitative		

Allen et al. (2008)	USA	Male prisoners aged 50+	Interviews to administer validated measures	Maximum security prison	Did not include a measure/focus on coping: Focus on spiritual experiences, forgiveness, feelings of abandonment, private religious practices, and religious meaning
Coid et al. (2002)	UK	3155 individuals admitted to services between 1988 and 1994	Retrospective review of admission data	Medium and high security mental health hospital	Did not include a measure/focus on coping: Focus on demographic data of admissions to the hospital
Das et al. (2012)	UK	26 younger patients (aged 45 and below) and 30 older patients (aged 60+)	Semi-structured interviews administering two measures based on healthcare and placement needs	Medium and high secure mental health hospital	Did not include a measure/focus on coping: Focus on assessment of healthcare and placement needs
Girardi et al. (2018)	UK	521 patients aged between 18-65+	Retrospective evaluation of routinely collected data	Low and medium secure mental health hospitals	Did not include a measure/focus on coping: Focus on the HoNOS outcome measure
Holtfreter et al. (2017)	USA	2000 men and women living in the community	Telephone interviews to administer surveys	Community	Research did not take place in prison or secure forensic mental health hospital
Iftene (2016)	Canada	197 male prisoners	Structured interviews	Minimum security unit and high secure prison	Did not include a measure/focus on coping: Focus on the protection of prisoner's legal rights

Kopera-Fry et al. (2013)	USA	111 Male prisoners enrolled on a specific prison programme (aged 53-83 years)	Survey packs including: demographics questionnaire, psychometric instruments, and ratings of treatment progress and program satisfaction	General prison	Did not include a measure/focus on coping: Focus on the outcomes of a specific prison programme
Koskinen (2017)	USA	Prisoners (number and ages undisclosed)	Cross-sectional data collected via surveys	General prisons	Did not include a measure/focus on coping: Focus on PTSD symptomology and stressful life events
Kromah (2013)	USA	100 male prisoners	Survey	General prison	Included participants under the age of 39: Aged 18+
Luke et al. (2021)	AUS	336 male prisoners (aged 18-79)	Survey	Maximum security prison	Included participants under the age of 39: Aged 18+
Maschi et al. (2014)	USA	667 prisoners (aged 50+)	Survey	General prison	Did not include a measure/focus on coping: There was an exploration of coping resources to alleviate distress from PTSD but article did not report findings specifically about coping resources – instead the focus was on comparing explanatory models
Maschi et al. (2015)	USA	1750 male prisoners (aged 50+)	Survey	Prisons	Did not include a measure/focus on coping: Focus was on coping with trauma, grief and loss rather than coping with the prison experience

Randall & Bishop (2022)	USA	261 male prisoners (aged 45-82)	Interviews to administer validated measures	Eight prisons	Did not include a measure/focus on coping: Focus on negative childhood events, forgiveness, social support, and religiosity
Rayel (2000)	USA	22 patients (aged 55+)	Retrospective review of routinely collected data	Secure mental health facility	Did not include a measure/focus on coping: Focus on demographic information
Regan & Regan (2002)	USA	671 prisoners (aged 55+)	Review of routinely collected data	Various prisons	Did not include a measure/focus on coping: Focus on mental health diagnoses
Scaggs et al. (2018)	USA	25571 prisoners	Review of 'recidivism dataset'	Prison database	Did not include a measure/focus on coping: Focus on recidivism, employment, and prison misconduct
Stanback (2011)	USA	6133 prisoners (aged 50+)	Survey	General prisons	Did not include a measure/focus on coping: Focus on correlates with mental health problems (for example life stressors)
Stolliker & Gali (2019)	USA	1907 male and female prisoners (aged 50-84)	Survey	Various prisons	Did not include a measure/focus on coping: Focus on demographics and mental health prevalence
Tomar et al. (2015)	UK	42 male and female patients (aged 65-78)	Retrospective survey	Medium secure mental health hospital	Did not include a measure/focus on coping: Focus on demographic and referral data
Wong et al. (1995)	UK	372 male and 96 female	Data review	High secure mental health hospital	Did not include a measure/focus on coping: Review of case notes, admission information, psychiatric and

		patients (aged 60+)			medical history, and criminal record in order to explore prevalences
Trotter & Baidawi (2015)	AUS	173 'older' prisoners (50+) and 60 'younger' prisoners (under 50 years)	Structured interviews comprising the collection of demographic information, yes/no scaled questions, and short-answer questions	Eight prisons	Did not include a measure/focus on coping: Focus on functional independence, difficulties in the prison environment, prison programs, and social functioning
Other					
Kakoullis et al. (2010)	UK	Undisclosed	Systematic literature review	Prisons	Article was not an original study: Literature review
Puening et al. (2018)	USA	1 male prisoner (aged 25)	Case report	Medical facility within prison	Article was not an original study: Case vignette