A QUALITATIVE EXPLORATION OF THE VIEWS AND EXPERIENCES OF MEN WITH INTELLECTUAL AND/OR DEVELOPMENTAL DISABILITIES WHO PARTICIPATED IN AN ADAPTED GROUP THERAPY FOR HARMFUL SEXUAL BEHAVIOURS.

By

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Thesis overview

This thesis is submitted as partial fulfilment for the degree of Doctorate in Clinical Psychology at the University of Birmingham. This thesis contains one volume, with three chapters.

Chapter one of thesis consists of the literature review. A meta-ethnography was conducted to explore the lived experiences of individuals with intellectual and/or developmental disabilities living in secure services and long-stay hospitals. This aimed to highlight the shared narratives by service users to guide service redesign and future policy. Chapter two of the thesis comprises the empirical paper, which utilised Reflective Thematic Analysis (RTA) to explore the views and experiences of participating in an adapted group therapy for harmful sexual behaviour provided to men with intellectual and/or developmental disabilities. The final chapter of the thesis presents the press release, which is a summary of the first and second chapter, written for public dissemination.

Acknowledgements and dedication

I firstly dedicate this journey and thesis to God Almighty. If it was not for faith in Him, I would not have made it this far. Secondly, I dedicate this period of hard work to my mum. She has, is, and always will be my rock. The support, patience, and kindness she has shown me over the years are unmatched and I could never repay. Her encouragements led me this far, and I hope I have made her proud.

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THE VIEWS AND LIVED EXPERIENCES OF INDIVIDUALS WITH INTELLECTUAL AND/OR DEVELOPMENTAL DISABILITIES WHO LIVE IN SECURE SERVICES: A META-ETHNOGRAPHY.

Abstract

Introduction

Since the 19th century, people with intellectual and/or developmental disabilities (IDD) have often been placed in large institutions or secure hospitals for a variety of reasons. Histories of scandals as a result of widespread abuse and neglect in some of these services prompted policy reforms and the rise of deinstitutionalisation. Despite these reforms, abuse in institutional care has persisted into the 21st century in countries such as the United Kingdom. However, secure settings remain necessary services for those with complex needs, i.e. co-occurring mental health problems and/or forensic presentations, which may require more specialised support. To avoid repeating past failures, changes to current service models are warranted. An initial step is understanding service users' perspectives to inform more effective and supportive care. Although service user involvement is widely recognised as essential for improving care, individuals with IDD remain largely excluded from research, especially in secure settings, highlighting a critical gap. This meta-ethnography aimed to synthesise the literature relating to the lived experiences of people with IDD living in secure services.

Methods

Using Noblit and Hare (1988) 7-step meta-ethnographic model, a systematic search of the literature was conducted on Embase, PsychInfo, and Ovid Medline. To evaluate the methodological quality of studies, the Critical Appraisal Skills Programme (CASP) framework was used.

Results

Eleven studies were included. Four primary themes were formulated: sense of self; where is my power?; navigating social relationships; and necessary evil. Of these, subthemes were formed to explore shared and contrasting views on belonging and identity, powerlessness, and meaningful social contact.

Conclusions

The findings reveal shared narratives by service users that highlight areas for improvement in in-patient care services. While insights can guide service redesign, the methodological quality of several studies was low, underscoring the need for more rigorous research. Clinical and research implications are discussed.

Introduction

Since the early 19th century, in many Western countries, the needs of individuals with intellectual and/or developmental disabilities (IDD) who required accommodation and support with daily living were typically met in large residential institutions or long-stay secure hospitals (Calabria & Cullen, 2024; Mansell et al., 2007). Within these settings, a dominant medical model shaped perceptions of IDD as a deficit or pathology, prioritising containment and control over care or rehabilitation (Surich, 1984; Šiška & Beadle-Brown, 2022). Over time, institutional care became increasingly associated with poor standards, segregation, and abuse (Mansell et al., 2007). In the United Kingdom (UK), numerous inquiries have documented the abuse experienced by individuals with IDD in long-stay hospitals and institutional settings. For example, in 1967, the Ely Hospital inquiry in Cardiff exposed widespread mistreatment of service users, including excessive use of sedatives to manage behaviour, neglectful care practices, and physical abuse such as bullying and threats (Butler & Drakeford, 2003). Although in the United States (US), individuals with IDD, especially those with forensic histories or co-occurring mental health conditions, have been disproportionately placed in correctional facilities rather than in specialised secure care (Leotti & Slayter, 2022), institutional settings have not been free from abuse. For instance, the Willowbrook scandal of 1972 exposed severe neglect and mistreatment within a residential institution for young people with IDD (Mason, 2016).

The neglect and abuse exposed by these and other scandals led to public outcry and shifts in social policy. In the UK, inquiries were launched to assess how individuals with learning disabilities were treated in secure hospitals under the National Health Service (NHS). The hospital advisory service was established to provide regular reports on the conditions of long-stay institutions (National Health Service, 1969), and the ‘better services for the mentally handicapped’ white paper outlined recommendations for care, including the closure of such institutions (Boardman, 1971). In the United States (US), the ‘protection and advocacy network’ was established in 1975 as a nationwide agency to safeguard the rights of individuals with IDD (Dalton & Carlin, 2002).

Alongside policy developments, the normalisation principle, which originated in Scandinavia (Nirje, 1969; 1985), was introduced to support individuals with intellectual disabilities. It was grounded in Swedish and Danish social welfare ideals that emphasised equality and the right to a good standard of living for all. The principle advocated for the right of individuals with IDD to live in conditions as close as possible to those of the general population (Nirje, 1969, 1985; Tøssebro, 2016). These policy and ideological shifts presented the groundwork for the deinstitutionalisation movement that gained momentum in the 1980s across various Western countries, promoting a transition from institutional care to community-based support as the preferred model (Calabria & Cullen, 2024). Understandably, the implementation of deinstitutionalisation varied internationally. Western Europe, particularly the UK, often led the movement with more established frameworks (Mansell, 1996, 2006). In contrast, while progress was made in countries such as the US and Australia in reducing the number of people with IDD in institutions, the process was frequently criticised as overly rapid. The pace of change often exceeded the development of adequate community infrastructure, which proved insufficient to meet the complex needs of individuals with IDD (Balogh et al., 2016; Wiesel & Bigby, 2015).

The occurrence of scandals, the rise of the normalisation principle, and evolving ideologies were key drivers of deinstitutionalisation (Mansell et al., 2007). A significant influence on these ideological shifts was Goffman’s (1961) theory of total institutions. Goffman combined psychological and sociological perspectives to criticise the medical model of IDD, reframing it as a socially constructed phenomenon rather than an intrinsic pathology. His theory highlighted the impact of institutional environments on individual identity and behaviour, contributing to a broader understanding of IDD and the harms of institutionalisation (Hamlin & Oakes, 2008). Building on Goffman's work and the development of the normalisation principle, the theory of social role valorisation developed by Wolfensberger proposed that the social value attached to roles influences how individuals are treated by society (Wolfensberger, 2000). This theory emphasised the importance of supporting people with IDD to attain valued social roles, in turn enhancing their quality of life, dignity, and inclusion.

Although care models have evolved since the 1960s, Goffman's work remains foundational and is frequently cited. His concepts can still be applied, though cautiously, to modern IDD secure services. Goffman's key argument was that institutions inherently exert control over multiple aspects of daily life, such as sleeping and eating routines. This often leads to the erosion of pre-institutional identities and the imposition of new identities shaped by institutional norms, which often differ from broader societal values (Bruce, 2021; Goffman, 1961). Notably, identity disturbances have been linked to mental health difficulties, including depression and anxiety (Klimstra & Denissen, 2017; Potterton et al., 2022), as well as to feelings of alienation and social maladjustment (Sokol & Eisenheim, 2016). Threats to identity have also been associated with reduced self-esteem and feelings of worthlessness (Moon et al., 2025), diminished sense of belonging (Allen et al., 2021; Hari, 2018), and challenges in forming and maintaining social relationships (Emerson et al., 2023), both in the general population and among individuals with IDD. Given these associations with psychological well-being, the continued relevance of Goffman's theory and subsequent research support the importance of minimising institutional practices and promoting a more socially integrated care model.

However, despite the warnings within previous research and the development of frameworks in response to the shocking scandals, the abuse of individuals with IDD in secure settings in the UK reoccurred numerously. For instance, in 1998 the Longcare inquiry exposed incidents of physical and sexual abuse towards service users (Buckinghamshire County Council, 1998). Less than a decade later, an investigation at Cornwall NHS Trust revealed a similar picture, highlighting widespread abuse and oppression of service users (Commission for Healthcare Audit and Inspection, 2006). Recommendations drawn from these inquires and others have echoed that of the Ely Hospital investigation, including increasing the number of inspections and visits at institutions, improving service users and staff involvement, and seeking service users' perspectives (Buckinghamshire County Council, 1998; Commission for Healthcare Audit and Inspection, 2006).

Unfortunately, a failure to fully implement these recommendations may have contributed to the continuation of scandals in institutional care. In 2011, a widespread abuse of service users with IDD was uncovered at Winterbourne View, highlighting the pressing need to improve service provision for individuals with IDD (British Broadcasting Corporation, 2012; Department of Health, 2012). Transforming Care was developed as an initiative to review the placements of individuals and facilitate transfers to community settings (Department of Health, 2012, 2015). However, the initiative ultimately failed to achieve its goal. In 2019, a further documentary exposed the abuse of individuals with IDD at Whorlton Hall (British Broadcasting Corporation, 2019), despite ongoing social policy efforts aimed at closing long-stay hospitals, reducing admissions to secure settings (Department of Health, 2001, 2015), and expanding community-based services (NHS England, 2015). However, it is to be noted that though the reported scandals provide evidence of institutional failings, the data is drawn from investigative journalism and inquires, rather than systematic research. Consequently, they do not provide generalisable evidence of the broader systemic conditions experienced by people with IDD. Furthermore, little to no systematic evaluation of whether and how recommendations were implemented across services has been presented, and the available evidence lacks comprehensive longitudinal tracking of outcomes for service users post-scandal, i.e. in terms of quality of life, limiting the understanding of the sustainability of the changes that have been implemented.

Various factors may contribute to the repetitive nature of the scandals witnessed in institutional care in the UK, including issues with implementing active support (Bigby et al., 2020; Mansell et al., 2002), poor staff culture (Fox et al., 2024), and funding difficulties (Brown et al., 2017). Specifically, a difficulty to house some individuals with IDD in the community has been raised as a notable factor (Bevan et al., 2018; Mencap, 2012). Though there has been a vast increase in community provision for individuals with IDD in the UK over the years, a census in 2019/2020 demonstrated that of almost 135,000 individuals with learning disabilities that received long-term support, only 12,635 lived in rented social housing and less than 4,000 rented from a private landlord, and an even smaller minority owned their own accommodation (Hatton, 2017; NHS Digital, 2022). Furthermore, for those with community housing, there are concerns that housing may be of poor-quality and unsuitable, particularly in the private rented sector (Mencap, 2012; Quilgars et al., 2024). Individuals with intellectual and developmental disabilities (IDD) experience higher rates of mental health disorders, which in turn heighten their vulnerability to various risks, including victimisation and offending, thereby giving rise to additional forensic needs (Cooper et al., 2006; Fogden et al., 2016; Verdonschot et al., 2009). Such risks, as well as increased likelihood of physical health difficulties (Cumella & Lyons, 2018), further compound upon the difficulties to house individuals with IDD.

The struggle to provide community housing for some individuals with IDD presents scope for the continuation of secure services. Secure services provide higher levels of security for individuals who may pose risk to themselves or others, or with treatment needs that may be difficult to manage in the community (Urheim & VandenBos, 2006). Although these institutions tend to restrict the choice and freedom of service users to reduce risk (Adams et al., 2018) and can be subject to very little inspection, especially when under private care (Quilgars et al., 2024), there is a clear and warranted need for this sort of care. To address the need for this care for individuals with IDD whilst also considering the long history of scandals and abuse in institutional care, the planning, development, and delivery of secure services needs to become ever more dependent on service user involvement, increasing service users' opportunities to be involved in treatment planning and delivery (Livingston et al., 2013). Currently, there is limited evaluative research on the experiences of individuals living within such services. Existing literature is often dominated by risk management frameworks or clinical evaluations, with fewer studies centring on the voices of service users themselves.

There is recognition in the NHS that the experiences of service users within care settings should be sought as they offer unique insights into what is successful and/or in need of development, informing service improvement (NHS England, 2015). The Department of Health England released the "White Paper, Valuing People", urging the exploration of the consumers and stakeholders' views which were noted as essential for the implementation of new initiatives (Department of Health, 2001). In line with the recommendations, service users involvement in research has been associated with various benefits, such as improvements in care coordination between patients and clinicians, improved clinical outcomes, and greater accessibility to services (Cegala et al., 2007; Crawford et al., 2002;), as well as improved mindful and respectful approaches to meet the needs of the patient group (Hauso et al., 2021; Simpson & Penney, 2018).

Despite the established interest and benefits of service user involvement, the extent to which service user involvement is sought with individuals with IDD is scarce (Sutton & Gates, 2020; Young & Chesson, 2006). Existing qualitative studies in this area are few and vary widely in methodological rigor (Bishop et al., 2023). Historically, the exclusion of individuals with IDD from research was due to the adoption of a primarily medical model solely focused on impairment, which in turn marginalised and ignored the voices of individuals with IDD (Montgomery et al., 2022; Stone & Priestley, 1996). Furthermore, marginalisation from research was also compounded by the societal view that adults with IDD are vulnerable individuals who require risk management and protection, which in many cases led to their oppression, as well as the removal of freedom and power in their everyday lives (Gilbert, 2004; Adams et al., 2018). Challenges to this perspective have encouraged NHS ethics committees to turn aside from protectionism and instead recognise the importance and empowerment gained from their participation in research (Gilbert, 2004).

This change in perspective provided momentum for research development exploring the views of service users with IDD of the support they receive in community services (O'Brien & Rose, 2010; Robinson et al., 2016; Sutton & Gates, 2020). Over the years, this research has primarily highlighted their desire for greater choice and control, as well as a need for professionals to re-examine and adapt their relationships with service users to appropriately accommodate their feedback. Notably, these studies have predominantly focused on the experiences of service users with IDD in community settings, with only a few studies exploring secure settings, and even fewer studies exploring lived experiences in secure settings, despite service users' desire for their views to be heard (McDonald, 2012). A literature review exploring the experiences of service users with IDD urged for more research on the topic, particularly in secure settings, as findings highlighted limited evidence of their involvement in research, supporting that little is known on the experiences of service users with IDD living in secure services (Lake et al., 2014) and much of the research has focused on the perspective of staff (Lee & Kiemle, 2015). The limited amount of research addressing service users' experience in secure IDD settings represents a significant gap in the evidence base. To improve the quality of secure care, more rigorous and inclusive research is required, that prioritises their lived experiences. A recent systematic review explored quantitative and qualitative outcomes of the effectiveness of in-patient treatment in individuals with IDD, however, this was not an in-depth exploration of the experience of service users (Melvin et al., 2022).

Aims

As such, the present study aimed to conduct a meta-ethnography to explore the views and lived experiences of people with IDD who live in secure services. To the author's knowledge, there are no prior meta-ethnographies synthesising this body of research.

Methods

The qualitative synthesis of literature is increasingly used in healthcare research (Barnett-Page & Thomas, 2009). Meta-ethnography is a widely used method for synthesising qualitative data from multiple studies to generate new insights into people's experiences and perspectives. According to Sattar and colleagues (2021), meta-ethnographies can inform healthcare policy and practice by producing novel theoretical contributions. They also support the development of new interpretations and frameworks that may guide the design of interventions and extend the applicability of findings across broader contexts (Sattar et al., 2021). Accordingly, a meta-ethnography was undertaken in the present study over other qualitative synthesis approaches to synthesise existing data on the views and lived experiences of individuals with IDD in secure services. This meta-ethnography has been registered on Prospero (CRD42024560843). Registering the meta-ethnography reduces the chances of the repetition of work.

Outline

This meta-ethnography followed the step-by-step method provided by Noblit and Hare (1988) and adapted by Sattar and colleagues (2021) (Table 1).

Table 1: Outline of seven stages of a meta-ethnography by Noblit and Hare

Stage		Description
1.	Getting started	Identifying an area of interest and considering how synthesising the qualitative data could valuably contribute to existing literature.
2.	Deciding what is relevant to the initial interest	Defining the focus of the synthesis, selecting relevant studies, developing the inclusion and exclusion criteria, measuring studies against a quality appraisal.
3.	Reading the studies	Familiarising with key concepts and detail of studies, extracting relevant data from studies.
4.	Determining how the studies are related	Considering a relationship between key concepts across the included studies.
5.	Translating the studies into one another	Comparing the concepts from one study with the concepts of each of the other studies to assess for commonality.
6.	Synthesising the translations	Formulating interrelationship of concepts across studies
7.	Expressing the synthesis.	Summarising findings, including strengths, weaknesses, recommendations, and disseminating findings

Stage One

The transition from secure services to community settings has been an ongoing policy scope in the NHS (Department of Health, 2015; Lewis, 2006). These ongoing changes have been of particular importance for individuals with IDD, reflected in the increase of research and funding provided (Department of Health, 2015). Nonetheless, secure services continue to play a necessary role in supporting individuals with complex needs, such as those with severe mental health conditions and forensic profiles. Despite this, there is limited understanding of how these services are experienced from the perspective of individuals with IDD. The gap in the literature provided the area of interest for this study.

Stage Two

A systematic search of the literature was conducted to answer the primary question of the review: "What are the experiences and views of people with IDD who live in secure services?"

Search strategy

A systematic search of the literature was first conducted on the 19th July 2024 and repeated on the 2nd of December 2024. Three electronic databases were used, Embase, Ovid Medline, and PsychInfo. These databases were chosen due to their wider coverage of research in psychology. Grey literature was also searched on Google scholar, along with reference checking. The purpose of the search was to gain comprehensive and rich data on the global experiences of service users in secure settings, which could influence service delivery and development. Furthermore, the review of the literature would also be further contributing to research in the field that has assessed qualitative outcomes for the effectiveness of in-patient services (Melvin et al., 2022). The search terms used related to the construct areas identified (Table 2) relating to IDD diagnosis, secure services, and service users' experiences. To combine the terms the Boolean operator "AND" was utilised.

Table 2: Search terms for systematic search

Key constructs			**Limits**
Secure settings	Intellectual/developmental disorders	Experiences	English language
inpatient setting* OR inpatient service* OR “AND” secure setting* OR secure service* OR secure hospital*	intellectual disab* OR learning disab* OR retard* OR “AND” development* disab* OR autis* OR ASD OR autism spectrum disorder* OR development* disorder* OR mental impairment OR mental handicap	experience* OR thought* OR view* OR report* OR perception* OR account*	Human studies

Systematic search

The inclusion and exclusion criteria were kept moderately broad, to provide a more comprehensive overview of the literature, for example considering variations in settings (e.g., forensic and non-forensic services), geographical location (UK and internationally), and publication year, given the limited number of studies on this topic, as noted in the introduction (Lake et al., 2014). Cross-national contextual differences in policy and social infrastructure likely influenced available studies for inclusion, particularly for those focused on qualitative research with individuals with IDD. The inclusion criteria included qualitative studies exploring the views, experiences, and/or accounts of secure settings by adult service users (male and female) who are or were under a secure service for IDD. Secure service was defined as inpatient services under private or public healthcare, including long-stay hospitals and forensic services, that provided support for adults with IDD. A diagnosis or a borderline diagnosis of IDD was used to determine inclusion. Included services were limited to adult services only, as the experiences of children in care settings are likely both qualitatively and quantitatively different from adult experiences, which may lead to bias during the analysis. Of note, particularly in the UK, adult services for individuals with IDD may start at the age of 16, although this varies based on specificity of service and location (NHS, 2024). As such, studies exploring the experiences of individuals with IDD aged 16 and above will be included in the meta-ethnography. Included studies were required to have quotes from service users regarding their experiences of the service and/or facets of the service, such as the activities provided or their relationships with staff. Restrictions were applied to study design. Further details of the inclusion and exclusion criteria are presented in Table 3.

Table 3: Inclusion and exclusion criteria

Inclusion	Exclusion	Justification
Qualitative studies and Mixed-design studies measuring the experiences of service users in secure settings, including case-control studies, cohort studies, and cross-sectional studies.	Quantitative, literature reviews, meta-analysis, protocols, clinical guidance.	Studies were required to be qualitative in design to explore the views of service users. Mixed-design studies with relevant aims were also included.
Adult services, including aged 16 and above		The experiences of children may be qualitatively different from that of adults, which may add further meaning and the possibility of bias.
English	Other languages that do not have translations	Including other languages requires the need for translation and interpreters. This adds further meaning to the interpretations derived which would inadvertently impact upon the analysis of the data (Van Nes et al., 2010).
Any country		Limitations on country were not set in order to more broadly address the gap in the literature.
Participants with borderline/ mild/moderate/severe diagnosis of intellectual disability, and/or IQ<70, and/or developmental disorders such as autism spectrum disorder Participants are under or have accessed IDD secure services Participants with a dual diagnosis	Participants with queried IDD Community services, short-stay wards (72-hour admission), day-centres	To adhere as closely as possible to the aims of the research, participants with queried IDD were not included, as it may be too broad for meaningful interpretability and analysis. An exclusion for dual diagnosis was not set as it was considered important to hear the voices of those under secure services irrespective of a dual diagnosis

Search results

Search results are illustrated in Figure 1. The database search yielded 378 records, including 14 grey literature records. This resulted in 257 records after the elimination of duplicates. Title and abstracts of studies were screened against the inclusion and exclusion criteria. Common exclusion for studies at this stage included study design not meeting the inclusion criteria. Twenty-one articles were screened against the inclusion criteria, of these, 11 met the criteria.

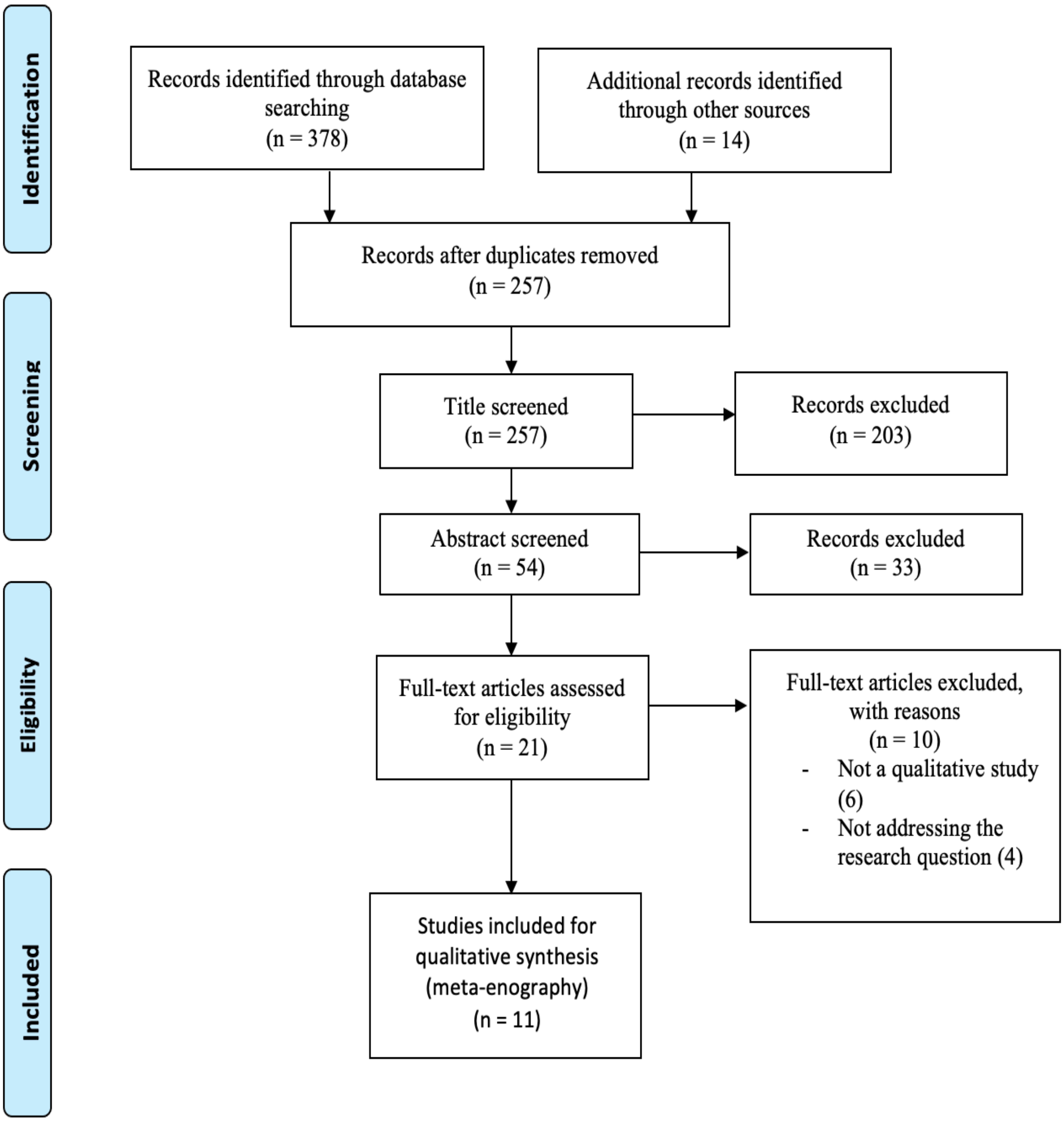

Figure 1: Prisma flowchart detailing the systematic search for articles to be included in the meta-ethnography.

Extraction of studies characteristics

Data extraction was completed by the author. Data relating to participant demographics, analytic tools, as well as researchers’ position was extracted from relevant full text articles for the purpose of the analysis. Eleven studies were included in the meta-ethnography. The individual views and experiences of secure settings was documented for at least 113 participants, the retrospective case-series study by Beckham and colleagues (2020) did not clarify how many participants were included in their study so it is not possible to provide an exact number. Descriptive study characteristics are illustrated in Appendix A.

Participants were selected from a range of secure settings, including medium-low secure forensic units and psychiatric units. For some studies, levels of intellectual functioning were determined using the Wechsler Adult Intelligence Scale (WAIS), one study utilised the ICD-10, however most studies provided poor reporting on the measure used to determine diagnosis of IDD or assessing level of intellectual functioning. All participants were described as falling within the borderline to moderate range of intellectual functioning. The combined articles provided an exploration of various facets that make up the experience of secure settings, including the transition to a secure setting, environmental characteristics, staff support, and living with other residents, presenting a robust account of the general views of service users in secure settings.

Participant ages ranged approximately between 17-56, though some studies did not specify participant ages. The majority of the studies (9) were conducted in the United Kingdom (UK), one study in the Netherlands, and another from the United States of America (USA). It is unsurprising that the majority of the studies originated from the UK, given the significant policy developments and the emergence of a strong service user movement (Department of Health, 2015; NHS England, 2015), both of which have contributed to the establishment of robust frameworks aimed at improving the lives of people with IDD and the conditions within secure settings. Only five studies detailed the ethnicity of participants. Of these studies, most participants were White British, others were from a range of ethnic backgrounds including

Asian British, Black British, and White Irish. The majority of participants identified as male (73.5%).

Quality appraisal

The Critical Appraisal Skills Programme (CASP) checklist is a 10-item checklist, which was used in the present study to measure the quality and validity of included studies and assess for risk of bias (CASP, 2024; Appendix B). Table 4 illustrates the quality appraisal table. The quality rating of papers was checked against inter-rater reliability for 20% of papers. Inter-rater reliability was measured with Cohen's Kappa (Sim & Wright, 2005). Values between ≤ 0-0.20 indicate no agreement, 0.21-0.40 as fair agreement, 0.41-060 as moderate agreement, 0.61-0.80 as substantial agreement, and 0.81-1.00 as perfect agreement (Sim & Wright, 2005). The inter-rater reliability value between the author and an independent researcher was 0.73, suggesting strong inter-rater reliability. The checklist was reflected through colour-coding: criteria met was highlighted as green; unclear if criteria was met was highlighted as yellow; criteria was not met was highlighted as red. A low number of met criteria would suggest greater risk of bias.

Overall, it appears that there was a mixed level of risk of bias in the studies. Most of the studies partly met most of the CASP checklist criteria, with only one study meeting the criteria in full. Identified strengths from the studies included a clear presentation of aims, evidence of ethical considerations, and rigorous analysis of data. Criteria that were variably met by studies included appropriateness of recruitment strategy and clarity of the data collection, with an ambiguous reporting of this presented by studies. Most studies did not clearly define the relationship between the researcher and participants nor consider its impact; this may have made it difficult to ascertain the researchers' positioning and in turn increased the risk of bias in this area. Two studies presented with a moderate risk of bias, with a few criteria that were either not met or unclear if met (Hudson et al., 2017; Wood et al., 2008). The studies by Murphy and Mullens (2017) and Beckham and colleagues (2020) scored the lowest ratings. Due to the limited number of studies researching this topic, these studies were not excluded from the meta-ethnography but were interpreted with caution due to the lower quality rating and higher risk of bias.

Table 4: CASP Quality Appraisal Rating

Research Paper and Author	Was there a clear statement of the aims of the research?	Is a qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
Williams et al., 2018.	🟩	🟩	🟩	🟩	🟩	🟨	🟩	🟩	🟩	🟩
Hudson et al., 2017.	🟨	🟥	🟨	🟩	🟩	🟥	🟩	🟩	🟨	🟩
Parkes et al., 2014.	🟩	🟩	🟩	🟨	🟩	🟥	🟩	🟩	🟩	🟩
Clarkson et al., 2009.	🟩	🟩	🟩	🟨	🟨	🟩	🟩	🟩	🟩	🟩
Heppell and Rose, 2021.	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩	🟩
Wood et al., 2008.	🟩	🟩	🟩	🟨	🟨	🟥	🟩	🟨	🟥	🟩
Chinn et al., 2011.	🟩	🟩	🟩	🟩	🟩	🟥	🟩	🟩	🟩	🟩
Neimeijer et al., 2021.	🟩	🟩	🟩	🟨	🟩	🟨	🟩	🟩	🟩	🟩
Beckham et al., 2020.	🟨	🟩	🟨	🟨	🟨	🟥	🟥	🟩	🟥	🟩
Murphy and Mullens, 2017.	🟩	🟥	🟥	🟨	🟨	🟥	🟩	🟥	🟩	🟩
Murphy et al., 1996	🟩	🟥	🟨	🟩	🟩	🟥	🟩	🟥	🟩	🟩

Green = Criteria was met; Yellow = Unclear if criteria was met; Red = criteria not met

Data analysis

Stage Three

Stage Three involved becoming familiar with the content and themes of the included studies and extracting raw data (Noblit & Hare, 1988; Sattar et al., 2021). This stage was conducted throughout the synthesis process wherein included studies were read repeatedly. The extraction of raw data involved extracting first-order (quotes from participants) and second-order data (the authors' interpretations of participant quotes) (Appendix C). This was extracted unto a spreadsheet. The data was extracted as verbatim, to ensure important data was not lost and that the terminology used was preserved. This aided with accurately examining the similarity between studies. The information extract on each study's characteristics provided context that was useful for the interpretation of first-order and second-order data.

Stage Four

This stage involved exploring whether there was a relationship between the concepts and themes across each study. Common or reoccurring concepts across studies were highlighted and a list of themes was created. Once the list was created, reoccurring concepts were grouped into categories, and a relevant underlying theme or metaphor was created. Reviewing the aim and setting of each study informed the creation of underlying themes. The categories were reviewed and revised through discussions with the supervisor of the project and an external review group.

Stage Five

Stage Five involved the comparison of concepts and themes from one study to that of other studies with shared themes. This was done for each concept across studies, providing a commentary of similarities and differences in interpretations, with respective additions from each study. This synthesis aided the development of the third-order constructs in Stage Six.

Further to this, stage Five involved ranking each study according to their quality appraisal scores, providing a weighting of each study (Table 5). With this ranking, the impact level a paper carried on the overall analysis was presented. The ranking of studies helped to reduce potential bias in the final analysis. For example, if a concept or interpretation was present only in lower-ranked (i.e. lower quality) studies, its inclusion was carefully considered due to the risk of bias. This approach was guided by the understanding that higher quality studies offer greater transparency and reliability in their insights and interpretations, which may not be the case with studies of lower quality.

Table 5: Weighting of papers according to CASP quality rating

Heppell and Rose, 2021	10	0	0
Williams et al., 2018	9	1	0
Chinn et al., 2011.	9	0	1
Clarkson et al., 2009	8	2	0
Neimeijer et al., 2021.	8	2	0
Parkes et al., 2014	8	1	1
Murphy et al., 1996	6	1	3
Hudson et al., 2017	5	3	2
Wood et al. 2008	5	3	2
Murphy and Mullens, 2017	4	2	4
Beckham et al., 2020	3	4	3

Green = Criteria was met; Yellow = Unclear if criteria was met; Red = criteria not met

Stage Six

The shared concepts defined in Stage Five noted both similarities and differences in experience and views. The grouping and commentary on the concepts led to the development of the third-order concepts, which is the present author's interpretation and understanding of the phenomena, in this case experiences of secure services, drawn from the first and second-order data. These interpretations were discussed with the research supervisor to allow for revision and redefinition of themes and subthemes.

Results

Four primary themes were developed, each with subthemes/concepts. Table 6 displays the themes: 1) Sense of self; 2) Where is my power?; 3) Navigating social relations; and 4) Necessary evil.

Theme One: Sense of self

The first primary theme presented narratives on perceptions of self within secure settings and how this was shaped. Reoccurring concepts were contrasting narratives on the experience of belonging, identity and depersonalisation, as well as skillset development and personal growth. Various studies of higher quality contributed to this theme, highlighting greater robustness and credibility to the insights presented.

Where do I belong?

Many participants reflected on their sense of belonging since admission to a secure service. Service users reflected that transition to a service often does not lead to experiencing their new environment as 'home', as services are often seen as solely a place to live in. Participants interviewed by Williams and colleagues (2018) carefully defined the concept of 'home', indirectly depicting how distantly they view secure services from their perception of home, *"it's a home when you comfortable, and you happy cos you have your own personal stuff…"*. The quote also alludes to service users' use of personalisation in their immediate environment to foster familiarity and contribute to developing an emotional attachment, evoking a sense of belonging.

Table 6: Theme synthesis, third-order construct

Primary Theme	Subtheme/Concepts	Studies contributing to the theme
Sense of self	*Where do I belong?* *Identity and depersonalisation* *Personal growth*	Heppell and Rose, 2021; Williams et al., 2018; Chinn et al., 2011; Neimeijer et al., 2021; Parkes et al., 2014; Hudson et al., 2017; Wood et al., 2008; Beckham et al., 2020
Where is my power?	*Seeking autonomy* *Lack of control*	Heppell and Rose, 2021; Williams et al., 2018; Chinn et al., 2011; Neimeijer et al., 2021; Murphy et al., 1996; Wood et al., 2008; Murphy and Mullens, 2017; Beckham et al., 2020
Navigating social relations	*How staff shape experiences* *Living with other residents* *What about my friends and family?*	Heppell and Rose, 2021; Williams et al., 2018; Chinn et al., 2011; Clarkson et al., 2009; Neimeijer et al., 2021; Murphy et al., 1996; Hudson et al., 2017; Wood et al., 2008; Murphy and Mullens, 2017; Beckham et al., 2020
Necessary Evil	*Unpleasant yet needed*	Williams et al., 2018; Neimeijer et al., 2021; Murphy et al., 1996; Murphy and Mullens, 2017; Wood et al., 2008

Service users admitted to in-patient services far from their home and their community, reported experiencing a reduced sense of belonging:

> At home there they speak in my language, and it's easier to speak in my language but I haven't spoken my language for a long time now… I used to speak Bengali loads of times when I was in London but I don't do that now because nobody speaks it here (Chinn et al., 2011).

The picture painted by this quote is an experience of a slow but yet noticeable stripping of cultural identity contrasted by a longing for it. For some service users, their loss of cultural identity and belonging may be perceived as a permanent change, due to long-stay placement or difficulties with gaining leave. This could contribute to possible long-term effects such as an enduring lack of belonging, often associated with behavioural difficulties as well as physical and mental health problems (Allen et al., 2021).

However, some reports by service users highlighted that being part of a group or engaging in a meaningful activity presented the opportunity to experience belonging (Hudson et al., 2017; Neimeijer et al., 2021). Participants identified being part of their therapeutic 'group' as a place where they found support and sociability (Neimeijer et al., 2021). Community football fostered companionship and togetherness amongst service users and staff members, as they shared a purpose and goal: "*I enjoy the footie, I enjoy meeting the patients, having a laugh and a joke*"; "*it's part of me. It's part of what I owe – I owe it to the coaches and team – no skiving off. I owe it to them to be there to help in tournaments"* (Hudson et al., 2017). Participation in a valued activity appears key in developing integration and inclusion amongst service users, which can foster belonging to a team and purpose. Interestingly, activities that could foster belonging are not required to be elaborate nor expensive in nature, as highlighted by Beckham and colleagues (2020). The authors recognised that group celebrations of birthdays and holidays, mimicked family gatherings, which evoked belonging even when far from home (Beckman et al., 2022). It may also be that this highlighted a sense of 'mattering', the experience of feeling significant and valued by others (Flett, 2021).

Identity and depersonalisation

Service users reflected on aspects they missed about their life in the community and that these were forcefully taken away from them despite being important parts of who they were, *"I used to go into Derby town centre with my mum's old school friend. But I miss all that since I'm here (hospital)"* (Williams et al., 2018). The quote from the participant indicated a loss of a cherished routine which contributed to their sense of identity. The description of this loss hinted that their identity and sense of self may be impoverished following admission to in-patient units.

Narratives on depersonalisation painted a perceived lack of recognition for individual characteristics and an uncomfortable experience of homogeneity (Chinn et al., 2011; Williams et al., 2018). The organisation of schedules and routines on a group basis left service users with little chance for personal autonomy (Chinn et al., 2011) and exercising individual preferences, such as adding personal touches to their routine, *"I want to have my own place, have my own support, be my own person… have my own place again"* (Williams et al., 2018). The emphasis on 'own' in this quote strongly highlights a yearning for their individualisation and a recognition of identity. Interestingly, the difficult balance between requiring group activities to experience belonging and wanting to be addressed as individuals was noted by service users. Service users emphasised wanting to be recognised as individuals within the group setting. This notes a need for individualisation and a protest against excessive uniformity, suggesting the requirement for an essential balance between provision of meaningful activities to foster belonging and supporting individual preferences to foster identity.

The paper by Hudson and colleagues (2017), illustrated this balance through community football. The authors highlighted that engagement in community football helped participants to develop of a new identity they were proud of, a sporting identity shared with others, which helped improve their self-esteem and experience belonging, *"I am a totally different person when I play football than when I am in here"* (Hudson et al., 2017). They noted that the characteristics of secure settings would undoubtedly impact service users' sense of self, but alternative identities can be encouraged through meaningful group activities. This was similarly supported in the findings by Beckham and colleagues (2020) who found that taking part of writing a newsletter led to a new proud identity, *"I'm a reporter! I wrote an article!"*.

Personal growth

Some service users reported on developing skills whilst in secure services, which contributed to their sense of self. Narratives on personal growth ranged from experiencing greater ability to manage mood and behaviour (Heppell & Rose, 2021; Wood et al., 2008), to everyday successes, such as preparing meals or receiving certificates after completing therapeutic courses (Neimeijer et al., 2021). Furthermore, the time spent engaging in meaningful activities helped service users develop a sense of purpose and independence skills that kept them busy (Beckman et al., 2022; Hudson et al., 2017),*"I just work work work because it gives me something to do, it keeps me active"* (Chinn et al., 2011).

Service users seemed to value the interpersonal developments they made. It provided them a goal to look forward to and improved their skillset. This is important when considering long-term goals, such as discharge back in the community, and whether service users can engage with the demands of community living.

Theme Two: Where is my power?

The second primary theme highlighted service users' desires for autonomy, greater control over decision making, and their perceived lack of opportunities to be independent. Notably, it was highlighted that gaining a greater sense of autonomy was closely related to developing a stronger sense of identity. Both high- and low-quality studies contributed to this theme, suggesting a shared meaning across the literature that enhances the transparency and rigour of the findings.

Seeking autonomy

Often, many service users transitioned from living at home with parents to an in-patient unit, with little to no experience of living independently or with staff support in the community. In the study by Heppell and Rose (2021), a service user (aged 27) commented on being in secure services for 11 years and reflected on his worries of going on unescorted leave.

> Interviewer: "do you mean you're a little worried about going out by yourself?"
>
> *Participant: "yeah. Because I haven't been had unescorted for… I've never had unescorted for rest of my life"* (Heppell & Rose, 2021)

Despite the noted worries, the service user shared his desire to live in the community and have independence, which he did not experience in the in-patient unit. Other service users expressed a similar sentiment, noting that they do not get to exercise autonomy and independence in secure settings, which ultimately reduces their confidence of being discharged to the community. This may suggest that the restrictions placed in secure services may delay or impede successful discharge to community, despite a push by stakeholders for greater community living.

Many service users described themselves as capable of independence and wanting to be seen as independent *"… I like my own space. I like to be independent"* (Williams et al., 2018) but reflected that they may never experience independence due to organisational restrictions. Service users expressed *"you don't get freedom… I wish I could leave here" "I don't want to be in hospital. Because you ain't got your freedom, like, when you're out there you've got your freedom"* (Williams et al., 2018). This perhaps describes a captive-like experience for service users, where the community is the desired treasure representing freedom and autonomy, whereas services represent restrictions that may be interpreted as punitive. Service users felt that their 'real life' and independence had been taken away from them due to restrictions, emphasising the stressful experience of having their privacy and life invaded (Murphy & Mullens, 2017). Restrictions were perceived as punishments, and service users reflected on feeling on edge, *"seclusion for negative behaviour or comments being over the top and makes me careful about what I can say"* (Murphy & Mullens, 2017). This paints a metaphorical picture of "a muzzle" over their mouth, where service users have to hold back from expressing themselves, further highlighting restrictions on their autonomy and expressions of self. An interesting notion raised was that autonomy in secure services may be unattainable as greater freedom is solely afforded because of rule adherence, irrespective of agreement with the rules, and when the rules are broken the freedom is taken away. Participants commented on receiving "rewards for good behaviour", such as leave to hospital grounds or family visits, but these benefits were not readily given (Beckman et al., 2022).

Service users felt that a balance needs to be struck. Staff need to recognise when service users should be given the chance to practice autonomy, *"I don't like that* (when sociotherapists are strict). *That way you will never become independent"*, but staff also need to provide a containing and secure environment to keep service users safe *"the sociotherapists should have protected me by not letting me go on my own. But they left me on my own… I was constantly taking drugs and I was constantly using again"* (Neimeijer et al., 2021). Service users hint to the notion of containment over control, to increase autonomy and maintain safety. Though service users recognised that in the community they would still require support, they expressed their desire to be allowed to be as independent as they possible *"having your own space means you can do what you want to do… it means you can go in and out"* (Williams et al, 2018).

Lack of control

Frustration was noticeable in narratives regarding organisational restrictions, leading to a lack of control and powerlessness. Service users felt they lack control over their life as they had little say on their care and their transitions to secure settings, *"… that's going to be scary because you don't know where you're going to live. Because they can put you anywhere can't they?"* (Williams et al., 2018). A real sense of fear is noticed in this narrative, the perception of powerlessness makes the experience of the future daunting.

During transition to secure settings, service users felt that they were left in the dark and had no say in the decision made, *"we don't have a choice about being here. How would anybody feel about someone coming into your home and telling you what to do"* (Parkes et al., 2015). This speaks to a forceful experience in a new environment with restrictions on their autonomy and freedom, and service users becoming passive receivers of care. Restrictions were particularly experienced as anxiety inducing when rules constantly changed, such as smoking policy (Parkes et al., 2015) or access to the kitchen (Murphy & Mullens, 2017). Service users highlighted the frustrations of following inconsistent rules with great uncertainty, which if broken resulted in punitive actions (Murphy & Mullens, 2017). In Murphy and colleagues' (1996) study, service users highlighted lack of freedom as what they disliked about the service, "*locked doors and I suppose the lack of freedom*".

The perceived lack of control ranged from everyday decisions to decisions about care. Service users attested to not having control over their daily diet, managing their money and possessions, nor feeling that their opinions are regarded in multidisciplinary team (MDT) meetings: *"no one's been listening to my opinion at the moment. As far as I'm concerned, it's been going out of one ear and the other"* (Chinn et al., 2011)*; "it says [participant's name] not [staff name] and they should not be able to touch that money", "I have little say [in MDT meetings] but I have to go before I've finished what I was saying"* (Wood et al., 2008). Service users depict a picture of muted voices, stripped away of autonomy and control. A frustration is gathered from these quotes, perhaps participants experience restrictions as a form of provocation, further aggravating their experience in services. It is key to recognise this as it may attest to how service users experience their needs being met. It also suggests a need for the development of a clear process to promote the autonomy of service users over time.

Interestingly, service users aimed to regain control by exercising their choice over their immediate environment, such as the activities they could partake in and decorating their room (Chinn et al., 2011). This provides scope for services to find other ways in which service users can exercise their decision making.

Theme Three: Navigating social relations

The third primary theme highlighted how service users navigated social relations in secure settings and raised questions of how their social needs were met. Subthemes included service users' experiences in relating with staff, the contrasting benefits and difficulties of relating with other residents, and their views on their external social relationships, including friends and family. Almost all studies contributed to the present theme, which suggests a higher level of trustworthiness in the data.

How staff shape experiences

Accounts of both negative and positive experiences with staff members were reported, providing contrasting experiences. An important factor that helped to shape a positive experience was feeling "seen" as more than just a patient, "*they treat you like a human being. They don't treat you like a patient. They talk to you like a human being [...] And other placements I been to, it's we're staff, you're patient.*" (Heppell & Rose, 2021). Service users expressed that if staff were to get to know them as a person, rather than patient, staff members would be better equipped to interpret and understand their symptoms and function of behaviour correctly (Neimeijer et al., 2021). Staff should take the initiative for contact, show interest and be patient, and most importantly not judge (Neimeijer et al., 2021).

Service users spoke warmly of staff members when they felt understood, *"if you look at it positively, you have more people around you, more people that understand you a bit better"* (Hudson et al., 2017). It was clear that participants felt that this made a positive impact in their life, their relationship with staff members held meaning and they felt valued, further highlighting a sense of mattering to others (Flett, 2021). Various accounts of valued attributes in staff members were shared, such as humour and helpfulness. *"They are patient with you and* *that, they are there to understand you when you have got things on your mind, and you can talk to them about it"*, *"even though they are just doing their job [staff] you can have a laugh, you can still have a laugh, you can have a joke."* (Clarkson et al., 2009; Wood et al., 2008).

Participants that experienced a trusting and understanding relationship with staff, described feeling protected by staff and desired to reciprocate this:

> It is normally the case that I help staff if they are in trouble. Because I have a lot of time for them. Because they have done a lot for me and if I can stop them getting hurt then I will do (Clarkson et al., 2009).

The mutual protection identified suggests a reciprocal need for one another. Intriguingly, a question around boundaries may be raised for service users reporting positive relationships with staff. A few service users described viewing staff as friends *"he's my closest friend, my best friend, special friend, more than a friend"* (Murphy et al., 1996) or in a parental role, "*he [staff member] is not just like a friend to me, he is like a father to me. Because he has been there for me. And honest truth, I look at him like my father"* (Clarkson et al., 2009)*; "he is like a dad to me yeah"* (Hudson et al., 2017). Understandably, for many service users, the relationship with staff members may be one of their only consistent social relationships, however, this may make boundary setting problematic for some service users, especially as the relationship is designed to be short-term.

Service users equated the rapport they had with staff to be indicative of the quality of care they would receive, with those who reported poor rapport with staff, informing of negative experiences of care. Service users who described feeling misunderstood - *"the cocky ones and that, the ones that don't understand you"*, not listened to - *"well I had a pain once and they* *said I was putting it on… they called me a hypochondriac"*, and mistrusting of staff members - "*I wouldn't tell them… cos I know they wouldn't keep everything confidential"*, some spoke of negative interactions with staff members, which were associated with greater distress and difficulties with managing their emotions and behaviours (Chinn et al., 2011; Clarkson et al., 2009). Service users reported being demeaned by staff, treated unfairly, intimidated, and called names, such as "idiot" and "nutcase". They described feeling treated *"worse than a dog"*, indicating that they perceived that staff may see them as less than human (Chinn et al., 2011). This is important as it indicates that some behaviours that challenge displayed by service users may be due to unsympathetic and threatening experiences with staff members, which may adversely influence their sense of self and internalised stigma.

Living with other residents

Similarly to reflections on their engagement with staff, there were reports on both the positive and negative experiences of living and engaging with other residents. However, there were fewer reports on positive experiences of living with other residents.

A service user commented on the meaningful aspect of being in a group and the shared trust gained, *"It is positive that we are one group and that we trust each other"* (Neimeijer et al., 2021). "One group" presents the view of uniformity between service users, in which they might rely on each other for social needs. In Hudson and colleagues (2017) paper, service users mentioned that football as a regular activity led to friendships and service users spoke fondly of other residents, *"I enjoy footie, I enjoy meeting the patients, having a laugh and a joke"* (Hudson et al., 2017). The positive group dynamic may support service users to meet their social needs and develop interpersonal skills that may help them in their journey in the community.

Nonetheless, a majority of service users reported disliking their experience of living with other residents. Service users highlighted difficulties with being grouped with people with different needs, different ages, and different personalities, which often led to arguments and fall outs amongst residents (Williams et al., 2018). Furthermore, managing the differences in need and complexity was described as tiring and anxiety inducing, as service users became hypervigilant of potential dangers from other residents' (Neimeijer et al., 2021). Service users expressed a need to 'get away', *"I'd rather have my family any day than these [patients]"* (Williams et al., 2018), suggesting a discomfort with living and interacting with other residents. This infers a sense of feeling 'trapped'. Service users are placed in a service, sometimes indefinitely, with individuals they may be unlikely to develop a rapport with. This was echoed in other studies, such as by Murphy and Mullens (2017) who noted that service users felt isolated, with no friends, and expressed a desire for contact with others that they could relate to. This is important as the appropriateness of setting is not solely based on diagnostic need but encompasses other key factors, such as social rapport.

The behaviour of others infringes upon the autonomy experienced by service users, for example, restriction in movements at certain times are introduced due to difficulties with managing the behaviour of some residents (Neimeijer et al., 2021) as well as meaningful and cherished activities being taken away, *"I was disappointed in all of us patients for blowing roller-skating. Some people were horseplaying."* (Beckman et al., 2022). This denotes that power and control is not only taken away from service users by organisational restrictions and staff members, but also by other residents' actions.

Based on the aforementioned reports, a key aspect of care in secure settings appears to be the people within it. For many service users, navigating social relationships may be difficult due to their diagnosis and symptoms, however there are aspects of living in secure settings that seem to worsen their ability to navigate socially effectively. This may present concerns for how the social needs of this population are met.

What about my friends and family?

Service users noted that the reduced proximity to family and friends, because of admission to secure settings, negatively impacted on their contact with them. Participants shared their concerns on how the distance would negatively impact their contact with their family, "*I said I don't want to go there because it is far from home"* (Parkes et al., 2015). Their concerns indicate they may feel that their contact with their community is not being considered during the transition/admission process despite their desire to maintain a connection with their home community, with a hope to one day return home. Similar reports were noted in other studies, in which participants felt stripped of their contact with family due to the far distance of their secure service, *"cause I don't see them, my family don't come and see me here. They can't come and see me in Unit X it's too far"* (Chinn et al., 2011). Participants described feeling *"A bit upset, inside, hurt inside, hurt inside, heart, heartbroken inside"* (Chinn et al., 2011) because they were unable to see their family due to being placed far from home. The language used denotes an interpretation of their placement as punitive. The difficulties with maintaining contact with 'home' are important to pay notice to as service users mostly described feeling isolated and without friends within services, posing the question of how their social needs would be met if they experience undesirable social contact with other residents and no contact with their community.

Contrarily, some service users do not want to live close to home. In Heppell and Rose's study (2021), service users described desiring to be far from home due to their hometown and family being associated with negative memories and a fear that due to their offending histories, they may be targeted, *"because of what I do in the past, I might end up… you know. People might know me or might do me in or something"* (Heppell & Rose, 2021). Balancing support in a way that meets everyone's needs is notably difficult, however these narratives ought to be considered when designing services.

Theme Four: Necessary evil

The final primary theme referred to service users' views of secure settings being necessary yet undesirable. Fewer studies contributed to this theme, and several were of lower quality. While the potential for bias was acknowledged during the development of this theme, the concept that emerged was considered to offer meaningful insight and was therefore deemed important to report. Caution should be exercised when interpreting this theme due to the possible influence of methodological limitations.

Unpleasant yet needed

Though many service users wished they did not live in an in-patient unit, some residents acknowledged the necessity of these settings. Service users recognised that the hospital environment may be unpleasant, yet it was needed for their development, *"it isn't the ideal place to live but on the other hand, I've got the help I've always wanted"* (Williams et al., 2018), *"although there are strict rules, I feel less anxious here"* (Murphy & Mullens, 2017). Service users who felt their behaviour was 'out of their control', welcomed the assistance provided by services, even though it equated to admission (Murphy et al., 1996). Service users recognised that the hospital environment may help to meet their complex needs, such as helping them understand their difficulties, but highlighted the frustrations of needing to be exposed to an unpleasant environment to have their needs met and develop the necessary skills to live independently (Neimeijer et al., 2021). Further conflicts related to their experience of treatment, such as viewing admission as *"punishment"*, but regarding some treatment as helpful *"sessions about drugs, alcohol, anger management; they've all helped"* (Wood et al., 2008). A scope for services may be to improve the overall service experience, so more service users may experience the benefits of being in these settings.

Discussion

The aim of this review was to synthesise the lived experiences of individuals with IDD living in secure services. To the author's knowledge, this is the first meta-ethnography of its kind. Overall, eleven studies were synthesised which produced four primary themes: 1) Sense of self, 2) Where is my power?, 3) Navigating social relations, and 4) Necessary evil. The findings suggest a range of homogenous experiences across service users, with recurring narratives which share the difficulties of belonging, the stripping of identity and culture, an unfailing sense of powerlessness, and the recognition of the unpleasant yet needed nature of secure services. Navigating social relationships was often challenging for service users, with contrasting reports on their experiences with staff, which included considerations for boundaries, difficulties with living with other residents, and a lack of contact with their home community.

The present meta-ethnography makes a significant contribution to the field of intellectual and developmental disabilities by synthesising and amplifying the first-person accounts of individuals with IDD from a range of qualitative studies. It offers valuable insights into how individuals with IDD experience identity, autonomy, belonging, and social connection. By focusing on the lived experiences of service users, the study aligns with the broader shift towards more inclusive and participatory research approaches (Veldmeijer et al., 2022). Importantly, this work helps to bridge the gap between service design and lived experience, where service provision may be misaligned with the needs and perspectives of users. For instance, the meta-ethnography emphasised the importance of meaningful activity. Across diverse settings, geographical contexts, and population groups, the synthesis highlighted the mitigating effect of engagement in meaningful activities, particularly in countering the loss of identity and belonging often associated with institutionalisation, both of which are known to have detrimental psychological effects (Potterton et al., 2022).

These findings stress the necessity of embedding meaningful engagement within care environments as a core component of therapeutic practice. The insights derived from this synthesis have clear implications for policy and service development, particularly in efforts to reduce institutional harm and promote more responsive, community-integrated models of care. The narratives of service users point to a desire for more personalised environments and greater opportunities to develop life skills. This suggests the potential value of redesigning secure services to include self-contained flats that provide the necessary security while minimising interpersonal conflict and supporting reintegration into the community. Such an approach could better meet the complex needs of service users while aligning service structures with their lived realities.

Convergence with the literature

Sense of self

The results of the review reported various narratives describing difficulties with experiencing a sense of belonging within secure services (Chinn et al., 2011; Williams et al., 2018). This raises questions regarding the possible consequences that a lack of belonging may cause to service users, especially for those experiencing a long-term stay in services. Belonging fosters safety and support, and it is found to be a key component for managing distress and behavioural difficulties (Allen et al., 2021). A persistent lack of belonging is associated with increased behavioural, mental, and physical health risks and difficulties (Allen et al., 2021). A possible way to mitigate this is through participation in community activities. In a recent study, individuals with intellectual disabilities defined belonging as spending time with friends and family, taking part in community activities, and having opportunities to connect with people (Kaley et al., 2021).

Notably, the narratives shared also highlighted the possible experience of a sense of mattering amongst participants. Though, in the literature ‘mattering’ is a relatively neglected core component of the concept of ‘self’, it is an important protective factor crucial for well-being, of which absence can be deleterious (Flett, 2021). The notable reports from participants hinting towards a sense of mattering, suggest that this psychological construct can be fostered in secure settings, providing residents with higher self-esteem. Furthermore, the current review found that being part of a group/activity, such as community football, led service users to experience belonging (Hudson et al., 2017; Neimeijer et al., 2021). This means that active participation in meaningful activities within services is a core element for establishing connections and promoting well-being (Haim-Litevsky et al., 2023; Tournier et al., 2022). The findings from this review provide evidence for the current inspection regime by the Care Quality Commission (CQC; Care Quality Commission, 2015). A core element of CQC inspections is the promotion of regulated activity in secure settings, including seeking and acting upon service users’ feedback on the experience of these activities (Care Quality Commission, 2015).

Queries around identity, including depersonalisation, were identified in the review, as service users alluded to feeling like less of their own person whilst in secure settings. They described the need for ‘ownness’, such as a recognition of their individual needs, personal characteristics, and personalisation of their environment (Neimeijer et al., 2021; Williams et al., 2018). The geographical distance of the service from their home community also contributed to depersonalisation and was experienced as a stripping of their religious and cultural identity (Chinn et al., 2011). Interestingly, the loss of identity may be met with the development of a new identity, which may often not be positive. Previous literature found that service users recognised a change in how they thought of themselves within hospital (as a ’bad’ person) compared to after discharge (Head et al., 2018). It notes that admission to a secure service may cause an experience of a new ‘undesirable’ self. However, engagement in meaningful activities, such as writing a newsletter, promoted the development of an alternative identity that service users held proudly (Beckman et al., 2022; Hudson et al., 2017). The introduction of meaningful activities may not prevent a ‘loss’ of identity but could counter the development of a negative sense of self.

Though difficulties with belonging and identity were noted, there were many narratives reporting on the development of skills, purpose, and personal growth as a result of living in a secure service (Chinn et al., 2011; Hudson,et al., 2017; Neimeijer et al., 2021). The upskilling of service users supported their social development and encouraged interactions with others, further nurturing a stable sense of self.

Where is my power?

Lack of autonomy and independence were raised throughout patient narratives. Despite service users describing themselves as capable of independence and wanting greater independence, the lack of control experienced over decision making, the many organisational restrictions, and their opinions not being considered, resulted in autonomy being perceived as an impossibility (Heppell & Rose, 2021; Murphy & Mullens, 2017; Neimeijer et al., 2021; Parkes et al., 2015; Williams et al., 2018; Wood et al., 2008). Their powerless and voiceless experience painted an anxiety-inducing picture of being trapped in service, without a way out. However, opportunities to exercise some control, such as decorating their room, were spoken of positively, demonstrating ways in which autonomy can be encouraged. The impact of a lack of power and autonomy is highlighted in other research. Powerlessness is known to threaten one’s identity (Aujoulat et al., 2007) and was viewed as a constant component in the journey through in-patient settings (Boudioni et al., 2015). This is important, as it denotes a consistent cycle of powerlessness and frustration for service users in these settings, that chips away at their identity.

Navigating social relations

Service users indicated that a positive relationship with staff members improved their overall experience of care and views of the service (Chinn et al., 2011). This is in line with the literature, which denotes interactions with attentive and caring staff as a primary driver of service user experience (Adams et al., 2024), with staff recognising that building a trusting relationship supported their ability to meet the needs of service users (D'Sa et al., 2024). ‘Mutual protection’ and wanting to be seen as a ‘person’ were notable narratives shared by service users. Interestingly, service users place their sense of safety with staff, trusting staff to create a comfortable and safe environment (Head et al., 2018). In cases in which this does not occur, service users are left to fend for themselves, feeling unprotected. The need to be ‘seen as a person’ was also echoed in a recent review (Havana et al., 2023), suggesting a desire by service users for their individuality and voices to be recognised and considered. Narratives on negative experiences with staff were defined as greatly distressing and unpleasant, with service users describing staff as untrustworthy, unfriendly and unsympathetic (Clarkson et al., 2009). These narratives resulted from perceiving staff as threatening, bullying, and treating them ‘worse than a dog’ (Chinn et al., 2011).

Notably, positive relationship with staff seem to blur boundary lines for some service users, who regarded staff as ‘friends’ or in a parental role (Beckman et al., 2022; Murphy et al., 1996). Although gaps exist in the literature regarding non-sexual boundary crossing between professionals and service users, a recent study highlighted possible consequences such as stress, burnout, and increased risk for staff, as well as forming a slippery slope for future boundary violations (Lampe et al., 2023). As such, it would suggest that attention needs to be placed on the maintenance of boundaries when developing rapport with service users, for instance providing training for greater professionalisation of the care staff role.

Living with residents of different ages, personalities, and needs was experienced as difficult, with many service users wanting to "get away" due to a discomfort and a lack of safety resulting from violent behaviours from other residents (Beckman et al., 2022; Chinn et al., 2011; Williams et al., 2018). This recurring narrative seems to suggest that service users want professionals to recognise that they too have to learn to cope with the challenging behaviours of other residents. The difficulty with managing other residents, the perceived lack of safety, as well as the reported loneliness and isolation (Murphy & Mullens, 2017), may exasperate service users' needs, bringing an even greater strain on staff and the service (Emerson et al., 2021). A possible practical suggestion to tackle this would be to develop smaller units, to reduce conflict. However, a shared meaningful activity counteracted this, as it fostered purpose and friendship between service users (Hudson et al., 2017). This is in line with reports in the wider literature, shared engagement in activities fostered real connections (Tournier et al., 2022).

Lastly, service users shared contrasting narratives concerning contact with friends and family, with some wishing their service was closer to home and others wanting to be as far as possible from home (Chinn et al., 2011; Heppell & Rose, 2021; Parkes et al., 2015). For those experiencing distance from their family, it begs the question of where they would get their social contact and support from. It appears that for many, their relationship with staff is their sole social contact, which if it were to be negative it would be unfulfilling and not meeting their needs. There is a sense that those with IDD living in secure services are forced into solitude and unfulfilling relationships for the rest of their lives. It is found in the literature that adults with disabilities are at greater risk to experience loneliness and remain lonely over time (Emerson et al., 2021), which is of concern due to the detrimental impacts of loneliness on physical and mental health (Emerson et al., 2023). It would suggest a need for services to intervene and tackle loneliness in services, such as by increasing access to joint activities and meaningful relationships.

Necessary evil

Many service users spoke on the conflict between the hospital being undesirable, yet in some cases their best alternative (Murphy et al., 1996; Murphy & Mullens, 2017; Neimeijer et al., 2021; Williams et al., 2018; Wood et al., 2008). This speaks to a desire for services to find ways to improve the desirability of the service, whilst still maintaining boundaries and restrictions. It would be notably difficult to strike the perfect balance. However, this desire has been echoed various times in research, with patients often describing frustrations that hospitals are not conducive to recovery and present too many barriers to access to the community (Glasby et al., 2024), as such, warranting a change to current systems and processes. It is interesting that service users' narratives speak to the need for secure service and yet contrast the current organisational and policy direction for a move towards community living. It could be that some of the supporting factors experienced in secure settings could be provided in the community, avoiding admission. One cannot be considered without the other, good social care and community health services are necessary in conjunction to prevent costly hospital admissions.

It was noted that fewer studies contributed to the current theme, and the quality of these papers was generally lower compared to those informing other themes. Nevertheless, this theme was included and developed because the concept it represents was considered meaningful. Sharing these participant narratives is important, as they shed light on an alternative perspective of services. However, given the potential for bias within this theme, the findings should be interpreted with caution.

Evaluating the review: Strengths and limitations

Strengths

A strength of this review lies in its explicit focus on the narratives and experiences of individuals with ID in secure settings. This meta-ethnography provides rich descriptions of individual, shared, and contrasting experiences, which may provide guidance for clinical practice. The findings also address and provide robust support for important policy areas, which may influence future service development.

A further strength of the review is the implementation of a thorough research methodology and design. The broad inclusion criteria enabled a wider overview of the literature on this topic. Studies were not excluded based on setting nor service users' intellectual functioning, allowing for the inclusion of views from service users residing in a range of diverse secure services. Lastly, the development and interpretation of themes was reviewed with the research supervisor, to minimise bias and personal influence.

Limitations

A primary limitation of the review is the small number of studies synthesised. Though there is not a recommended minimum number of studies for a meta-synthesis (Finlayson & Dixon, 2008), a suitable number of studies is dependent on the research question and can vary substantially. As the current review aimed to gain greater understanding of service users' views of secure services, a larger number of studies could have provided more robust confidence in how generalisable and transferable the findings are. The limited number of studies found highlights a research need in the topic.

The methodological quality of many of the studies was rated as moderate to low quality. For almost all studies, the epistemological positioning of the authors was either not clarified or mentioned, possibly augmenting undetected influences and biases. There was a lack of detail regarding the recruitment strategy, design methods, and analyses, and it was often difficult to extract information about individual differences among participants, such as ethnic background. There were limited reports on the experience of views of women as well as limited ethnic diversity in samples. A greater number of diverse views may present an increased understanding of the cultural competencies of services. Due to the small number of studies found, all studies that met the inclusion criteria were included irrespective of quality rating. The studies were 'weighted' according to quality rating, though mindful consideration was held to not allow higher 'weighted' studies to skew the analysis by reviewing interpretations and theme formation. Given the inclusion of low-quality studies, the present results should be interpreted with caution. As included studies are a representation of the current literature in this field, it is hoped that this will warrant future research of higher quality.

Implications: clinical, research, theoretical

Important implications can still be drawn from the findings. It is important to note that the majority of the studies were conducted in the UK. As such, these implications may best be generalised to services in the UK, rather than globally.

Clinical and service-wide implications

The present findings contribute to the ongoing push to improve services and ‘transform care’ for individuals with IDD, wherein a reduction of inpatient admission is being sought (Department of Health, 2012, 2015). The themes highlight a lack of belonging and identity impacting sense of self, powerlessness, and difficulties with connectedness and relationships. However, many of these difficulties were lessened when service users engaged in meaningful and cherished activities. These findings present as a useful guide for the continued development and provision of meaningful activities in these services. Service providers should continue to seek the views and interests of service users to provide tailored and appropriate activities that they would engage in (Care Quality Commission, 2015).

A powerful narrative shared by service users is a desire to be seen as a person and not a patient, in turn developing a trusting relationship with staff and their sense of belonging. Service users informed this could be achieved by staff taking the time to get to know them individually. This can understandably be difficult to achieve in services with high staff turnover and/or understaffed. However, simple efforts, such as collaboratively developing individual plans with service users and/or increasing opportunities for personalisation of their environment, can be helpful steps towards the development of improved interpersonal relationships between staff and service users (Hermsen et al., 2024). The implications from the present review not only support but confirm the importance of adhering to the good governance frameworks set by the CQC as part of the Health and Social Care Act (Health and Social Care Act, 2008). A further component that could impact staff interactions with service users is the organisational culture (Hermsen et al., 2024). Organisational and team cultures were found to be important to staff members to manage negative emotions, which may impact how relationships with service users are interpreted (Hermsen et al., 2024). This may come as a guide and encouragement for service providers on how to navigate this difficulty.

Lastly, the review highlighted that social connection within secure settings is heavily influenced by institutional design and constraints. The reported difficulties in forming meaningful social relationships, for example, due to mismatched placements, illustrate how secure environments can hinder social development. Understanding the complex social ecology of secure settings is crucial for service commissioners, as placement decisions must consider social compatibility alongside diagnostic needs (Woolcott et al., 2019). Clinical teams should consider the individual service user in relation to social compatibility and geographical proximity to existing community ties in order to reduce isolation and enhance social connections.

Research implications

This meta-ethnography highlights the current state of the literature in this field, revealing a limited number of studies, many of which demonstrate poor methodological rigour. There is a clear need for further high-quality research employing robust methodologies, including more longitudinal and participatory approaches. This is particularly important given the potential long-term impact of these findings on individuals' lives. Future studies could investigate how experiences of identity, belonging, and autonomy evolve over time within secure settings, and identify factors that influence their development. Involving service users as co-researchers may also enhance the understanding of subjective experience.

The current context for service delivery in the UK is a significant change from in-patient settings to community services, though it is still recognised as important to ensure that in-patient services provide a beneficial treatment model. To achieve this, service providers should continue to explore and adapt service provision according to the views and experiences of service users, recognising the need for these services despite their undesirability. Perhaps, a greater emphasis on a clear pathway from secure setting to community living, with the inclusion of rehabilitation facilities to support skill development and greater autonomy, preferably in close proximity, would support the voices and desires of service users with IDD (NICE guideline NG53, 2016).

Understandably, not all service users desire the same level of social contact with peers and family. Future research could examine how factors such as past trauma, neurodiversity, and individual social preferences influence the sense of belonging and the development of social relationships within secure settings. This may also prompt exploration into how service users interpret and navigate boundaries with staff, particularly when staff members are perceived as surrogate family or friends. Such research could shed light on implications for emotional development, dependency, and readiness for discharge, thereby informing more nuanced assessments of the social and psychological needs of individuals admitted to secure services. Lastly, more focus could be placed on developing more meaningful relationships between family/carers and services, their voices would also be important in co-designing more appropriate and effective services.

Theoretical implications

The traditional framing of ‘secure care’ has predominantly focused on physical safety and containment in services for individuals with IDD. However, the current meta-ethnography suggests that secure care should be re-theorised to equally prioritise relational security, psychological safety, and social identity (Tighe & Gudjonsson, 2012). These concepts align with key aspects of Goffman’s theory of institutionalisation and Wolfensberger’s theory of social role valorisation, reinforcing the crucial need to transform how secure service provision is conceptualised, particularly in the aftermath of the various scandals.

Conclusion

The present meta-ethnography set out to explore service users' views and experiences of secure settings for individuals with IDD. The findings provided shared and contrasting narratives, which hold clinical, research, and service-wide implications.

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Chapter two: Empirical research paper

A QUALITATIVE EXPLORATION OF THE VIEWS AND EXPERIENCES OF MEN WITH INTELLECTUAL AND/OR DEVELOPMENTAL DISABILITIES WHO PARTICIPATED IN AN ADAPTED GROUP THERAPY FOR HARMFUL SEXUAL BEHAVIOURS.

Abstract

Introduction

Research into treatment for men with intellectual and/or developmental disabilities (IDD) and harmful sexual behaviours (HASB) has grown, with adapted cognitive behavioural therapy (CBT) interventions showing promise in reducing reoffending. The Sex Offender Treatment Services Collaborative – Intellectual Disabilities (SOTSEC-ID) is an adapted CBT group intervention currently being evaluated against treatment as usual in a cluster randomised control trial (HASB-IDD). Given the possible treatment implications of SOTSEC-ID, understanding participants' experience may prove insightful as it could guide treatment development. This study aimed to explore the views and experiences of men with IDD and HASB who participated in the SOSTEC-ID intervention.

Methods

A sample of participants was interviewed at various in-patient and/or community sites in the United Kingdom. The interviews sought to elicit participants' overall impressions of the programme. Reflexive thematic analysis (RTA) was used to identify patterns within narratives and generate a breadth of themes capturing participants' experience.

Results

Of the eleven men interviewed, ten interviews were analysed (one participant withdrew). Four superordinate themes, each with sub-themes, were developed: 1) motivators for participation; 2) concerns, fears, and emotional vulnerability; 3) empowerment and development of self-efficacy; and 4) navigating between social vs individual needs. Overall, participants described the intervention positively, valuing components such as group discussions, the content, and shared experiences with group members. Challenges included the emotional demands of self-disclosure and the intensity of some topics.

Discussion

The themes revealed the emotional and psychological engagement required in the group, the impact of social dynamics, and the empowering nature of the intervention. Insights gained have implications for tailoring future programmes and guiding continued research in this field.

Introduction

Over the last decade, public concern regarding the increasing volume of sexual offending in the United Kingdom (UK) has risen (Elkin, Office for National Statistics, 2023). Sexual offending can result in devastating, long-term consequences for victims, including cognitive deficits, poor physical health, and mental illness, which in turn increase demand on healthcare services and associated costs (Oram, 2019; Trickett et al., 2011; Castro et al., 2019). The prevalence rate of sexual offences over the last 20 years has fluctuated, however, a significant and steady increase has been observed since 2014 (Elkin, Office for National Statistics, 2023). Given some of the individual and societal impacts of sexual offending, there is a growing body of research exploring treatment possibilities for sexual offenders, who mostly tend to be men. Treatment programmes have typically involved the use of cognitive-behavioural therapy (CBT - Gannon et al., 2019; Harrison et al., 2020). The core Sex Offender Treatment Programme (SOTP) was an intervention that drew upon CBT approaches, delivered in prisons in England and Wales (Mews et al., 2017). The primary aim of SOTP was to target maintenance cycles of sexual offending, in turn reducing recidivism. However, an initial review deemed the programme to be ineffective (Mews et al., 2017), highlighting a need for the development and assessment of the efficacy of similar programmes.

Rates of sexual offending or harmful sexual behaviours (HASB) have been reported to be higher in individuals with intellectual and/or developmental disabilities (IDD), compared to those without IDD (Cortoni et al., 2017). Intellectual disability (ID) is characterised by limitations in intellectual functioning and adaptive behaviours that impact daily living, and is often defined by an intellectual quotient (IQ) under 70 (British Psychological Society, 2015). In this study, the definition is extended to include developmental disabilities, which include conditions like cerebral palsy and autism spectrum disorder (ASD; National Institutes of Health, 2021). In this paper, HASB will account for any sexual behaviour in which the other person either did not consent or was unable to consent, and therefore would be considered illegal even if it did not result in prosecution.

To best understand sexual offending in relation to individuals with IDD, it is essential to be aware of the historical context of this population in the UK, alongside relevant theoretical perspectives. Throughout much of the 19th and 20th centuries, people with IDD were largely excluded from community life and placed in large, often overcrowded and poorly resourced institutions located in remote areas, which served as long-term placements for thousands (Houston, 2020). Conditions within these institutions were frequently inadequate, with residents having limited access to education, work, or social opportunities (Houston, 2020; Mansell & Ericsson, 1996). Investigations from the 1960s onwards revealed widespread abuse and neglect within institutional care (British Broadcasting Corporation, 2012, 2019; Buckinghamshire County Council, 1998; Butler & Drakeford, 2003; Commission for Healthcare Audit and Inspection, 2006).

Public outcry during the 1980s and 1990s in response to these conditions prompted significant shifts in social policy, including a focus on social inclusion, rights for individuals with IDD, and a move towards community-based care and deinstitutionalisation (Department of Health, 2012, 2015; NHS England, 2015). The aim was to close large institutions and provide support within community settings. Although many hospitals have since closed, secure care persists, particularly within forensic services, which house individuals with IDD, often detained under mental health legislation, who have committed or are perceived to be at high risk of committing offences (Murphy & Mason, 2014). The dual treatment pathway for individuals with IDD, either through hospital detention under the Mental Health Act or involvement with the criminal justice system, reflects a range of factors, including recognition of their vulnerability and reduced culpability, which often makes hospital settings more appropriate for treatment (Murphy & Mason, 2014).

Theoretical accounts have attempted to shed light on the possible factors that may influence men with IDD to be susceptible to sexual offending. The understanding provided by psychological theories may guide the development of appropriate and targeted interventions, perhaps reducing recidivism in this population. The theory of counterfeit deviance (CD) suggests that sexual offending occurs because of a lack of sexual knowledge (Hingsburger et al., 1991). This has been reinforced in recent studies, supporting a need for individuals with IDD to increase their sexual knowledge (Svae et al., 2022). Though, developments to CD theory suggests that men with IDD may understand that their perpetrated incidents are wrong but are unable to comprehend the extent of the social and emotional consequences of their actions (Lindsay, 2017), possibly due to difficulties with abstract reasoning and/or theory of mind impeding their understanding of various mental states and social interactions (Karoğlu, Ferguson, & Ciardha, 2021).

On the other hand, the self-regulation model (SRM) by Ward and Hudson (2000) proposes that sexual offending results from difficulties with self-regulation, wherein self-regulation is a tool that promotes the suppression of challenging behaviour and the development of positive behaviour and regulation of emotional states (Ward & Hudson, 2000). This model aligns with wider cognitive psychology theories, which highlight that individuals with IDD may experience delays and impairments in executive functioning, leading to poor decision-making and inability to consider long-term consequences of behaviour (Fidler & Lanfranchi, 2022). Further theories include theories of cognitive distortions, lack of victim empathy, and deviant sexual preferences (Blanchard et al., 1999; Boer et al., 1995; Keeling et al., 2009; O'Connor & Rose, 1998). Theories of cognitive distortions, in which harm is either minimised or justified, suggest that distortions can be exacerbated in individuals with IDD due to difficulties with abstract reasoning and empathy (Keeling et al., 2009). Finally, the integrated theory of sexual offending (ITSO) offers a comprehensive model by drawing together biological, psychological, and ecological domains (Ward & Beech, 2006). ITSO implies that sexual offending emerges from interactions between neurodevelopmental impairments (i.e. cognitive deficits), adverse social environments (i.e. abuse, poverty, institutionalisation), and difficult to manage psychological states (i.e. emotional regulations). Despite the insights offered by these theories, empirical validation remains limited, and studies evaluating related interventions often demonstrate poor methodological rigour (Marotta, 2017).

Prevalence figures for sexual offending in men with IDD are difficult to determine accurately and could be misjudged. These vary greatly often due to underreporting, variations in how IDD is categorised, and possible difficulties in communication during assessments (Heaton & Murphy, 2013). Some studies estimated that around 6% of men with IDD engage in HASB (Swanson & Garwick, 1990; Thompson & Brown, 1997), whereas other evidence suggest that 41% of men with IDD engage in HASB, of which 17% are reported to the police (McBrien et al., 2003). Such discrepancies underscore the lack of methodologically rigorous and standardised research in this area. Much of the existing evidence relies on small non-representative sample sizes and poorly defined outcomes which limit the ability to generalise the findings (Craig & Hutchinson, 2005; Heppell et al., 2020).

Research into effective interventions for this population is limited (Westphal, 2020). Literature shows that in those with IDD sexual recidivism rates are between 3.5-6.8 times that of individuals without IDD, with men with IDD presenting an increased risk of re-offending within a quicker period of time (Craig & Hutchinson, 2005; Heaton & Murphy, 2013). However, as many studies in this area lack methodological rigour, the validity of these figures is limited (Westphal, 2020). Recurrent sexual offending not only presents with devastating consequences for victims but also long-term societal consequences. Convicted individuals with HASB may result in imprisonment under the criminal justice system or sectioning under the Mental Health Act. As of 2022, the cost of a prison confinement per individual in a year was £31k and quotes for secure NHS service per individual a year were up to £200k (Ministry of Justice, 2022). Of note, research also suggests that individuals with IDD who engaged in HASB report lower quality of life due to a lack of interventions to support them, evidencing adverse consequences at perpetrator-level too (Courtney & Rose, 2004).

There is some evidence for the effectiveness of adapted SOTP and group-based CBT interventions at reducing rates of recidivism in men with IDD (Cohen & Harvey, 2016; Gannon et al., 2019; Heppell et al., 2020; Jones & Chaplin, 2020). However, the overall quality of the literature in this field is generally poor, with a lack of randomised control trials, small sample sizes, variation across studies for treatment length and follow-up time, and a lack of clarity on what components are effective, which complicate the measurement of recidivism and the development of appropriate treatment (Ashman & Duggan, 2008; Cohen & Harvey, 2016; Craig & Hutchinson, 2005; Heppell et al., 2020; Marotta, 2017).

The Sex Offender Treatment Services Collaborative – Intellectual Disabilities (SOTSEC-ID) is a group intervention provided to men with IDD who may have committed sexual offences or are at risk of sexual offending (Sinclair et al., 2002; SOTSEC-ID Group, 2010). The intervention is guided by theoretical developments, providing an adapted CBT-based intervention to support men to understand their thoughts and behaviour, manage emotions, and improve victim empathy, to reduce risk of reoffending. There is some evidence for the long-term effectiveness of SOTSEC-ID in reducing sexual reoffending and improving attitudes towards sexual behaviour in men with IDD-HASB (Heaton & Murphy, 2013; Heppell et al., 2020; Murphy et al., 2023; SOSTEC-ID Group, 2010). However, these findings are drawn primarily from non-randomised and observational designs, which may be prone to bias due to a lack of comparative control groups. The potential effectiveness of SOTSEC-ID suggests promising treatment implications, both at individual and societal level. Given this, it would prove insightful to gain an ‘insider’s perspective’ on participants’ experience of the intervention, as a guide for future development. It is widely recognised in the literature that seeking service users’ views on their experience of a service can provide direction on how to tailor support to meet their needs and targeted outcomes (Department of Health, 2012, 2015; Vereenooghe & Langdon, 2013). In addition to this, the perspective of service users can also provide implications at a systemic level, such as presenting important guidance for social and health care policy development (Attree et al., 2011; Department of Health, 2012, 2015; Offender Health Collaborative, 2015; Omeni et al., 2014).

SOTSEC-ID is currently being trialled in in-patient and community settings, in a cluster randomised control trial named HASB-IDD. The trial compares various outcomes for participants in a treatment arm (SOTSEC-ID) against those in a ‘treatment as usual’ (TAU) arm. Effectiveness is measured from baseline to post intervention and includes a two year follow up. Outcomes assessed include sexual knowledge, victim empathy, locus of control, cognitive distortions, and recidivism. This is the first ever RCT for this treatment and it aims to establish the efficacy of SOTSEC-ID. Exploring the perspectives of participants in the SOTSEC-ID intervention would not only advise on their experience and the acceptability of the processes and outcomes post-intervention, but would also provide them with a voice as individuals with IDD are often excluded from research, despite expressing their desire for their voices to be heard (Hoole & Morgan, 2010; McDonald, 2012).

Aims

The current study aimed to capture the experiences and views of men with IDD-HASB who participated in the SOTSEC-ID intervention. The qualitative analysis aimed to gain a rich understanding of the personal experiences of participants, informing on their perceptions of the helpful and challenging aspects of the intervention.

Methodology

The present study is embedded within the larger HASB-IDD trial. The overall methodology of the trial is outlined, followed by the methodology and design of the qualitative study.

HASB-IDD Trial methodology

Trial Aims

The aim of the trial was to determine whether SOTSEC-ID reduces cognitive distortions, reduces/prevents further HASB, and improves the sexual knowledge, self-esteem, empathy, and locus of control, in men with IDD-HASB compared to TAU. Furthermore, the trial included a process evaluation which aimed to assess the views and experiences of service users, carers, and therapists participating in the SOTSEC-ID programme.

Trial design

A single-blind controlled cluster-randomised trial of the SOTSEC-ID model for men with IDD-HASB was conducted (HASB-IDD Protocol, 2022). A multi-site trial, each site was led by a qualified psychologist either in community or secure hospital settings. The sites for the trial included NHS, as well as voluntary and private care in the UK.

The trial is split in two arms, arm A: SOTSEC-ID; and arm B: TAU, where TAU was risk management, typically including medical interventions and/or counselling and behavioural interventions. In Arm A, the intervention was delivered as a group intervention to groups of up to 10 men for up to 6 months. This resulted in 50 sessions, two sessions per week, lasting two hours each. Each session comprised of a minimum of two therapists facilitating each session. The sessions covered 6 modules:

- Group aims and rules
- Sex education
- Cognitive model (thoughts, feelings and behaviour)
- Victim empathy
- Sexual offending 4-stage model
- Relapse prevention plans.

Participants

The inclusion and exclusion criteria for the study are presented in Table 1.

Table 1: Inclusion and exclusion criteria of participants

Inclusion Criteria

I. Adult men, aged 18 yrs+
II. With borderline or mild intellectual disability, determined by an IQ below 80 or a score below 80 on the Verbal Comprehension Index, as well as deficits in adaptive behaviours, with or without autism.
III. With one or more instances of harmful sexual behaviour within the last 5 years, regardless of conviction.
IV. Relatively good verbal comprehension, to be determined by assessing clinicians.
V. With capacity to provide informed consent.

Exclusion Criteria

I. Major mental health difficulties that would prevent participation in the group.
II. Currently a resident in prison or high secure services, or on a probation order.
III. Has completed a CBT programme for HASB within the last three years.

Data collection and outcomes

Table 2 details the primary, secondary, and qualitative outcomes of the trial. Outcome data collection occurred at four separate time sets. Time One - baseline and assessment, Time Two occurred 8-months post baseline, Time Three - 12-months post baseline, and Time Four - 24-months post baseline.

Table 2: Outcomes of the HASB-IDD Trial

Primary Outcome	Cognitive distortions measured by the Questionnaire on Attitudes Consistent with Sex Offences. The primary outcome was measured at each Time set (Time One to Time Four)
Secondary Outcomes	1. Sexual Knowledge, measured with the General Sexual Knowledge Questionnaire 2. Victim empathy measured with the Victim Empathy Scale–Adapted 3. Self-esteem measured with the Rosenberg Scale 4. Men's Locus of control, measured with the Nowicki-Strickland Locus of Control Scale 5. Health care services accessed by participants measured by the Client Services Receipt Inventory and from carers' report 6. Any further harmful sexual behaviour measured from carers' reports 7. Men's Quality of Life measured with the EuroQol quality of life measure, EQ-5D-5L Secondary outcomes were measured at each Time set (Time One to Time Four)
Qualitative outcomes	A sample of service users, therapists, and carers were interviewed at Time Two to explore their experiences of the SOTSEC-ID groups. The qualitative data from interviews was analysed using Thematic Analysis (TA).

Qualitative Study: methodology for service users

Epistemological position

An inductive, experiential, and constructivist orientation were adopted for this study. Reflexive thematic analysis (RTA) was adopted as it aligns with a constructivist and experiential epistemology, highlighting the author's role in meaning-making (Braun & Clarke, 2021). An experiential stance places priority on understanding the meaning ascribed by the respondent to a given phenomenon, by investigating their thoughts, experiences, and feelings. Constructivism posits that meaning of a phenomenon can be constructed in different ways by people (James & Busher, 2009) suggesting that when developing an understanding of others' experiences, one's own personal experiences influence the meaning drawn. Due to this, the meaning drawn from narratives of service users participating in the SOTSEC-ID intervention cannot be understood independently of the researcher's own previous knowledge. Researchers that take a constructivist epistemological position are urged to reflect on the paradigms that may underpin their research and influence interpretation (James & Busher, 2009). The author of this meta-ethnography kept a reflection diary and utilised supervision space to reflect upon their position and how this influenced their interpretation of results.

Design and procedure

Within the context of this study, the author's role was situated exclusively within the qualitative arm of the wider trial. Specifically, the author was responsible for developing the interview schedule, as well as organising and conducting semi-structured interviews with participants who had completed the intervention, as well as conducting the qualitative data analysis. The author had no prior therapeutic or supervisory relationship with participants, and was not involved in the selection, recruitment, or clinical delivery of the intervention. This positioning afforded a degree of independence from the core clinical and trial team, thereby facilitating a more transparent engagement with participants during data collection.

To evaluate the qualitative outcomes of the trial, service users, facilitators, and carers were interviewed. The present study analysed the qualitative data from interviews with male service users who participated in the SOTSEC-ID intervention. Beside one interview which was conducted via telephone, all interviews were face to face and took place at respective sites. Information of the purpose of interviews was disseminated to participants at the start of the trial and reiterated at the start of each interview.

Recruitment process

All service users in the intervention arm were invited to a qualitative interview to share their views on the SOTSEC-ID intervention. More than one participant per site was invited, resulting in multiple interviews per site. This occurred to circumvent difficulties with site recruitment and time constraints for data collection. The aim was to recruit a minimum of 6 participants, as per literature guidelines (Fugard & Potts, 2015).

Eleven men were interviewed. One of the men chose to terminate the interview and retracted his consent, as such his data was not included in the analysis. The age range of participants was 21 to 65 years (M = 34.5, SD = 12.3). The majority of men identified as White British (9 men, 82%); two men identified as Scottish (18%). Participants were recruited from four sites. The sites have been renamed for data protection: Site A, Site B, Site C, Site D. The delivery of the intervention at site C terminated early due to organisational restructures. Though short, the experience of participants in site C were determined to still provide meaningful insight, and as such, interviews were conducted at Site C. All interviews were conducted after the completion of Time Two quantitative data collection (Table 3).

Table 3: Group and interview dates

Group start and end date	Interview date
Site A	Site A
From [redacted] of April [redacted] to [redacted] November [redacted]	[redacted] February [redacted]
Site B	Site B
From [redacted] of February [redacted] to [redacted] September [redacted]	[redacted] September [redacted]
Site C	Site C
From [redacted] of May [redacted] to [redacted] June [redacted]	[redacted] and [redacted] December [redacted]
Site D	Site D
From [redacted] of July [redacted] to estimated [redacted] of February [redacted]	[redacted] February [redacted]

Considerations of Ethics and Health & Safety Risks

Full ethical approval for the trail was received by the NHS Health Research Authority and Health and Care Research Wales (IRAS ID: 291027; Appendix D). The study was sponsored by the University of Kent.

Easy read information was shared with participants and informed consent was sought prior to enrolment in the trial (Appendix E and F). Participants were informed of their right to withdraw from the study. Participants were made aware of their rights and limits to confidentiality and data protection, and were identified by a participant identification number on all written documents. For the purpose of the paper, participants have been given pseudonyms. Audio tapes of interviews were deleted following transcription. Digital copies of research material and transcripts were stored in an encrypted folder, and printed copies were disposed of securely through shredding.

Interviews

A semi-structured interview format was utilised (Appendix G). Interviews were guided by a flexible schedule following the aims of the HASB-IDD trial to support individuals to express their thoughts and views. Semi-structured interviews allow for natural flow of conversation, promoting rapport, and freedom to explore new insights (Smith & Osborn, 2007). Interviews were conducted face to face in a private room to encourage higher levels of engagement. On two occasions the researcher was accompanied by an assistant psychologist due to the risk level of the participants being interviewed.

The interview schedule aimed to explore general perceptions of the group and included prompts for reflection to articulate concepts and thoughts. The interview schedule was developed by the author in collaboration with the wider research team. The schedule comprised

14 questions, covering various categories drawn from the aims and modules of the trial, including expectations of change, perceptions of the helpful aspects, as well as any concerns that may have risen. I acknowledge that the categories within the schedule reflected not only the theoretical underpinnings of the trial but also my own assumptions and interest in understanding both the positive outcomes and the potential challenges experienced by participants. These factors inevitably influenced the framing and focus of the questions. It was important to the author that the schedule reflected language and concepts that were appropriate for the participants, effectively captured their experiences, and that the questions were easily understood. To achieve this, the author collaborated with a service user with IDD-HASB from a non-participating site to explore whether the language and questions within the schedule were appropriate, and whether the length of the schedule was suitable. This was conducted via a telephone conversation, during which the service user provided feedback on each question. Furthermore, the schedule was also presented in a Patient and Public Involvement meeting with carers of individuals within the trial, to gain further feedback and make any necessary changes. This led to a simplification of wording and additional questions addressing the relational needs of the group. Interviews were recorded with a dictaphone and transcribed verbatim for analysis. The interview schedule was again reviewed with the research supervisor after the first round of interviews, to ensure face validity.

Prior to each interview, participants were reminded of their right to withdraw. Furthermore, the researcher ascertained their emotional state towards completing the interview, providing the opportunity to discuss any questions and/or concerns. Participants were given the opportunities to take breaks if required (two participants utilised the break - Bruvis and Charlie). Following each interview, the researcher provided participants with a £10 voucher. Table 4 details participant demographics and the length of each interview per participant and site. One interview was conducted over the phone due to scheduling difficulties. One interview was terminated before completion by the participant who withdrew from the study.

Table 4: Participant demographics and interview details

	Participant (age)	ASD	ABAS	WASI	Legal status	Length of interview
Site A	Andrew (32)	Yes	[redacted]	[redacted]	Detained under MHA section 38	25 minutes, 34 seconds
	Bruvis (22)	Yes	[redacted]	[redacted]	Detained under MHA section 3	23 minutes, 11 seconds
Site B	Charlie (65)	No	[redacted]	[redacted]	CTO	24 minutes, 24 seconds
	Dan (27)	No	[redacted]	[redacted]	CTO	21 minutes, 41 seconds
	Elliot (45)	No	[redacted]	[redacted]	SHPO (indefinitely)	32 minutes, 41 seconds
Site C	Frank (36)	No	[redacted]	[redacted]	Community living	13 minutes, 29 seconds (telephone interview)
	Gilbert (21)	Yes	[redacted]	[redacted]	SHPO	12 minutes, 01 seconds
	Hugh (30)	Yes	[redacted]	[redacted]	SHPO	8 minutes, 06 seconds
Site D	Isaac (29)	Yes	[redacted]	[redacted]	Detained under MHA 37-41	12 minutes, 16 seconds
	James (27)	No	[redacted]	[redacted]	Detained under MHA 37-41	7 minutes, 34 seconds (interview terminated by participant)
	Kevin (45)	No	[redacted]	[redacted]	Detained under MHA section 3	18 minutes, 56 seconds

Footnote: ABAS – adaptive behaviour assessment system; ASD – autism spectrum disorder; CTO – Community treatment order; MHA – Mental Health Act; SHPO – Sexual Harm Prevention Order; WAIS – Wechsler adult intelligence scale

The sites were located in different regions of the UK. The timing of intervention delivery varied across sites due to organisational factors, such as staff and participant availability. The duration of the interviews was expected to range between 15 and 60 minutes, in line with previous research reporting similar timeframes (Heppell et al., 2020; Hollomotz, 2017). Several factors may influence interview length within this population, including communication difficulties, fatigue, cognitive processing, and attention span. To account for these factors, careful consideration was given to ensuring the schedule was concise and used clear, accessible language.

However, the differences in interview duration across Sites A and B compared to Sites C and D were noted. The previously mentioned variables do not fully account for these differences, and other confounding factors may have contributed. For example, Site C terminated the intervention early due to organisational changes. The limited exposure to the intervention likely resulted in participants from Site C offering less detailed responses, leading to shorter interviews. Additionally, Site D had not yet completed the intervention at the time of the interviews. While there were only a few sessions remaining at site D it is possible that this also contributed to the brevity of participant responses. The decision to proceed with interviews at Site D was informed by time constraints within the wider trial. Conducting the interviews prior to the completion of the intervention ensured that as many participant voices as possible were heard and included in the analysis, thereby promoting broader participant inclusion. Additional confounders at Site D that may have influenced the length of interviews included one participant withdrawing from the process and another participant choosing to withhold information due to concerns about confidentiality within the group. It is noted that the length of interviews as well as conducting interviews before the end of the intervention may have had an impact on the results. Reflections on this are presented in the discussion.

Analysis

Braun and Clarke’s (2021) work on the concepts and design in reflective thematic analysis (RTA) guided the methodology for the study. Their initial six-phase process RTA is displayed in Table 5 (Braun & Clarke, 2012). RTA was chosen as the analytical approach as it facilitates the analysis of patterns in a dataset through the researcher’s interpretive analysis, promotes the development of theoretical frameworks (Byrne, 2022), and can help with the identification of recurring experiences or issues that participants face during a clinical trial (Braun & Clarke, 2021; Jowsey et al., 2021). The uncovering of themes can support the improvement of the intervention design and implementation.

Table 5: Braun and Clarke's (2012) analytical process

Phase	**Description**
1. Becoming familiar with the data	This phase entailed the repeated reading of the dataset to produce familiarity and draw out relevant information.
2. Development of codes	This phase entitled producing descriptive labels for information sets relevant to the research question. Codes are important for the generation of themes.
3. Theme development	Codes are reviewed to ascertain shared meaning. These are then analysed to develop themes or subthemes. A relationship between codes is constructed to determine the narrative of a theme.
4. Revision and review of possible themes	Key questions are asked to review themes, such as the quality of the theme and whether enough data is present to support the theme.
5. Naming the themes	A detailed analysis of the themes and sub-themes developed should present an informative narrative of the dataset. Primary themes should be consistent with the data within them and should not overlap with other themes.
6. Producing the report	This stage entails the write-up of the qualitative analysis. The write-up is interwoven throughout the process of analysis, and as such can change and evolve over time with the analysis.

Phase One

The interviews were listened to in full before transcription to attend to any technical difficulties and to develop an understanding of how topics were addressed during the dialogues. Following the playback of interviews, each interview was manually transcribed verbatim. Each transcript was read various times and notes of initial trends were jotted down.

Phase Two

The transcripts were systematically attended to, and relevant data items were coded. The coding of items was conducted using NVIVO, a software for qualitative analysis. This allowed for greater ease with coding, ensuring that double-codes or overlaps did not occur. An inductive approach was used, meaning the development of codes was not made to fit into previous coding frameworks (Braun & Clarke, 2006). Codes were redefined numerous times during this stage (Appendix H). Once the dataset was coded in full, codes with similar meanings and interpretations were collated. Examples of participant comments against corresponding codes are displayed in Appendix (I)

Phase Three

Initial themes were formed in this phase. Codes were organised using a mapping diagram to visually identify groupings and emerging themes (Appendix J). Codes with shared meanings were collapsed into prospective themes. Codes that did not appear to fit in any prospective theme or pattern were combined into a miscellaneous theme, which was later reviewed for relevance. Prospective themes were presented within a thematic map.

Phase Four and Five

Phase Four involved careful consideration was given to the meaningfulness of themes, what was being communicated from the themes, the congruency and relationship between themes, as well as the quality of themes. The review of themes was conducted with two research supervisors, engaging in reflective discussions regarding the patterns drawn from codes and reviewing whether the themes provided appropriate interpretations and relevant contributions. This reduced researcher bias. Any code that did not appropriately inform a theme, and/or any themes that did not provide an appropriate interpretation of the dataset were removed. Throughout this process, reflexivity remained central. The researcher continued to interrogate how personal perspectives shaped analytic choices. Phase Five involved the defining and naming of each theme. Braun and Clarke (2013) encourage the use of creative and catchy names, to capture the attention of readers, whilst being concise and informative.

Phase Six

The write-up of the analysis was written alongside the revision process of codes and themes. Changes and reflections during this phase were documented in the reflective diary.

Reflections and positionality

Overall, the interviewing process was well structured, which meant that I felt safe and capable to conduct the interviews, despite lone working. However, at a particular site, staff were not prepared for my arrival, despite prior email exchanges confirming details. This meant that the interviews were delayed, and a service user did not attend due to short notice. As a result, I felt quite disorganised, and I noticed myself focusing a lot more on following the interview schedule which meant a more structured and less conversational interview. I found this particularly hard and utilised supervision to reflect on my thoughts. In supervision, it was explored that the interview schedule was drafted to support the flow of conversation, such as using prompts, which likely still allowed the interview to be free flowing. It felt particularly important to me to use the supervision space in this way, as to not add bias to my interpretation of findings.

I have previous clinical experience working with this client group, which both informed and motivated my decision to undertake this research. My professional background shaped my approach to the interviews, influencing elements such as pacing, sensitivity to participants' emotional states, and a willingness to allow breaks or adapt the structure of the conversation. This clinical lens also informed how I engaged with and interpreted the data during analysis. I acknowledge that my prior involvement in this field may have introduced assumptions that influenced how I understood participants' accounts. In line with a reflexive thematic analysis approach (Braun & Clarke, 2021), I engaged in ongoing reflexivity to critically examine the influence of my positionality on knowledge production. This included maintaining a reflective diary and engaging in regular supervision to question, contextualise, and challenge my interpretations. Given my clinical background, I adopted an ‘in-betweener’ position, neither fully insider nor outsider (Wilson, Janes, & Williams, 2022). This positionality enabled me to recognise shared understandings and appreciate the nuances of participants' experiences, offering both familiarity and analytical distance in engaging with the data.

Results

Ten interviews were completed and analysed. Analysis resulted in the development of four superordinate themes, with corresponding subthemes: ‘motivators for participation’; ‘concerns, fears, and emotional vulnerability’; ‘empowerment and development of self-efficacy’; and ‘navigating between social vs individual needs’. Figure 1 depicts the thematic map of developed themes.

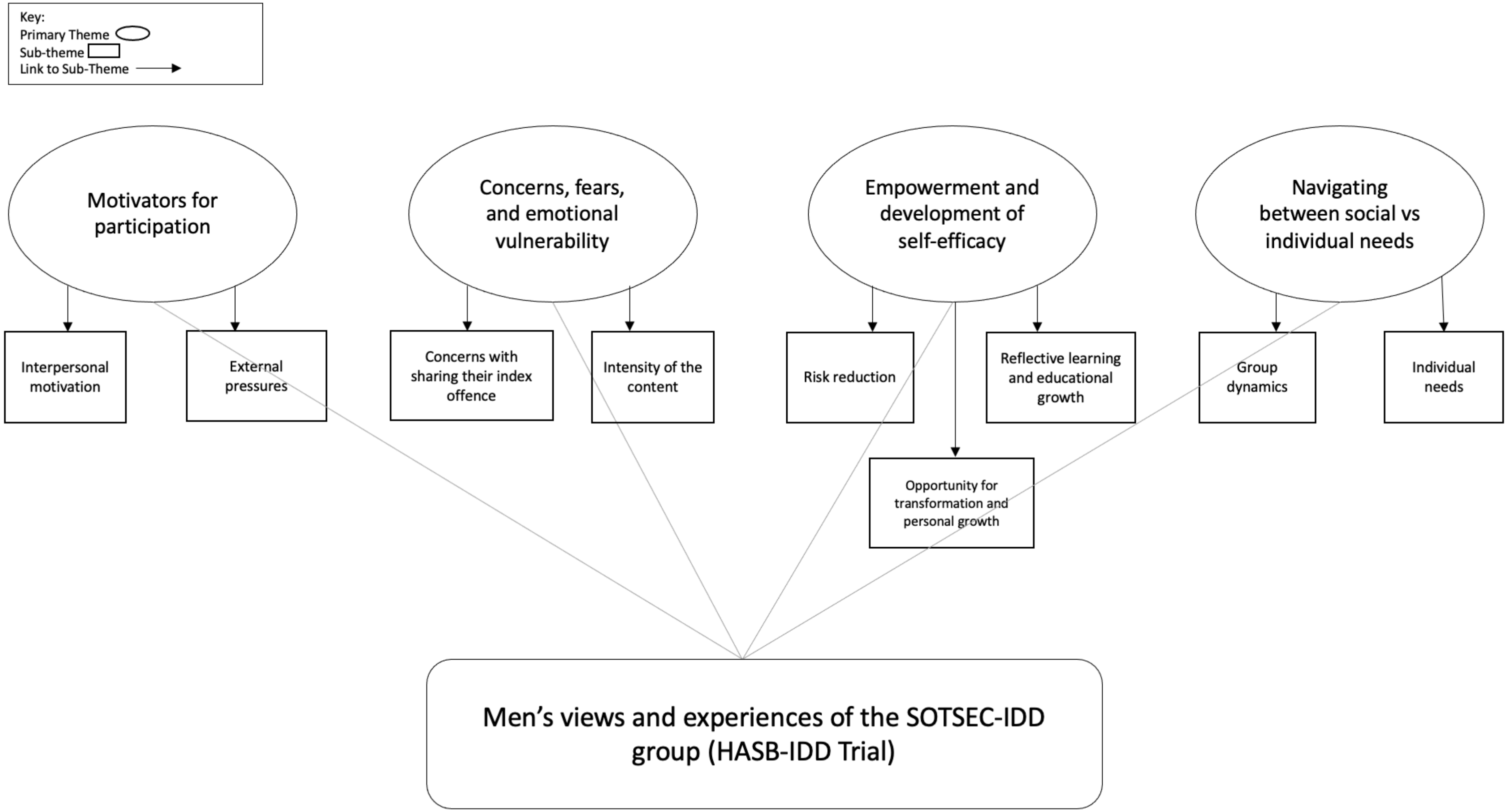

Figure 1: Thematic map

Superordinate theme 1: Motivators for participation

Following the analysis, it became apparent that participation in the group was driven by conflicting motivators, some participants were driven by intrinsic motivations, whilst others by external pressures.

Interpersonal motivation

Some participants openly shared their desire to participate in the group, "*…that was something I wanted to do*" (Frank); "*I was not forced to do this (group). I was offered it and obviously why would I say no to it*" (Andrew). Desire for participation seemed to be influenced by an intrinsic recognition of helplessness in managing their risks and difficulties. Participant narratives noted a 'need for help', with the group being viewed as an answer to meet this need.

> You know I have been in and out of you know custody and stuff like that because of my old mistakes. When I was told that they were running a SOTSEC-ID group I thought this is what I need because it's like you know my planning it's not always working (Elliot)

The statement "*my planning it's not always working*" indicates the participant's previous attempts to manage his difficulties, highlighting his personal aspiration and desire for change. However, faced with the failure of achieving his desired change, the group may have presented as a saving grace, giving him another opportunity to fulfil his personal aspirations.

Various participants discussed the changes they aspired to make following the group. These ranged between abstract changes, such as "*to be able to enjoy life more*" (Bruvis), to understanding themselves better, improving their relationships, and working towards community living, "*Understanding myself better and obviously being in control of myself*" (Andrew); "*To live a better lifestyle in the community… I would get a job and have something* *to do*" (Isaac). In this way, the group was seen as a tool to achieve long-term aspirations and notably many participants who held personal motivations for engagement, spoke to the usefulness of the group.

> I feel like what I have taken from the course is helping me to be a better person out there. If this course had not been mentioned, I wouldn't know what I am doing, this course has given me a lifeline, it's lifted me up and I am grateful for staff taking time out to do the sessions (Elliot).

In my reflective diary, I found myself resonating with participants who expressed strong intrinsic motivations for engagement in the group. As someone who values autonomy and internal motivation, I noticed a tendency to interpret these narratives more positively in my notes and reflections. Reviewing my reflective diary helped me to pause on how my identity was influencing my interpretations and meaning making. This helped me to reflect that external motivations to engagement still hold powerful and meaningful space in the potentially transformative journey of participants.

External pressures

Contrastingly, other participants noted that their participation may not have been wholly voluntary. Though the group was not compulsory, some participants noted that they did not want to partake in the group, "*I didn't want to take part… I just want to move quickly*" (Gilbert).

The quote "*I just want to move* quickly" (Gilbert), denoted the participant's view of the group as a required step before a potential discharge to the community, rather than also an opportunity for personal change. Participants felt that their engagement in the group was a requirement of their treatment and experienced external expectations and pressures to participate, "*Because [facilitator's name] told me to*" (Kevin).

It is possible that feeling obligated to participate may have adversely influenced the overall experience of these participants. Participants may have been less likely to engage with the content, and it could be that they may have required further support to understand how the group could contribute to their personal goals and aspirations.

Given my clinical background in this field, it felt familiar to hear participants describe a lack of interest or engagement in the intervention. In my clinical experience, low engagement in such interventions is not uncommon. However, I became aware of the risk of anticipating to hear these accounts and interpreting participants' narratives through the lens of these prior assumptions, generalising their experiences based on what I had come to expect in practice. I reflected on the potential for these assumptions to overshadow participants' narratives. Through supervision, I explored this and worked to separate my assumptions from the data. This process supported a more valid representation of participants' perspectives, allowing their voices to emerge more clearly in the analysis.

Superordinate theme 2: Concerns, fears, and emotional vulnerability

The present theme reflects the emotional challenges participants faced when navigating their vulnerability in group settings and engaging with content that was experienced as difficult.

Concerns with sharing their index offence

Participants shared that their primary concern with participating in the group was sharing about their index offence with others. The men expressed that they feared the perception others would have of them. "*I struggled to speak up about myself and what I did. It was hard to say what I did*" (Charlie); "*talking about it at the start of the group I was shy, I* *didn't know what people were going to act on. I thought what would people think about me and I was a bit scared too*" (Dan). The concerns about sharing personal information denote the emotional challenge of vulnerability within a group. This is of note as the fear of experiencing judgement from others could prevent participants from openly sharing in the group and may present as a barrier to their personal development.

"*I was kind of worried and a wee bit upset you know when started talking about my offending, I felt quite emotional inside*" (Elliot). This quote vividly paints the emotional discomfort experienced by a participant, but notably the participant later stated that despite the discomfort he felt it was important to share his story. This was echoed by another participant

> One thing I was worried about talking about the index offence because that was something I was trying to avoid doing but there was no way of getting out of that, so I just sort of suck it the courage and just going for it (Andrew).

This suggests that though emotional discomfort may be part of the experience, participants value the space and opportunity for development provided by the group and can push past their comfort zone to achieve this. A participant notably expressed that his difficulty with sharing about his index offence was due to having a female facilitator, noting a sense of experiential distance between himself and the facilitator. "*it's a bit hard to discuss that in front of a woman… when she does not know how we feel when we have to discuss about sex*" (Frank). This may be important to note when considering adaptations to the delivery of the group to meet participants needs. Frank's comment about finding it difficult to discuss sexual matters in front of a female facilitator resonated with me personally, as I identify as a woman and have previously facilitated similar groups. This prompted reflection on how gender dynamics may create a perceived experiential distance, potentially influencing what participants feel comfortable sharing in group settings. It also led me to consider how my gender may have shaped the interviews, affecting not only what participants chose to disclose, but also how openly they expressed their experiences.

Interestingly, there were narratives from participants expressing discomfort and concern regarding hearing others share their index offence. A participant expressed that the most difficult part of the group was hearing about others' offence.

Interviewer: "what was difficult about that (hearing about others' offence)

Isaac: "*to understand why they did their offence*"

Though there may be no means to circumvent this, this could be raised as a point of reflection in the group.

In my reflective diary, I noted that participants' hesitation and emotional difficulty in disclosing their offence in a group setting highlighted how the group, while familiar and structured to me, could feel daunting and emotionally risky for participants. This insight deepened my sensitivity to the power dynamics embedded in group therapy. Participants' accounts revealed that emotional safety within the group had not yet been fully established, which made expressions of vulnerability more difficult. I found it particularly meaningful to hear how participants navigated their boundaries and gradually attempted to build trust in a highly sensitive group context. This led me to reflect on whether there might be more effective strategies to support individuals with IDD in disclosing sensitive information within such settings.

Intensity of content

Narratives on the intensity of the content were shared by participants. Comments such as "*it was quite an intense group*" (Andrew), "*I think honestly the group has been difficult*"

(Elliot), point to the heaviness of some of the material. Participants expressed feeling uncomfortable at times, especially when discussing particular topics, such as victim empathy, "*that was difficult, writing letter to the victim*" (Bruvis), "*it was one of the difficult modules to begin with but we got into it*" (Elliot). The reflections required to engage with the victim empathy module may understandably feel overwhelming and uncomfortable for participants, which could lead to avoidance for some, "*I didn't like it, I did not feel comfortable*" (Gilbert). Furthermore, some participants struggled with engaging with some of the content due to previous personal difficult experiences: "*I think honestly the group has been difficult, there have been some modules where I have not particularly taken part in because of what has happened to me a long time ago… I am not very comfortable with that*" (Elliot). However, despite the difficulty of the content, participants recognised that the group was an opportunity to learn new information, "*it can be quite embarrassing to do stuff like that and talk about it, but you know, if you want to know about these things, you are going to have to talk about these things*" (Elliot).

Superordinate theme 3: Empowerment and development of self-efficacy

This theme highlights that participants experienced the group as a space for personal transformation and growth, fostered through the development of coping skills, self-reflections, and skill acquisition. Notably, the group was also experienced to play a critical role in risk reduction.

Opportunity for transformation and personal growth

Many of the men reflected that attendance at the group resulted in noticeable interpersonal changes, "*I've seen a massive change in myself compared to how I was when I came here. I mean the difference is like chalk and cheese*" (Andrew). For instance, participants shared narratives of recognising improved overall coping and emotion control: "*I have been getting better at controlling my emotions. If I've had a few thoughts… I would tell them about it… the difference I've noticed is the courage, the group was helpful, and yeah and the teamwork*" (Dan). The quote "*the difference I've noticed is the courage*" points to a development of the participant's self-confidence to confront difficult situations, including navigating negative thoughts and emotions. This quote also highlights that guidance is provided to participants to develop positive coping strategies, such as approaching their difficulties by sharing them with 'teammates' and finding solutions through 'teamwork'. Participants shared various other coping strategies that they developed within the group that they recognised would be important for their relapse prevention, "*Practice taking yourself off to a safe space in time of difficulty as well and talk to people as well*" (Andrew); "*Go bowling, go train spotting*" (Bruvis).

Further to this, a participant reflected that the group supported him to feel more comfortable and confident in public, despite various years in the community following their last admission "*nine years I have been out of hospital, the group helped with how to be in the public"* (Charlie). The group was described to provide a "*second chance at life"* (Andrew), as various participants shared that gaining a better understanding of their thoughts helped them to reflect on where they may have gone 'wrong' and improve their self-esteem, "*it kind of help and driven me to be successful… thinking where I have gone wrong*" (Elliot). These quotes suggest that the group creates a platform for self-reflection, supporting participants to gain insights into their beliefs, experiences, and thoughts, and how these shape their actions. The reflections facilitated by the group appear to be central to triggering transformation and personal change in participants.

Reflective learning and educational growth

The content of the modules was mostly seen as useful and helpful. Participants noted that the content helped them develop a "*better understanding*" (Isaac), with some participants noting learning the information shared for the first time, "*I didn't know these things, they taught me how to like how to see stuff like what's the rules about sex*" (Dan).

Reflections on the 'sex education' module were shared by most participants. Eight participants reflected on their key learning regarding 'consent', noting that this was "*covered pretty well*" (Elliot), with various discussions amongst participants to develop their understanding. A participant shared that the module helped them to challenge their thinking and consider the consequences of their actions, "*maybe to handle it like more better, maybe you sit back and you think am I doing the right thing? Yes I am or no I am not. And if I am not, yeah I won't do that*" (Charlie). In contrast, a participant expressed that the 'sex education' module was not applicable to him and therefore not useful. He noted that the module solely covered "*straight relationships… they just talked about men and women*" (Gilbert). He stated that as he is homosexual, he felt unable to contribute to the discourse. This may be an area of improvement for the intervention, to include material that is applicable to different sexual orientations.

The 'cognitive model' as well as the 'victim empathy' module were seen as impactful and central to the personal changes participants wanted to make.

> Oh yeah that was really helpful and pinnacle point yeah… where you can sort of realise that thoughts links into that and that into that and into that again, and you can sort of realise a whole chain building. It's shocking how far the harm spreads, you think it's one person but actually it's everyone that is around that person… so yeah it was a real eye opener that was. (Andrew).

Quotes such as these provide clarity on the components of the SOTSEC-ID intervention that are experienced as helpful and key to participants' learning. This is important to consider when developing further interventions and support for this population group.

Risk reduction

Participants noted that the facilitated reflections helped them to gain a better insight into their risk behaviours. "*Compared to when I first started the group and finishing the group, obviously a lot of things are a lot more clearer*" (Andrew). Participants expressed that the coping strategies developed in the group were central to the reduction of their risk, "*... more so talking to staff members... without that support I would still be re-offending, so I am grateful for that support*" (Elliot).

The key learnings from modules as well as the greater confidence and self-efficacy developed appears to have supported participants to make key interpersonal changes that lower their potential risk, "*I am going to start getting feelings like that but it's how I deal with it and how I prevent my feelings turning into bad behaviours*" (Elliot); "*I don't buy sex now, I don't buy it anymore. I don't buy people. I used to do it in the past but after the group I don't want to do it anymore*" (Charlie). During supervision, I reflected on how this quote stood out to me. I wondered if Charlie was referring to prostitution when he said "I don't buy people," and considered how best to interpret this in my analysis. However, I realised that I was making precarious assumptions about the meaning of his words. In the interview, I had not asked for clarification and during the analysis I tried to fill the gap with my own interpretation. In supervision, I acknowledged that it would be more valid to present Charlie's exact words and openly reflect on my uncertainty regarding their meaning, rather than impose my own preconceptions onto his narrative.

The positive outcomes identified by the participants, i.e. greater knowledge and confidence, emotional control, and risk reduction, suggest that participation in the group could lead to various interconnected transformative interpersonal changes in the men. These changes may reflect the broader concept of a sense of empowerment. As participants experience self-improvement, they may feel empowered to make adaptive choices and reintegrate into the community. This theme also highlights the duality of engagement in the group. Though the group may present with challenges and emotional difficulties, it also provided a space for empowerment and personal transformation. While developing this theme, I noticed a tendency to focus on narratives of risk reduction. In supervision, I reflected on this and acknowledged that I felt pleased to see these narratives. However, I considered that this satisfaction might stem from my prior therapeutic work, where ‘progress’ was often measured by risk reduction. This may have influenced my desire to document such narratives. Although, reporting on risk-related narratives remains important, I also made a deliberate effort to capture the complexity of participants' experiences, including those who questioned the relevance of certain modules. As such, I reinforced the value of therapeutic interventions through risk reduction, I aimed to not minimising more ambivalent or nuanced narratives.

Superordinate theme 4: Navigating between social and individual needs

The interaction between individual needs and group dynamics was a recurrent narrative. This theme encapsulated the tension between the benefits of group engagement and equally addressing individual needs.

Group dynamic

Various participants spoke positively of the group, “*I really enjoyed it, I loved* it” (Dan), noting that the group was “*quite fun*” (Elliot). For some participants, a central factor to the group being enjoyable was the positive group dynamics. Participants noted that they did not feel judged in the group, which meant they were able to speak openly, develop friendships, and feel comfortable with each other, "*we supported each other… we all had a laugh with each other*" (Frank). It is possible that discussing difficult topics, including their index offence, may have contributed to the bond developed, through the realisation of shared challenges. The group may have provided a space to meet needs for connectedness. Participants expressed that they enjoyed "*having cups of tea in the break*" (Bruvis) with other participants and staff members. The simplicity of having a hot drink with others seems to have provided a positive shared experience spoken of fondly.

The facilitators of the group were described as a notable factor that supported a positive group dynamic. Participants expressed feeling supported by staff and described them as "*kind and honest*" (Charlie), "*top class*" (Elliot), "*very understanding, very patient, very helpful*" (Isaac). These descriptions suggest that facilitators were likely successful in creating an atmosphere of trust, which may have fostered stronger connections between participants. Importantly, participants noted that having facilitators that they were familiar with, i.e. staff members that worked within their hospital, helped them to feel more comfortable and increased the likelihood of them engaging with the group, "*I've known them for ages, if they had anyone else, I wouldn't have applied*" (Frank).

Interestingly, there were mixed reports between participants regarding the number and length of sessions. A few participants mentioned that the two-hour session were enough and there was not a need for more. However, other participants stated the sessions went quickly, and they would've preferred more sessions that lasted longer, "*Yes, I wanted more, more sessions would have been better*" (Charlie).

> I would've preferred for it to be a bit longer than that period of time because if there was anything that I needed to ask or anything you know… I would've rather you know spent more time to go through it you know (Elliot).

It is possible that the desire for more sessions may reflect a need for structure, of which consistency may be perceived as quite containing. Overall, the quotes suggest that the group was perceived well by participants. The length and number of sessions appeared to have been important in relation to participants needs to develop understanding and possibly trusting relationships.

Individual needs

Though the collective nature of the group appeared generally positive, some participants struggled with the social dynamics, "*it was all in a circle and people were looking at me… I didn't really talk*" (Gilbert). This participant shared his preference for individual sessions, as "*I would have felt a lot more* comfortable" (Gilbert), which was echoed by another participant who noted a preference for a mix between group and individual sessions (Bruvis).

A motivating factor for desiring individual sessions was a difficulty with processing speed. A participant expressed feeling overwhelmed with the information shared in the group, requiring for the information to be repeated a few times, "*staff were just throwing them and storming them at me (material)… which I found difficult because of processing the information… at least I got it, once it was said twice or the third time, it then sunk in*" (Bruvis). A few other participants echoed possible differences in learning capacity, with a few participants feeling that the content was "*a bit slow to start with*" (Andrew), whilst others noted difficulties to recall the content learnt, "*I don't know, I can't remember much. I'm autistic*"

(Hugh), "*because sometimes I would forget what that means*" (Dan). These quotes denote a diversity of learning needs, with differences with memory or pace of learning, highlighting a need for more individualised learning approaches.

It is important to note a potential confounding variable that may have influenced the noted difficulties with recall. For some participants, the interviews took place a while after the group ended. This may have likely had an impact on their ability to recall some of the content from the group, "*I'm struggling with my memory because that was at the beginning*" (Andrew). It may be of note to consider this going forward, possibly introducing 'refresher' sessions for participants, to keep the momentum of learning and personal changes going.

In developing this theme, I was drawn to the tension between participants' positive experiences of group connection and their varied individual learning and social needs. Reflecting on my own clinical background and familiarity with group-based interventions, I recognise my tendency to view group cohesion and peer support as inherently therapeutic. This may have influenced my interpretations of the positive narratives, in which I interpreted the group as a place of shared growth.

Discussion

The present study sought to explore the views of service users who participated in the SOTSEC-ID group intervention. Utilising RTA, four superordinate themes were developed, with accompanying sub-themes: 1) motivators for participation; 2) concerns, fears, and emotional vulnerability; 3) empowerment and development of self-efficacy; and 4) navigating between social vs individual needs. In line with Braun and Clarke's (2021) approach to reflexive thematic analysis, the themes presented were constructed through my interpretive engagement with the transcripts, shaped by my clinical background and previous experience with this population. My interpretations of participants' language and meaning was influenced by my familiarity with their context, which may have allowed for deeper empathic insight, but also posed risk of bias. I recognise that the findings presented are one possible interpretation of the data. Different researchers may have constructed different themes based on the same data. However, throughout this process, I aimed to be consciously aware of how my personal circumstances and values shaped the development of meaning, and I sought to reflexivity question my assumptions by engaging in supervision and keeping a reflective diary.

Overview of findings

Reflections on the interviews

Interviewing the participants as a female researcher inevitably introduced complex dynamics that may have influenced their openness. The sensitive nature of the topic may have heightened feelings of shame and/or guardedness, for instance when discussing issues such as sexual behaviour and empathy. Some participants may have moderated their responses due to perceived fear of judgement or concern about how their disclosures might be interpreted by a woman. Nonetheless, for others, the presence of a female interviewer may have provided a less confrontational atmosphere, potentially encouraging greater reflection. These dynamics likely influenced both the content and depth of what some participants were willing to share.

The shorter interview times in site C and D, due to both organisational and interpersonal barriers, may raise questions regarding the richness and quality of the data provided by participants. Understandably, participants may have offered less insightful and in-depth contributions, particularly in site C, which may question the validity of findings. Furthermore, although a rationale was presented for conducting interviews at site D prior to the end of the intervention, this may have impacted findings. Participants interviewed before the completion would have not had the full experience of the group and had less opportunity to consolidate their learning, which may have affected their ability to reflect on the full scope of the interventions impact and their experience. However, though limited, the contributions from participants in all sites, including C and D, were deemed meaningful. Each contribution, however small, supplemented to concept and/or theme development. Participants' contributions from sites C and D sites provided valuable insight into participants' initial reactions, expectations, and the process of engagement in the group, which are essential components of understanding the intervention's acceptability and perceived relevance.

The length of interviews corresponded with the number of quotes analysed and presented in the findings. Participants who elaborated on their experiences more extensively naturally contributed more information and consequently resulting in a greater number of quotes. Their accounts provided rich insights that helped develop and shape the themes. However, the uneven representation of voices is noted. This was not due to a lack of value in their contributions but rather reflected the challenge of equally balancing voices in samples where some participants express their views less than others. Importantly, influential quotes were also gained from shorter interviews, which were included in the analysis, though these were fewer in number. I was mindfully aware of this imbalance and aimed to honour and include the contributions of all participants, irrespective of interview length or the amount of data provided, to ensure that less prominent voices were not overlooked or undervalued.

Theme: Motivators for participation

Dual motivators for participation were captured in this theme. For some participants, engagement in the group felt driven by personal aspirations. Participants shared a ‘need for help’, seeking the group to meet their need due to previous failed attempts to manage their own difficulties. Furthermore, participants with personal aspirations and goals, i.e. discharge to community living, were motivated to participate in the group and make desired changes. As self-motivation plays a key role for positive treatment outcome (Görgülü, 2020) and is linked to greater treatment response and engagement (Thai et al., 2024), it was unsurprising that participants who had personal motivations for engagement spoke to the usefulness of the intervention.

Contrastingly, some participants felt that their participation was influenced by external pressures, participants spoke to an obligation to engage as part of their treatment requirements. This may highlight an ambivalence that some participants may experience towards the intervention, unsure of the potential benefits of the group. However, research has shown that though intrinsic motivational processes are more effective at producing positive treatment outcomes, external factors, including pressure from loved ones, can positively influence engagement and outcomes (Görgülü, 2020; Miller & Rollnick, 2012), suggesting that participants may still benefit from participating in the group. Nonetheless, considering methods to improve participants’ self-motivation are still merited. In instances in which external pressures present as the primary motivator for engagement, facilitators could assist participants to build understanding of how the group could contribute to their broader goals, in turn developing personal investment.

I do acknowledge that my interpretation of motivation as a binary concept (external and internal drive) may reflect a concept more common in psychological clinical practice. This is likely to have shaped how I interpreted narratives on obligation or personal goals. I recognise that a different researcher with another perspective may have focused on other concepts, such as power dynamics.

Theme: Concerns, fears, and emotional vulnerability

The second superordinate theme highlights the difficulties experienced in the group. Several participants expressed that the material was intense, often leading to emotional discomfort. This was noted as one of the difficult components of group attendance, in line with previous research that report that discomfort and embarrassment present as challenges to group engagement (Poole, Smith, & Simpson, 2015). In particular, engaging with the victim empathy module was uncomfortable for many participants, and led to avoidance for some; supporting wider research findings that show that autistic men often struggle with some components of victim empathy (Brewer & Murphy, 2016; Rawdon et al., 2024). The plausible avoidance is important to note as engaging in victim empathy modules remains an important component of offending programmes for risk reduction (Wormald & Melia, 2021), and as such cannot be removed. This may warrant adaptations to how the victim empathy content is delivered, for instance based on the current study increasing facilitated discussion amongst participants may help reduce avoidance by encouraging shared engagement with the material. Barnett and Mann (2013) also recommend a more general approach to the empathic process, rather than a sole focus on empathy for victims, which through creative techniques, perhaps focusing on cognitions, may target participants' overall blocks to empathy.

Participants also shared that another difficult aspect of engaging with the group was sharing their index offence with other group members, a finding in line with previous research (Hays et al., 2007). Participants in the current study feared others' perception and judgement, which for some may have presented as a barrier to openly sharing in the group. The emotional discomfort experienced also related to hearing others share their index offence. This may suggest that emotional discomfort is in one way or another an unavoidable and inherent part of the SOTSEC-ID intervention. Preparation for this may be important and could support participants to maximise their engagement. Though sharing about their index offence was predominantly seen as difficult, some participants equally found it helpful, as they viewed the group as a space for mutual support.

The intensity of the content combined with the vulnerability of sharing their index offence, created an environment where participants understandably felt exposed and vulnerable. However, as the group also fostered self-confidence, efficacy, and empowerment, it appears that the concerns by participants were mitigated. Participants were able to address their difficulties and make desired changes, as well as enabling the development of a safe and supportive group environment.

I note that due to my clinical background, I may have been focused on signs of discomfort or avoidance in participants. Initially, I interpreted participants discomfort as something that needed to be addressed. However, the more I engaged with the data, I aimed to reframe my approach, noting that these narratives are important in their own right, not as evidence of possible 'downfalls' of the group, but as part of how participants engaged with therapy.

Theme: Empowerment and development of self-efficacy

This theme captured the valued and helpful components of the intervention, which fostered personal growth, a sense of empowerment, and transformation for many participants. Participants shared that they often engaged in meaningful reflections within the group, which they attributed to encouraging change and personal growth. Participants reflected that discussions with 'teammates' helped them to share their difficulties and discover solutions through teamwork. It can be said that the group created a safe environment in which participants experienced understanding from one and another, leading to a joint effort to tackle difficulties. The space for questions and discussions was highly valued by a participant, who reflected that though talking about the past may have been difficult, he wished there was more time allocated for discussions. Group discussions have variously been denoted as a helpful tool to promote collective and individual learning as well as increase understanding of new perspectives, which drives personal development (Gustavsen & Vennebo, 2024). In this way, the group discussions within the SOTSEC-ID group were likely essential for participants' personal transformation and self-efficacy.

Positively, various participants shared that the group also supported them to reduce their risk of further sexual offending. The men shared that following the group they developed greater understanding of their risk, which helped to develop self-efficacy and reduce risk. Notably, self-efficacy is theorised to directly impact the initiation or cessation of behaviour, leading to the development of healthy habits (Jo et al., 2018). Furthermore, in line with SRM (Ward & Hudson, 2000), the group may have influenced the development of self-regulatory behaviour, through better understanding of their thinking patterns and behaviour, supporting the men to supress problematic behaviour and engage in goal-oriented behaviour (Keeling & Rose, 2012). Participants also shared that participating in the intervention supported them to feel more comfortable and confident in public. It is likely that many participants with IDD-HASB experience shame regarding their offence (Henson, 2023; Tewksbury, 2012) and coupled with difficulties with experiencing social inclusion (Robinson et al., 2021; Tilly, 2019), being in public settings proves difficult. This suggests that the group presents as a helpful stepping stone to improve self-confidence in social settings, necessary for community integration. This is of importance as poor reintegration into the community has been shown to weaken treatment outcomes of offending programmes (Willis & Grace, 2009). The likely experience of shame in the group may suggest additions to the intervention approach, for instance introducing material on self-compassion.

Participants also highly valued the content of the intervention, particularly the cognitive model, sex education (consent), and victim empathy modules. A few participants shared that they did not have prior knowledge of some of the material covered in the sex education module and found it helpful to use to reflect on their past ‘wrong-doings’. This supports that sex education for those with IDD can be an important tool to support positive sexual behaviours (Strnadová et al., 2022) and is in line with a systemic review that shows that individuals with IDD desire more sex education (Brown & McCann, 2018). However, one participant raised a notable suggestion to ensure the content is applicable to different sexual orientations. Both the cognitive model and victim empathy module were regarded as central to the personal transformations that participants made. Participants reflected that changes to their thinking patterns and considerations of the impact on victims helped to develop new perspectives that motivated their personal development and a possible reduction in recidivism, in line with the concepts of ITSO theory (Keeling et al., 2009; Ward & Beech, 2006). Nonetheless, though participants valued the content of the intervention, a few participants struggled to recall the material. Positively, the manual includes 6 weekly maintenance sessions, which may aid recall as well as the long-term impact of the intervention.

In supervision I reflected that while familiarity with the study's context enabled a meaningful engagement with the data, my interpretative lens was shaped by my therapeutic values around personal transformation and risk management. These values may have guided which aspects of the data I made prominent, particularly themes of self-efficacy and personal transformation.

Theme: Navigating between social and individual needs

This theme broadly reflected the interaction between group dynamics and individual needs, and how this may impact participants' overall experience of a group learning environment. In terms of the perceived benefits of the group dynamics, participants considered the atmosphere to have been comfortable. Participants generally spoke positively of the group, noting the opportunity to learn from one another, as well as feeling supported. The relationships created within the group were discussed positively as the group provided a space for connectedness, wherein participants did not feel alone with their difficulties and were able to have a positive shared social experience. This also related to the facilitators, who were viewed as a supportive component of the group. These reports were similarly found in previous research (Hays et al., 2007) and are important to note as positive social engagement is known to reinforce learning (Zhu et al., 2025), which would suggest that more content from the intervention would be retained by the men. It is possible that the sessions being held twice a week over 6 months rather than once a week over a year, may have also contributed to the development of positive social relations. However, mixed views on the structure of the group were shared, with some participants suggesting longer sessions, whereas others felt the number and length of the sessions were about right.

A few participants shared their preference for individual treatment over group intervention. One motivating factor for this was the difficulty with maintaining the pace of the group. This highlighted a diversity in learning needs amongst participants, showcasing how individual needs may go unnoticed and be less apparent in a group setting. By identifying the different learning needs amongst participants components of the intervention could be tailored to introduce personalised support. Adaptations can help balance the collective aspect of the group with the individual needs of participants, ensuring that no one feels left behind, maintaining a supportive atmosphere for all participants.

Evaluating the study: Strengths and limitations

Strengths

A primary strength of the study regards the utility of the themes. The themes are interconnected and reflect both the emotional and psychological aspects of the group, the social and individual dynamics of participation, and the useful and empowering components of the intervention. Each theme helps to provide a lens by which the SOTSEC-ID intervention can be evaluated, ensuring that the intervention truly meets the needs of its participants. Assessing the aspects of the intervention that are perceived as most helpful presents valuable insights that can be used to tailor the approach and delivery of the intervention. Such insights are difficult to capture from quantitative data. Furthermore, this study was a part of the process evaluation of the trial. Process evaluation is an important component in trials of complex interventions as it serves to design and test the intervention as well as measuring the impact of context and implementation (Massazza et al., 2022).

The choice of analysis was a further strength. Other qualitative analytic methods were considered, such as interpretative phenomenological analysis (IPA; Smith et al., 2009). However, this was not deemed an appropriate method in the context of a process evaluation of a clinical trial. Conducting RTA enabled the exploration of emerging themes across a group, providing a breadth of themes that meaningfully evaluated the experience of the intervention (Braun & Clarke, 2006). My decision to use RTA also aligned with my epistemological position, where I aimed to construct meaning through my engagement with participants' narratives. This choice allowed me to work interpretatively with the data, while acknowledging my bias as a researcher.

A further strength of the study lies in its methodological rigour and its contribution to the limited body of research that captures the voices of individuals with IDD (Lake et al., 2014). Previous research has highlighted a lack of methodological quality in this field (Heppell et al., 2020; Onyeama & Rose, manuscript in preparation). In contrast, the current study meets established criteria for methodological quality by providing detailed information on the recruitment strategy, data collection process, and the researcher–participant relationship. These elements enhance the credibility and robustness of the findings.

The interviews were conducted by a researcher who was not a facilitator nor directly involved with the development or delivery of the group intervention. This was a methodological strength as it minimised the possibility of desirability bias, in which participants may have attempted to appease the interviewer with their responses and may not have been honest about their views and experiences. However, this may also have meant that participants may have been reluctant to disclose information to an unfamiliar professional, placing a limit on gaining a true understanding of their experience.

Limitations

Though the study had various strengths, it was not without limitations. Firstly, the interviews were conducted in multiple sites, and due to time constraints, some sites were not approached for interviews and therefore participant views were not included in the present study. Data collection at Time Two needed to be completed prior to qualitative interviews, and this process was slower than hoped. This limited the number of participants and narratives contributing to the analysis and the richness of the dataset. The wider research team will attempt to gather further participant narratives, but for this analysis, it can be said that the meaning drawn should be interpreted and applied with caution.

The time between the group end date and the interview date may have also adversely impacted the breadth of the data. For site A and site C, interviews took place three months and six months (respectively) after the end of the group. A few of the participants in these sites stated that they had forgotten parts of the content covered and struggled with providing insights. This undoubtedly affected the depth of the analysis due to limited or lack of responses on some questions.

Though service user input was considered during the design of the interview schedule, there was scope for greater involvement and co-production with service users. For instance, service users could have been involved in the data analysis process, i.e. review codes and theme production, and may also be involved in the dissemination process (i.e. co-presenting findings). Involving service users in the analysis may have enriched the interpretations drawn and strengthened their roles as active contributors in participatory research. However, ethical consideration may require attention due to the sensitive nature of the data and services in which participants resided in (Hewitt et al., 2023).

Lastly, the initial coding from the data were not assessed by a second rater for the process of reliability. The absence of a second coder meant that the analysis was shaped entirely by my own interpretative lens. While this aligns with Braun and Clarke's (2021) assertion that reflexive thematic analysis does not require inter-rater reliability, it placed greater responsibility to be transparent during analysis. I note the potential bias during the analysis as alternative interpretations are possible. I note importantly that the themes solely represent a version of participants' experiences, shaped by my positionality.

Implications: clinical, service-wide, research

The present study supported the identification of the components of the SOTSEC-ID intervention that are perceived as useful and helpful by participants. By drawing on participants personal meaning, an understanding of their experience was developed. This is of importance as it can help to refine future versions of the intervention, along with broader implementation considerations.

Clinical implications

Findings from this study suggest the importance of flexible delivery formats to accommodate the diverse needs and preferences of participants. Several individuals expressed a clear preference for individual sessions or a hybrid model combining group and individual formats. For some, individual sessions were not simply a preference but a method to support learning consolidation. Clinical services should consider integrating individual input either as a preparatory phase before the group begins or alongside group delivery to reinforce learning and engagement. Given the diversity in cognitive and learning abilities across participants, it is also recommended that an additional facilitator be present during group sessions. This role would involve providing real-time, tailored support to participants, managing pace, and ensuring accessibility of content. Where resources permit, separating groups based on ability level may offer a more targeted and effective learning environment.

Finally, the content of the intervention must be inclusive and responsive to the diverse sexual orientations represented within the service user population. This includes not only language and imagery, but also scenarios and discussion content that represent a broad spectrum of identities and experiences. Neglecting this risks alienating participants and undermining therapeutic engagement. Tailoring content in this way is central to delivering ethical person-centred care.

Interestingly, though in previous research a diagnosis of autism was associated with recidivism at 6-months and a greater likelihood of further sexual offending (Heaton & Murphy, 2013; SOTSEC-ID Group, 2010), in the present study men with autism spoke positively of the intervention and were able to engage with the content, noting the meaningful impact it had on their behaviour. This points to the broader applicability of the intervention, to both intellectual and developmental disorders. However, participants' self-reflections of their risk reduction may not accurately reflect their behaviour or scores on quantitative risk measures.

These findings have relevance beyond the immediate context of the SOTSEC-ID programme and may inform the design and delivery of other group-based interventions within forensic and/or broader disability services. For instance, the identified need for slower pacing and tailored communication highlights important considerations for intervention accessibility. These adaptations could enhance engagement and therapeutic outcomes in other structured group settings, such as anger management, substance misuse, or skills-building programmes for people with IDD (Chaplin, 2011). The emphasis participants placed on feeling respected and included underlines the value of trauma-informed relational approaches, which could be adopted across diverse service models (Houck & Dracobly, 2022; Keesler et al., 2025).

Participants valued being part of a group but also needed support to express vulnerability without shame. Interventions could include preparatory one-to-one work, to promote emotional safety, empowerment, and relational support. Furthermore, the present study provides helpful logistical implications for future qualitative evaluative studies in this field, for instance, in relation to timing of interviews or provision of breaks during interviews. By embedding the principles derived from this paper, future group interventions may become more responsive to the complex needs of individuals with IDD, particularly in secure or restrictive environments.

Research implications

Due to time constraints, a limited number of participants were included in the present research. Future research in this field could benefit from having a larger number of participants. Lastly, as participants noted difficulties with retaining information covered in the intervention, strategies to support memory may be appropriate. Future research may be required to determine what participants would find beneficial to support their retention of information.

Furthermore, scope for future research may include embedding experts by experience throughout the research phase, i.e. development and design, analysis, and dissemination, as it would positively enhance co-production.

Conclusion

The findings from the present study suggested that participants generally found the SOTSEC-ID intervention positive, with components such as group discussions, content covered, and group members, described as useful. Difficult aspects of the intervention regarded the emotional vulnerability required and the intensity of the material. An interesting theme that arose was the sense of empowerment and self-efficacy developed because of the group, wherein participants highlighted meaningful reflections as contributors to their personal growth and change, noting their vested interest in their recovery journey.

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Chapter Three: Public dissemination, press release

LISTENING TO LOCKED VOICES: WHAT PEOPLE WITH LEARNING DISABILITIES SAY ABOUT LIFE IN SECURE CARE.

AND

FINDING A WAY FORWARD: WHAT MEN WITH LEARNING DISABILITIES SAY ABOUT A NEW GROUP PROGRAMME FOR HARMFUL SEXUAL BEHAVIOUR

Listening to locked voices: what people with learning disabilities say about life in secure care

This study explored the lived experiences of people with intellectual and/or developmental disabilities (IDD) in secure services. Drawing on 11 qualitative studies, the findings highlight conflicts in service users' perceived sense of identity, autonomy, and relationships. By focusing on the voices of individuals often excluded from research, the study sheds light on how care environments can affect wellbeing, both positively and negatively.

A long history of poor care

Since the 1800s, people with intellectual and developmental disabilities (IDD) in many Western countries were often placed in large institutions focused more on control than care. Over time, these places became known for neglect and abuse. Many individuals with IDD experienced neglect and abuse. In the UK, a series of major scandals, from Ely Hospital in 1967 to Whorlton Hall in 2019, exposed repeated mistreatment, poor oversight, and lack of proper housing options. In the U.S., the 1972 Willowbrook case showed children with disabilities living in terrible conditions, leading to new laws to protect their rights.

In the 1980s, countries like those in Western Europe began to push for change. Inspired by ideas from Scandinavia, they promoted the belief that people with IDD should live lives as normal and independent as possible. This led to the move away from institutions toward community-based care, known as deinstitutionalisation.

Despite decades of reform, problems like poor care and lack of oversight continue. This study adds to the growing calls for real change, including greater accountability, better support systems, and making sure people with IDD are heard and involved in shaping their care.

Methodology

Following a structured meta-ethnographic framework, the authors systematically reviewed 11 qualitative studies, mostly UK-based. These studies included direct quotes from people with IDD living in secure services. The research focused on their personal accounts, what life felt like, what mattered to them, and how they experienced care.

Key findings

The review identified four main themes:

1. Sense of self: several participants described feeling stripped of their identity often compounded by the geographical distance from family and community. However, some individuals regained a sense of identity through shared activities, which fostered belonging.
2. Where is my power?: A recurring narrative was the lack of autonomy. Service users described being excluded from decisions about their care. Small freedoms, i.e. decorating their room, were viewed as meaningful, suggesting that greater autonomy could improve well-being.
3. Navigating social relations: Social relationships with residents and staff were variable. Positive encounters built trust and self-worth, while negative interactions had adverse emotional effects, wherein many struggled to feel safe or connected.
4. Necessary evil: Secure services were described as both protective and punitive. Service users acknowledged the benefits offered by secure care while simultaneously expressed a desire to leave.

A Call for change

While participants acknowledged that secure services can offer needed support, many also described feeling depersonalised, disempowered, and disconnected from family and community. The findings call for:

- More personalised care: Greater opportunities for autonomy, personalisation of environments, and shared decision-making.
- Staff development: Improved training on respectful, person-centred care and clearer professional boundaries.
- Social connection: Expanded access to meaningful activities, improved support for relationships within and outside the service, and consideration of distance from home when placing individuals.
- Service improvement driven by lived experience: Individuals with IDD should be directly involved in shaping services, not just studied by others.

Finally, the study urges more robust and inclusive research, especially in secure settings, to inform future policy and practice. By listening to those directly affected, we can build safer, more empowering systems of care.

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Finding a way forward: what men with learning disabilities say about a new group programme for harmful sexual behaviour

This study explored the experience of participating in a therapeutic group intervention for men with intellectual and/or developmental disabilities (IDD) who had previously engaged in harmful sexual behaviours (HASB). With growing concern about sexual offending, particularly among men with IDD, this study offers valuable insights. It highlights which components of the intervention were experienced as helpful, and what changes could make it even more effective and accessible in future.

Addressing a need for intervention

Men with IDD present with higher rates of HASB and reoffending compared to the general population. Despite this, treatment options remain limited, and traditional approaches often prove ineffective or inaccessible for this group. The Sex Offender Treatment Services Collaborative – Intellectual Disabilities (SOTSEC-ID) intervention was developed specifically for men with IDD. It uses adapted cognitive behavioural therapy to increase sexual knowledge, improve emotional regulation, develop empathy, and ultimately reduce the likelihood of reoffending (Sinclair, Booth, & Murphy, 2002; SOTSEC-ID Group, 2010).

While early studies suggested the programme had promise, the HASB-IDD trial was designed to evaluate its effectiveness more robustly. As part of this trial, a qualitative component explored participants' lived experiences in the group. This study provides an insider's view into how the intervention was received, what felt useful or difficult, and what might help improve it.

Methodology

Ten adult men were interviewed after completing the SOTSEC-ID group intervention at different sites across the United Kingdom, including community and inpatient settings. The interviews were analysed using Reflexive Thematic Analysis (RTA), which allowed researchers to identify shared themes in participants' accounts and explore their personal reflections on the group experience.

Key findings

The analysis revealed four key themes:

1. Motivators for participation: Motivation for engagement varied. Some participants had strong personal goals, such as improving themselves or moving towards independent living. Others felt they were expected or encouraged to attend by professionals, even if they were unsure about the group at first.
2. Concerns, fears, and emotional vulnerability: Talking about past behaviours, especially their index offences, was emotionally difficult for many participants. Some worried about how they would be judged by others. Topics like victim empathy and consent were particularly intense. Despite this, many men appreciated the group as a safe space where they could talk openly and support one another.
3. Empowerment and development of self-efficacy: Participants described feeling more confident and self-aware after the programme. They reported learning new coping strategies, such as recognising risky situations and managing their emotions. Some said the group gave them a "second chance at life."
4. Navigating social and individual needs: Many valued the social aspects of the group, including mutual support and positive relationships with facilitators. However, participants also had different learning needs. Some struggled with the pace of the

sessions or found it hard to retain information. Others felt that the group content did not reflect their personal experiences, such as being in same-sex relationships.

Implications for intervention design

The intervention helped participants begin to reflect on their behaviour and make meaningful changes. The group setting created a shared experience, which helped reduce shame and increase motivation for change. However, the study also showed that not all participants benefit in the same way.

To better meet individual learning needs, future adaptations could include offering a mix of group and individual sessions, more support during and after the group, and content that reflects a wider range of sexual identities and experiences. The study also suggests that facilitators play a key role in creating a safe and respectful group environment, which helped many participants feel more comfortable and engaged.

Conclusion: a step forward

Overall, the findings suggest that the SOTSEC-ID intervention is a promising approach to supporting men with IDD who have engaged in HASB. Participants reported positive outcomes, including increased self-awareness, improved emotional control, and a stronger sense of empowerment. However, challenges related to emotional vulnerability and diverse learning needs remain important to address. Listening to participants' voices has provided rich insight into how the intervention works in practice and offers a strong foundation for continued improvement of treatment options for this often-overlooked population.

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Appendices

Appendix A: Study characteristics extraction table

Title, author, and year of publication	Country conducted	Participant demographics	Operationalisation of LD/IDD	Type of inpatient/secure setting	Questions/topics asked to service users	Analytic tools used	Themes and findings	Researcher positionality
Williams, Thrift, Rose, 2018. The subjective experiences of women with intellectual disabilities and offending behaviour: exploring their experiences of 'home'.	UK.	7 female participants. Aged 27-56. All participants were white British.	Diagnosis of mild-to-moderate intellectual disability as determined by FSIQ (WAIS-III).	Low secure unit for women with ID under Mental Health Act or detained for offending.	Semi-structured interview including exploring what/where participants considered as 'home', housing experiences, the experience of living in the secure unit, helpful aspects of their living arrangements, and what they value in home environments.	Interpretive phenomenological analysis	Superordinate themes: Hospital as helpful Hospital as undesirable A sense of belonging "I want to be as independent as I can"	A female researcher conducted the interview. There were no explicit accounts on the potential influence of the gender of the researcher on the perceptions or answers of the women interviewed. Other perspectives on the reports of experiences by participants were considered in research supervision and in an IPA support group. These perspectives were in line with researcher's interpretations, suggesting they were grounded in the data.
Hudson et al., 2017. Community football teams for people with intellectual disabilities in secure settings: "They take you off the ward, it was like a nice day, and then you get like medals at the end".	UK.	8 participants, male (7) and female (1). Aged 24-51.	Diagnosis of mild-to-moderate intellectual disability.	Low secure forensic unit.	Interview questions focused on the experience of being part of the football team, health and fitness, mood and behaviour, social contact, and suggestions for improvements to the programme.	Thematic Analysis	Superordinate themes: Health Psychosocial benefits	Two staff members, who were also authors in the research, recruited participants for the study. The interviewing authors were not the same as the recruiting authors, however it was unclear if the interviewing authors also worked in the service. This might impact the interpretation of data as completing interviews with members of staff could influence answers and increase bias.

Research Paper and Author	Country conducted	Participant demographics	Operationalisation of LD/IDD	Type of inpatient/secure setting	Questions/topics asked to service users	Analytic tools used	Themes and findings	Where is the researcher in relation to the data (positioning)?
Parkes et al., 2014. 'Going into the unknown': Experiences of male patients in secure settings during environmental transition.	UK.	9 male participants. Aged 24-51. 6 were white British; 2 were Black British; 1 was Asian British.	Diagnosis of mild-to-moderate intellectual disability.	Two medium-secure wards for adult men with mental health disorders and intellectual disability.	The semi-structured interview comprised of questions to elicit discussions of the experience of transition to, and within, secure services, and the current experience of the transition.	Thematic Analysis	Superordinate themes: Information Transition Behaviour	There was not rich detail on the researchers positioning in relation to the data. The interviews were conducted by two researchers, through a semi-structured interview. The lack of detail on this creates difficulty in understanding the possible influence of the researcher on the interpretations drawn from data.
Clarkson et al., 2009. What characteristics do service users with intellectual disability value in direct support staff within residential forensic services?	UK.	11 participants (8 males and 3 females). Aged 20-53. Participants who had resided at the hospital for an average of 4 years (range 1–10 years).	Diagnosis of intellectual disability.	Low and medium secure inpatient unit for people with ID who have offended or are considered at risk of offending.	No clarity on the type of questions asked or/and topics covered. Statement from the paper "The schedule contained an introductory verbatim script and for each category that had emerged from the focus group analysis, open and exploratory questions were composed that reflected that theme. General questions such as "why do staff choose to work at this hospital?" were also included."	Interpretive phenomenological analysis	Superordinate themes: Staff relationship factors Staff attributes	The first author and two members of staff facilitated the group. The interviews were conducted by the first author. To acknowledge the researchers positioning, the authors had an external supervisor to explore potential areas of bias. No detail on the positioning of the author but measures were taken to reduce bias.
Heppell and Rose, 2021. Men with intellectual disabilities and sexual offending histories: An exploration of their experiences of living within a secure hospital setting.	UK.	9 male participants. Aged 25-50. 6 participants were white British, 2 were Asian British, 1 white Irish. History of sexual offending.	Diagnosis of an intellectual disability or borderline intellectual disability as defined by the ICD-10.	Secure forensic unit.	Semi-structured interviewed that explored the participants' experiences of living a secure rehabilitation unit, including exploring their understanding and experiences of treatment, experiences of living away from home, and their plans.	Thematic Analysis	Superordinate theme: Hospital environment Personal journey through secure services Closeness to home	A psychologist within the service recruited for the study. The interviewer was the author, who was external to the service. The coding and themes were discussed between the researchers and with an additional researcher to explore alternative perspectives. This helped to reduce researcher bias when drafting the themes. The interviews were conducted by the first author who conducted the analysis. The study reported the use of supervision and reflective diary to processes positioning and feelings throughout the interviewing and analysis process.

Research Paper and Author	**Country conducted**	**Participant demographics**	**Operationalisation of LD/IDD**	**Type of inpatient/secure setting**	**Questions/topics asked to service users**	**Analytic tools used**	**Themes and findings**	**Where is the researcher in relation to the data (positioning)?**
Wood et al. 2008. Service user satisfaction in a low secure forensic learning disability unit?	UK.	7 participants (5 male, 2 female). Aged 18 and over.	Diagnosis of mild-to-moderate intellectual disability. FSIQ scores within the mild/borderline range (WAIS maximum score was 75).	Low secure forensic unit.	No clear description of the topics covered, or questions asked. Statement by the study "The semi-structured interview protocol was developed following consultation with all service users on the unit who were asked what factors they thought would be important if there was to be a survey of their views of the care they received".	Content analysis	Superordinate themes: Restriction/detention Treatment	Authors were staff members at the service. The senior researchers' role was to guide the study and overview analysis, including credibility checking. A third researcher sought participants to ensure that service users did not feel obligated to partake in the study. There was not clarity whether the authors conducted the interviews, which may have led to bias. No further discussion on the researchers' positioning.
Chinn et al., 2011. Psychiatric in-Patients Away From Home: Accounts by People With Intellectual Disabilities in Specialist Hospitals Outside Their Home Localities	UK.	17 participants (13 male, 4 female) Aged 17-52. Half were white British; others were from other ethnic minority communities.	Diagnosis of mild intellectual disability.	Specialist psychiatric in-patient unit.	The semi-structured interviews explored life in the secure setting, including the physical environment, safety, activities, food education, socialisation, and religious needs.	Thematic Analysis	Superordinate themes: Punitive versus therapeutic treatment Discomforting environment Demeaning versus supportive staff relationships Power and hierarchies Group vs individualised treatment Far from home	Researchers contacted the service for recruitment of participants. The interviews were conducted by an assistant psychologist. It is unclear if the assistant psychologist worked in the service or solely part of the research team.
Neimeijer et al., 2021. "Back off means stay with me". Perceptions of individuals with mild intellectual disability or borderline intellectual functioning about the group climate in a secure forensic setting.	Netherlands.	12 participants (4 women; 8 men) Aged 22-45.	Diagnosis of mild intellectual disability or borderline intellectual functioning.	Secure forensic unit.	The semi-structured interviews explored support, growth, group climate, and the engagement with the socio-therapists get along.	Interpretive phenomenological analysis	Superordinate themes: Autonomy Recognition Uniformity Competence Dignity	The interviews were conducted by the first and second authors. The authors are not working in the service. The authors do have extensive experience in the field. This could influence their interpretation of experiences, such as influences based on prior contexts.

Research Paper and Author	Country conducted	Participant demographics	Operationalisation of LD/IDD	Type of inpatient/secure setting	Questions/topics asked to service users	Analytic tools used	Themes and findings	Where is the researcher in relation to the data (positioning)?
Beckham et al., 2020. Voices from the Newspaper Club: Patient Life at a State Psychiatric Hospital (1988-1992)	USA.	Female and male participants with an intellectual disability and mental health disorder.	Diagnosis of an intellectual disability.	Psychiatric state hospital. Dual Diagnosis Unit, that supported individuals with both intellectual disability and mental health disorders.	Retrospective, drawing themes from written newsletters. The newsletter evoked the daily routine of a long-stay state psychiatric institution and the dynamics patients.	Thematic Analysis	Themes: The mundane Good behaviour Advocacy	Independent coding of all data by more than one author; analysis from three disciplinary perspectives from the authors (a medical humanist; a medical historian and public historian; and a public historian and museum studies scholar). There was no description how disciplinary perspective could impact the meaning drawn and their positioning.
Murphy and Mullens, 2017. Examining the experiences and quality of life of patients with an autism spectrum disorder detained in high secure psychiatric care	UK.	7 male participants.	ASD diagnosis. Several participants levels of intellectual functioning fell in the “borderline” range.	High secure forensic psychiatric unit.	Previous experience before coming to the hospital as well as their views linked to various issues within the hospital (such as whether individuals believe staff are aware of their difficulties and sources of personal stress, etc.).	N/A	N/A	Unclear, no explanation or descriptions provided.
Murphy et al., 1996 Services for People with Mild Intellectual Disabilities and Challenging Behaviour: Service-user Views	UK.	26 participants (10 women and 17 men) Aged 18-53.	Mild intellectual disability.	Forensic in-patient unit.	Retrospective, drawing on service users’ memories of the service, such as staff, progress made, aspects they liked and disliked about the service.	N/A	N/A	Unclear, no explanation or descriptions provided.

ASD – autism spectrum disorder; FSIQ – Full scale Intelligence Quotient; ICD-10 - International Classification of Diseases; ID – Intellectual disability; N/A – Not Applicable; USA – United States of America; UK – United Kingdom; WAIS – Wechsler Adult Intelligence Scale.

Appendix B: CASP Critical appraisal checklist

Section A: Are the results valid?	
1. Was there a clear statement of the aims of the research?	Yes No Can't Tell
CONSIDER: • *what was the goal of the research?* • *why was it thought important?* • *its relevance*	
2. Is a qualitative methodology appropriate?	Yes No Can't Tell
CONSIDER: • *If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants* • *Is qualitative research the right methodology for addressing the research goal?*	
3. Was the research design appropriate to address the aims of the research?	Yes No Can't Tell
CONSIDER: • *if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)*	

4. Was the recruitment strategy appropriate to the aims of the research?	Yes No Can't Tell
CONSIDER: • *If the researcher has explained how the participants were selected* • *If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study* • *If there are any discussions around recruitment (e.g. why some people chose not to take part)*	
5. Was the data collected in a way that addressed the research issue?	Yes No Can't Tell
CONSIDER: • *If the setting for the data collection was justified* • *If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)* • *If the researcher has justified the methods chosen* • *If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)* • *If methods were modified during the study. If so, has the researcher explained how and why* • *If the form of data is clear (e.g. tape recordings, video material, notes etc.)* • *If the researcher has discussed saturation of data*	
6. Has the relationship between researcher and participants been adequately considered?	Yes No Can't Tell
CONSIDER:	

• *If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location* • *How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*	
Section B: What are the results?	
7. Have ethical issues been taken into consideration?	Yes No Can't Tell
CONSIDER: • *If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained* • *If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)* • *If approval has been sought from the ethics committee*	
8. Was the data analysis sufficiently rigorous?	Yes No Can't Tell
CONSIDER: • *If there is an in-depth description of the analysis process* • *If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data* • *Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process* • *If sufficient data are presented to support the findings* • *To what extent contradictory data are taken into account* • *Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*	
9. Is there a clear statement of findings?	Yes No Can't Tell

CONSIDER:

- *If the findings are explicit*
- *If there is adequate discussion of the evidence both for and against the researcher's arguments*
- *If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)*
- *If the findings are discussed in relation to the original research question*

Section C: Will the results help locally?

10. How valuable is the research?	Yes No Can't Tell

CONSIDER:

- *If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature*
- *If they identify new areas where research is necessary*
- *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*

Appendix C: Meta-ethnography analysis steps: first, second, and third order

	First order	Second order	Third order
Similar themes across studies	Participant quotes	Researchers’ interpretations	Present author’s interpretations
Belonging	“I enjoy the footie, I enjoy meeting the patients, having a laugh and a joke” Connor “when you are out in the community people don’t know if you’re in hospital or not you could just be you know like like just… they probably think you know you’re just with your friends” Anna Hudson et al 2017 “the first few days was very strange for me, it was trying to fit in, getting to know the staff, getting to know the other patients, and for them getting to know me as well. It certainly was all quite strange for me” P4 Parkes et al 2014	Participants experienced a sense of belonging, which can increase self-esteem and social interaction. The football programme unifies individuals, broadens acceptance of differences and encourages various people from various backgrounds to coexist. Essential intervention that improves the lives of devalued individuals. Hudson et al 2017 Patient experiences of adapting to change often appeared to relate to feeling accepted and settled within the new placement, which in turn appeared to be associated with the interlinked notions of home and sense of belonging. Parkes et al 2014 No quote offered by the authors, but the authors alluded to the fact that participants described that they belong to the group and/or feel at home, as the group members offer them sociability and support. There is a strong need to be seen and treated as an individual though. Neimeijer et al 2021 Celebrations at the hospital mimicked family gatherings, possibly providing sense of belonging. Beckham et al	The study by Williams et al highlighted a sense of belonging was associated with familiarity to a place, and the secure setting feeling like home. Quotes included 'home is a place I know". There is an emotionality attached to familiar places, which secure settings often are not. sense of belonging may arise from feeling quite familiar with people and the environment. participants in the study mentioned that they never had a home, or felt a sense of belonging. secure settings did not feel comfortable, and the often transition from one place to another reduced familiarity. starts to place questions on where participants would feel they belong? can they feel settled in the place they are? what if they're moved, would they belong? but also the place they are may not feel like home, but in the same breath they have not been home for a long time, so where exactly do they belong? how would they reconcile with the feelings of a lack of belonging and how would that manifest in terms of behaviour towards self and others. This sentiment of being far from home and possibly losing sense of belonging from that is echoed in Chinn et al's study. Authors discuss that being far from home has removed some service users from their cultural background and identity. a quote from a service user is that she no longer speaks Bengali and only speaks English. I wonder what that does to a sense of belonging to their community when they no longer speak like those in their community. Previous study shows that they don’t automatically feel like they belong in secure services, so where do they belong to? the study by Parkes highlights this very well. it explores how transition to a secure service is perceived by service users. service users made mention that it can be hard to fit in and get on with other service users and that this can take a while. Participants really highlighted wanting other to get to know them for them, emphasis on their sense of identity. it seemed that settling in the new environment was directly related to a sense of belonging, which was often reduced when issues with communal living arose. participants felt that there is nowhere to escape and lack of private areas, which would arguably be very different when compared to their home. Conversely the study by Neimeijer found aa sense of belonging by participants. They found that service users that were part of a group within a secure service felt aa sense of belonging to the group, the authors described it as a sense of home. they highlighted that participants wanted to spend time together and do activities, as the group was a place for support and sociability. It may suggest that being in a secure service along is not enough to feel like you belong, but engaging in activities, setting group is essential to foster this. belonging is described as key part of identity and fosters positive emotions. a lack of this can have negative consequences, so there is a need for services to foster this. similarly, the study by Hudson highlighted how the use of activities, such as community football, helps to foster a sense of belonging. motivation to engage in the activity was influenced by the benefits of being a team member, the authors discuss a strong sense of companionship and togetherness between the service users (quotes). this seemed to improve an acceptance of self, service users felt that though usually they would be marginalised, this brought them together and they were just like any other person. sense of belonging can increase self-esteem, sense of unity, and identity. participants spoke on feeling included and the value they experienced in this. the benefits of this is that better communication and skills were develop. lastly, Beckham et al found that even as simply as having celebrations in the home can help foster a sense of belonging, having celebrations at the home, like birthdays, holidays etc helped to mimicked valued family gatherings, fostering that sense of belonging together

	First order	Second order	Third order
Similar themes across studies	Participant quotes	Researchers' interpretations	Present author's interpretations
Identity	"I used to go into Derby centre with my mum's school friend. I miss all that" Ann "I want to have my own place, be my own person" Pam and Laura "A home is place you call your own, it's a home where you comfortable, and you happy… cos you have your own personal stuff in it" Jane Williams, Thrift, Rose, 2018 "I'm a totally different person when I play football than I am in here" Trevor Hudson et al 2017 "There's lots of people [at home] there they speak in my language, and it's easier to speak in my language but I haven't spoken my language for a long time now… But I don't speak Bengali now, I have to speak English all the time. I used to speak Bengali loads of times when I was in London. But I don't do that [now] because nobody speaks it here." Amir Chinn et al 2011 "treating everyone the same regardless of any personal situation and no attempt was made to understand my problems" Murphy and Mullens, 2017	Ann refers to missing particular people, her mum's old school friend, and the activity of going into her favourite town to meet someone. Perhaps these were an important part of Ann's identity which may be diminished or altered whilst she is in hospital. There is a sense from Pam and Laura of being less of their own person in hospital. Jane speaks to the importance of personalisation and ownership. Williams, Thrift, Rose, 2018 Trevor speaks to recognising himself as an individual, focused on his own rehabilitation Participants felt they shared an identity with one another. Hudson et al 2017 The aspect of the inpatient units reinforced depersonalisation, disempowerment and deindividualization. Participants described limited opportunities for individuals to practice, explore and develop their cultural and religious identities. Chinn et al 2011 No flexibility, no individuality, identity stripped away it seems Murphy and Mullens 2017	Williams et al spoke on different aspects of identity and what felt like influenced service user's identity. One of the things was in regards to missing friend and family, and the town centre, and the routine the service user used to do. Whilst in the secure service, the service user is unable to do these things and it's likely that this impacted upon her sense of identity, what she loved to do and her interests. questions around sense of self and 'who am I' are raised in the study, as participants alluded feeling like less of their own person whilst in hospital as they didn't have their own place which was equated to being their own person. "you know having my own place again". they described the need for their own individualisation and personalisation, where they have their own things and feel at home. Chinn et al also found a similar theme around a feeling of depersonalisation and lack of individualisation. participants felt that they were treated as part of a group and not as an individual person. they made mention of meal times and activity schedules being organised as a group, leaving little chance for personal autonomy. it may be hard within services to change this, but important to consider when thinking about the sense of identity of service users. the distance from home for some service users also contributed to the stripping of their personality, being far from their backgrounds and communities stripped them of their religious and cultural identities. In Neimeijer et al study it was highlighted that being part of a group in a secure setting can help with a sense of belonging, however, participants also emphasised the need and value upon being treated individually, recognise 'me' in the group, strong need for individual needs to be met and avoid excessive uniformity. taking positive activities together improved self-image but so did the feeling of being seen as a person. service users emphasised a sense of dignity. Hudson et al showed how activities can also influence the development of individual identity, such as a sporting identity. Hospitals can make you lose sense of self and identity but activities such as this can help to produce a new sense of self/alternative identity that is beyond their diagnosis. helped to develop a sense of self that they can proudly discuss and describe. Beckham also described that activities like writing newsletter contribute to a new sense of identity that service users are proud of "I'm a reporter1 I wrote an article!". Wood et al also discusses the recognition from service users about their progress since joining the unit, with positive quotes from service users
Skill development	"I must keep focusing, that I am at work, work, work. So, I don't stop working, I just work, work, work, because it gives me something to do, it's keeping me active" Charles Chinn et al, 2011 "I'm improving here… the staff support me and I got all my, I got my happy mood back" Daniel Heppell and rose, 2021 "I'm a reporter! I wrote an article!" Beckham et al 2020	Participants mentioned opportunities for developing independence skills. Engagement not only provided enjoyment and passed the time, but also gave aa sense of purpose. Chinn et al, 2011 A sense of personal growth, positive changes were recognised by participants, they were able to make these whilst at the hospital Heppell and Rose, 2021 Sense of growth and achievement, skill development influencing how they seem themselves. Beyond being a service user Beckham et al 2020	Chinn et al mentioned that service users felt their sense of purpose was developed through activities and leisure activities, by giving them independence skills. Participants felt bored in places where there was nothing to do, which would steal from a sense of comfortability in secure services. Heppell and rose indicated that personal growth was also to do with emotional control, service users mentioned feeling that they can manage their mood better and that they are improving at the hospital. secure services seem to foster growth, when done correctly. Neimeijer et al highlighted that service users valued feeling independent and feeling they had achieved something, everyday successes included preparing a meal for the group or receiving certificates in their therapy. this felt important to them when considering their long-term goals, in and outside of the hospital, the likelihood of being able to be back in the community. Hudson et al highlights that the football brings together different people from different level of security, who have to work together to achieve the same goal, it helps with upskilling service users and support their social development, by encouraging interactions with others. Beckham discusses how being a reporter is a development of skill for service users, writing and channelling their attention.

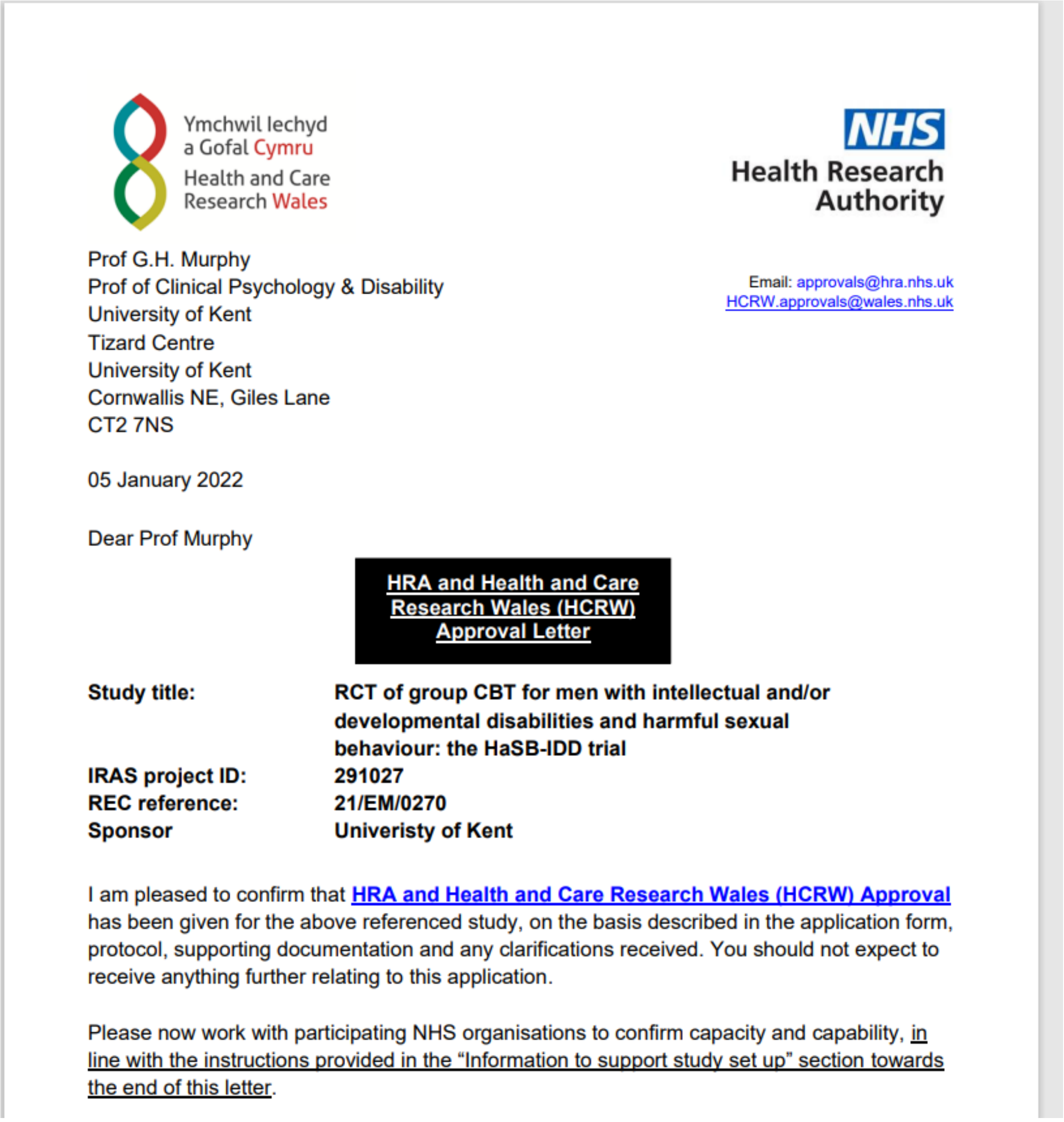
	First order	Second order	Third order
Similar themes across studies	Participant quotes	Researchers’ interpretations	Present author’s interpretations
Control, autonomy, independence	“I’m safe here (hospital) until I move on. Because they can put you anywhere, can’t they?” “Nowhere is comfortable” Pam “don’t get freedom… I wished I could leave here” Ann “I don’t want to be in hospital. Because you ain’t got your freedom, like, when you’re out there you’ve got your freedom” Jane Williams, Thrift, Rose, 2018 “manager picked bedroom. We’re not happy with it, none of us’ P5 “We don’t have a choice about being here. How would anybody feel about someone coming into your home and telling you what to do?” P3 Parkes et al 2017 “not enough staff on is there? Always on one-to-one’s or, you know what I mean” peter Heppell and Rose 2021 “it’s the staff who control things.” “I don’t [have enough contact] I see them once a week (regarding parents)” “No one should’ve moved them without my permission” “I don’t get enough of it [ground leave]”. “I don’t like hospital food” “beds aren’t comfortable, the mattress is hard” “I can understand they are busy but I have to wait to have a word with them” Wood et al 2008 “no one’s been listening to my opinion at the moment. As far as I’m concerned, it’s been going out of one ear and the other” Emilia “Nah, I feel that I don’t know what they’re discussing, because my CPA meetings, they go out and speak to each other” Boris Chinn et al 2011 “I’m not a twelve-year-old child. We are all adults, and that is sometimes forgotten.” Neimeijer et al 2021 “not being trusted with a computer has taken away my independence and real life” “seclusion for negative behaviour or comments being over the top makes me careful about what I can say” Murphy and Mullens 2017	There is a sense of powerlessness, feeling she has no control, fearful of future home and care environments. Jane’s use of ‘in hospital’ and ‘out there’ reflects a distinction for some participants between the community, associated with freedom, and hospital, associated with restriction and lack of freedom. Sense of importance of autonomy and decision making. Restrictions around social and daily activities illustrate their value for freedom. Sought freedom, want independence. Williams, Thrift, Rose, 2018 Concerns related to uncertainty and lack of control, such as bedroom allocation. Change was experienced as stressful, not knowing what to expect. Could this lead to behavioural difficulties? Parkes et al 2017 Staff limited numbers leading to restrictions for service users Heppell and Rose 2021 Restrictions are frustrating and provocative, it a sense of lack of control, even in terms of food accessibility to staff support, and the environment. Things that we can change in our environment. Wood et al 2008 Relating to whether participants felt they were offered choices and were able to exert control. Participants felt that many aspects of everyday life were decided by unit staff, like what to watch on TV, medication, ability to use the phone to speak to relatives, and frequency of visits. Chinn et al 2011 Participants expressed they want rules and boundaries to be explained to them in a respectful and mature way, explaining the measure taking. Uncertainty can lead to increase in problem behaviour. Sense of lack of power. limitations in autonomy, wanting freedom of movement. Neimeijer et al 2021 Good behaviour would mean patients have their privileges or these could be revoked by staff. Beckham et al 2020 Experiencing regular room searches, restrictions and seclusion, felt like a loss of freedom for patients Murphy and Mullens 2017	Heppell and rose discuss the fact that many service users do not experience autonomy and independence. Many of them went from living at home with parents to secure settings, so no real independence in adulthood. Williams discussed that participants shared wishes to leave the secure setting "I wish I could leave here" and expressed a sense of valuing and seeking freedom. secure settings restrict freedom to maintain safety but are the restrictions too much? how can we help foster sense of freedom and autonomy? participants spoke much on valuing freedom and the decision to choose, further highlighting the value of autonomy. service users described themselves as capable of independence, and liking to be independent. is it a matter of making opportunities for them to show their independence and skills? Neimeijer et al highlighted that participants recognise the limitations to their autonomy, and though they recognise that these might be necessary to keep people safe, they highlighted the need for staff members to recognise when a person should be given the chance to be autonomous and when not. this emphasises a notion of containment that is being sought from service users, to be kept secure and safe but also allow to spread their wings - containment, not control. murphy and Mullen’s discuss that participants felt that their lack of freedom in secure settings had a wider impact upon their life, even in the community. quote from participant feeling that their independence and real life had been taken away, with a further lack of autonomy on what you can say because of potential punishment, such as seclusion. participant made mention that seclusion made them be careful about what they could say, a sense of a muzzle over their mouth. In Beckham’s study, feels like autonomy might not be a true feeling. service users behave in certain ways to receive reward for good behaviour, what happens when they don’t? how autonomous did they truly feel. Heppell and rose presented accounts of service users’ frustrations with the hospital organisation, like lack of staff accessibility when they required. But a real sense of frustration came with feeling that the restrictions from the service impacted upon their progress, which affected how likely they'd be to leave the hospital. Williams described a sense of powerlessness experienced by service users, that they can be moved anywhere and not have a say. if they had control in other aspects, how would this be of help? Chinn et al highlighted that lack of choice is not just with big things but also with the smaller things like lack of choice on what to eat, as highlighted by a service user. if even the smaller things are decided, where do they have autonomy? however, they did highlight areas they could exercise choice which increased their sense of control, like how they decorated their room and activities. this would suggest that staff and professionals do not have the whole control. Neimeijer et al highlighted how communal living can restrict the freedom of some due to the behaviours of others, participants felt that their restrictions of movement where at times affected because of another badly-behaved person. it gives the sense that they are just a pawn, being taken for a ride and told what to do and when. Parkes et al explored how transition is experienced, when looking at this, service users often felt that they were being left in the dark and are not involved in decision making, even with things such as picking bedrooms. there is a sense that they don’t have a choice, this is their physical home and yet they are without choice. change is then often experienced as stressful. wood et al highlighted the often-reported restrictions experienced by service users, such as restrictions to contact family, restrictions with managing their money, restrictions to keeping their possessions how they want and having people move them, but also restrictions with access to the community. Murphy and Mullens interestingly highlighted the difficult for service users as rules are not created by them, but these are inconsistent at times, and if rules are broken, they experience punishment. so what control do they have?

	First order	Second order	Third order
Similar themes across studies	Participant quotes	Researchers' interpretations	Present author's interpretations
Relationship and experiences with staff	"well they're really been good to me especially when, when I've been upset and harmed myself and that" Jane "I'm meeting the staff and I'm getting support and help" Pam Williams, Thrift, Rose, 2018 "if you look at it positively, you have more people around you, more people that understand you a bit better" Connor "He is like a dad to me yeah, he tells me off sometimes and he, he wants me to succeed in life" Trevor Hudson et al 2017 "the staff want to care for the service users, they want to help the service users to understand what they are feeling" Participant 4 "because they are just not bothered, and you can tell that by their body language" P7 "Well I had a pain once and they said I was putting it on" P3 "They can tell when I am a bit down, because they have got used to it now" P2 "It's normally the case that I help staff if they are in trouble… because they have done a lot for me" P6 Clarkson et al 2009 "they treat you like a human being, they don't treat you like a patient" Shaun "I had someone there if I wanted to talk" Jake Heppell and Rose, 2021 "they are busy all the time, it would be nice to meet with them more" "I've talked to staff and they have helped me" Wood et al, 2008 "Pat is nice to me sometimes. She lets me visit and sit in her office and talk to her. She is pretty with curly hair. She is my best friend. I like to her pictures of her kids on her desk." Linda Beckham et al 2020 "having psychoeducation had allowed me outthink my ASD by being more careful in my planning and appreciation of other" Murphy and Mullens, 2017	Staff offered support when needed. For some participants like Pam, staff made their experience at the hospital positive. Williams, Thrift, Rose, 2018 Participants spoke quite nicely of their coaches of the team, they felt understood by them which increased their motivation to want to take part in the team Hudson et al 2017 Comments on the emotional relationship with staff, the positive impact on their relationship, implying staff were understanding and caring. But there were also comments on staff failing to demonstrate this and not listening to them. Sense of alliance and sensitivity built over time with staff members, this increased the strength of their relationship, regarding trust too. Participants were protective over staff because staff provide safety for them, Is there a sense of protection in the relationship? Protecting emotional needs. Clarkson et al 2009 Staff approach to service users was essential for a sense of support and feeling that they are valued at the hospital. This seemed to better their experience and improve their overall outlook of the hospital and settling in. Heppell and Rose, 2009 Relationship with staff was describe positively, with even a desire of more time to be spent with them Wood et al, 2008 Participants expressed a need to be known as a person by staff in order to build trust and maintain their relationship Neimeijer et al 2021 Patients described staff members as 'friends; and 'best friends' at times. Are there blurred lines because this is their only form of social contact? Are their social needs primarily only met here by staff, as they meet no one else and they may undoubtedly already struggle with social interaction. Beckham et al, 2020 Patients found clinical staff had helped them gain understanding and make a positive difference in their life. Murphy and Mullens, 2017	Heppell and Rose discussed the importance of staff support, especially with emotional support, activities, and staff assistance. It was especially seen as important when moving to the secure support for the first time. Service users compared that their old place they were just left to their own devices whereas here they were supported, they also found it important that they were treated like human beings rather than patients. there is something to the quality of treatment that signifies a change for participants, and makes it feel like they are treated like a person. availability of staff when considering emotional support was also highlighted as important, especially when feeling low, anxious, or scared. this can often present differently across people, especially with a learning disability, having staff available seemed more important than having a psychologist, so it's more so about having someone there rather than having someone with specific skills to deal with it. Having greater number of staff, maybe for every 2 service users, there's 1 staff member. Similarly, Williams et al noticed that staff support was important to service users, with service users feeling staff gave the support she felt she needed. residents highlighted that good staff support improved their experience of the hospital and made it more positive. however interestingly, service users highlighted the hierarchical positions of staff and how not all the have the same influence. interesting to consider how service users view staff relationships and how these can impact their own personal experience. This further highlight that a key factor of the experience of hospitals is the people in it and the way they feel they are treated by them. in Chinn's et al study a lot of service users discussed their negative experiences with staff, the negative interactions experienced, being greatly distressing and unpleasant, they deemed staff as unfriendly and unsympathetic. little to no talk on experiencing staff as supportive. the interesting aspect of this, is what can they do about it? a sense of feeling trapped and not being able to do anything. this is their home, where they don't feel safe AND have bad relationships but they're stopped from escaping the environment and are forced to stay. Clarkson et al highlighted what service users' value in their relationship with staff members in secure services. themes such as a trust, sensitivity, helping and mutual protection came up. service users highlighted the need to feel understood, and having rapport with staff. they equated their level of rapport to be indicative of the level of care they'd receive. helping and mutual protection were interesting subthemes as they related to feeling protected from other service users but this was mutual so participants were also protected towards them. there is a sense of needing each other that arises, as though there is a common ground/evil that they are on the same side of. negative attributes were also highlighted with regards to staff being arrogant and nasty, and how this influenced their trusting relationships. Neimeijer et al highlighted what service users request from staff members, service users emphasised that staff should get to know them as a person and be intentional about building a relationship with them. this seems to highlight this need for relationship, like a craving, that possibly isn't being fulfilled elsewhere because they are in secure services. When exploring positive relationship that arise from doing activities, Hudson et al highlight that it was positive for service users to be part of a team, they spoke positively of their coaches but also teammates, improving the outlook on these relationships all round. having something that connects them beyond diagnosis and being in a hospital could improve their experience of hospitals. Wood et al highlighted a different type of frustration from service users, an inability to decide which staff members to work with, which highlights control of their choices again, they felt time with staff was limited though they had positive relationships with them. Murphy and Mullen's also stated good relationship with staff, good humour and understanding, valued this, helped them improve. Interestingly, Beckham et al highlighted that service users approached their relationships with staff members as they were their friends/best friends. this suggests some blurred lines, as though due to lack of relationships outside, they've made their relationships with staff, lack of boundaries

	First order	Second order	Third order
Similar themes across studies	Participant quotes	Researchers' interpretations	Present author's interpretations
Living with other residents	"I'd rather have my family any day than these (patients)" Ann Williams, Thrift, Rose 2018 "getting out and relaxing with my friends… I made friends through football as well… some of them are funny and some of them are loud" Jamie "seeing new people and mixing with other people" Mark Hudson et al 2017 "I don't feel safe, so most of the time I won't have my dinner up until the kitchen is clear" Simon "staff was picking on me" Fatima "A bit upset inside, hurt inside, hurt inside, heart, heartbroken inside" William Chinn et al, 2011 "if you say something wrong, it can get nasty, that makes me nervous. You shouldn't interfere with other clients and focus on yourself" Rachel Neimeijer et al 2021 "I was disappointed in all of us patients for blowing rolling skating. I went to my room, I laid down and went to sleep. I was mad at the patients" Jimmy Beckham et al 2020	Things are difficult with living with other patients and some compare it to living with family. For a patient, Laura, independence was defined as living away from other patients at the hospital Williams, Thrift, Rose, 2018 The social aspect of joining the group had clear benefits, they got together and interacted with others Hudson et al 2017 Mostly stories of difficulties with relationships with other residents, feeling that others' behaviours are unpredictable and violent. This is not only with residents but staff too. Chinn et al Clients seemed ambivalent and scared to live in a treatment group, they said living with others feel dangerous and unpredictable at times and in a secure setting they cannot leave. Sense of safety lost. Sense that it is tiring to have to adapt to other residents and be alert, causing anxiety and tense (Oliver). Neimeijer et al 2021 There were time were other patients denounced other patients and were annoyed at how they acted. Sense that consequences are not within your reach others impact you. sense of having to surveilled each other's behaviour Beckham et al 2020 All patients stated they felt lonely with no friends and wishing for more contact with others they could related Murphy and Mullens, 2017	Williams et al mentioned how service users experienced living with other residents. Difficulties with this were highlighted, such as all having different needs/problems, different agrees, different personalities, which led to falling outs amongst residents. residents would prefer living with family and "get away", so there is a discomfort with having to interact with others and be around others that isn't family or that they're not used to. The peculiarities of service users aren't just a factor to consider for staff but also how other residents manage with this. one service users highlighted that for her independence meant being away from other residents. Similarly, to this theme, Chinn et al found varying experiences service users have with other residents, some residents experienced supportive and friendly relationships, some others negative ones where they were spat on, called names, possibly violent experiences. some service users made mentioned to not feeling safe. it's difficult to bring harmony about, and the lack of feeling safe for some could really exasperate their difficulties. Hudson et al mentioned how this activity led to friendships for residents, so it was beyond just getting them out and giving them something to do, it met further needs that they clearly highlight and demonstrate. service users quoted being able to joke with each other. these are service users of difference ages and sex. Wood et al highlighted preferences from male participants of having male only wards, female participants didn't find any difficulties with mixed-sex but male service users felt it was the female that mostly kicked off. now to consider female and male only what are the positive aspects in either direction? why would mixed be good or bad. Murphy and Mullen's highlighted a sense of loneliness and isolation, service users felt they had no friends in the wards despite the ward having up to 20 residents. they expressed for more contacts with people they could relate to, though some were happy with isolation. what can be done to manage the isolation for some? still points to doing more team building activities with them, require staff involved. Beckham et al also highlighted difficulties living with others, patients would feel disappointed when other patients ruined activities for them especially as these were not all the time, so consequences were for the whole group, group dynamics would be affected.

	First order	Second order	Third order
Similar themes across studies	Participant quotes	Researchers' interpretations	Present author's interpretations
Friends and family	"I said I don't wanna go there because it's far from home" P5 Parkes et al 2014 "well because basically it's away from my home. You're looking at about a seven-and-a-half-hour drive. And that's why just don't like being in hospital because it's too far for me to travel" Heppell and Rose, 2021 "A bit upset inside, hurt inside, hurt inside, heart, heartbroken inside" William Chinn et al, 2011	There were concerns from participants about reduced proximity from friends and family and the impact that this would have on their family contact Parkes et al 2014 A sense of not being able to see family and friends, due to the hospital being far from their hometown, this was difficult. However there were people that also wanted to far from their hometown due to the difficulties of dealing with bad memories and fears of being targeted because of their histories Heppell and Rose, 2021 There was distance away from family which affected their contact and upset residents. Chinn et al Outing days from the hospital were an opportunity to connect with family and felt like a reward to patients for exercising self-control. Beckham et al 2020	Heppell and Rose the geographical location of the hospital was also raised, such as if the hospital was far from hometown, some service users found it difficult, hinting on the difficulties to see family and friends. So, there is a need here. Others actually preferred because of negative experiences they may have experienced in their hometown and wanting to avoid being targeted. some services users were upset about not seeing their family and some about taking the hospital as a punishment because of their actions. there's a sense of maybe increasing control, decision of how close to home, for those who want the relational support. there is also questions that those who can't be in touch with family back home, where do they get their family support? is it from staff relationships only? and for those who don't want support, where do their relationship needs get met? It's giving that staff is the only they have left, "you're all I got left". great responsibility for staff. Similarly, in Chinn et al study service users talked about the difficulty of being far away from home, and feeling upset about unable to make regular contact. this is mostly important to note as they also mentioned awful relationships with staff, so truly, where are their relational needs met? are they destined to a life of solitude and unfulfilling relationships? The theme of fears around being far from home was also picked up by Parkes et al service users were concerned about a reduced proximity to family and friends, their concerns indicate their considerations for life outside the hospital and the hope to return to that. so, there is a yearning for that, aspects that secure hospital cannot meet
Necessary evil	"it isn't the ideal place to live, but on the other hand, I've got the help I've always wanted. So, it has been good for that, getting the help and doing treatment like DBT. But I do hope I can leave here soon" Laura "it's the best alternative" Pam Williams, Thrift, Rose, 2018 "I don't like that [when sociotherapist are strict]. That way you will never become independent. [….] the sociotherapists should have protected me by not letting me go on my own. But they left me on my own […] I was constantly taking drugs and I was constantly using again" Charlie. "although there are strict rules I feel less anxious here" Murphy and Mullens 2017 "it's punishment. But sessions about drugs, alcohol, anger management, they've all helped" Wood et al, 2008	Conflict between valuing the therapeutic benefits of the hospital but also not wanting to remain there, seen as undesirable but necessary. Williams, Thrift, Rose, 2018 Detention felt like a punishment but there were aspects of it that felt beneficial Wood et al, 2008 Patients reported that these restrictions in their autonomy were necessary to help maintain their safety and to protect them and/or society. Neimeijer at al 2017 Recognition of conflict in emotions but seeing as the necessary evil. Feeling that they may not be able to live independently outside the hospital environment Murphy and Mullens, 2017	Williams et al to the hospital being helpful and yet undesirable. Service users conflicted between the therapeutic benefits of the hospital and not wanting to be there, they recognised however that it may be the best alternative. This highlights the necessary evil of it. it this aspect of being in a place that takes your independence and freedom and yet without it you'd be worse of. the dissonance that this may cause within could account for the difficulties with managing this population group in secure settings. furthermore, the more they stay the more familiar it feels so more comfortable but also the longer their freedom and choice was taken away, so what to do with long-stay clients or those who cannot leave? Neimeijer et al also highlighted this conflict for service users, where limitations on their autonomy concerned them but they also realised these are necessary for safety and quality of life. but there is still a need to reach a balance in a way that does not feel too overwhelming. Wood et al also noticed this conflict, treatment at the unit was seen as both beneficial and punishment, restrictions were perceived as punishment, but sessions about drugs, alcohol and anger management were seen as helpful. murphy and Mullens "although there are strict rules I feel less anxious here" notion that some didn't feel they had the skills to be independent outside so needed to stay further in secure settings, so are all these restrictions actually helpful if they cannot go on to the community in the end?

Appendix D: Ethical approval



Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

Prof G.H. Murphy
Prof of Clinical Psychology & Disability
University of Kent
Tizard Centre
University of Kent
Cornwallis NE, Giles Lane
CT2 7NS

05 January 2022

Dear Prof Murphy

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

Study title:	**RCT of group CBT for men with intellectual and/or developmental disabilities and harmful sexual behaviour: the HaSB-IDD trial**
IRAS project ID:	**291027**
REC reference:	**21/EM/0270**
Sponsor	**Univeristy of Kent**

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

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

Appendix E: Information sheet

Participant Information Sheet

The HASB-IDD trial:

RCT of group CBT for men with intellectual and/or developmental disabilities and harmful sexual behaviour

Participant Information Sheet – Version 0.1 June 2021

Introduction

This leaflet tells you about some research for men with learning disabilities or autism who have got into trouble over sexual behavior. It is called the HaSB-IDD trial, for short.

The research is looking at whether a talking treatment, called SOTSEC-ID, helps men to stop doing harmful sexual behaviour.

You are being asked to help in the research because you got into trouble over sexual behaviour.

What are we asking you to do?

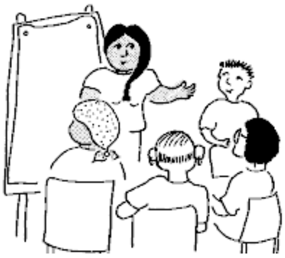
We want to ask you some questions about your feelings and what you think about sexual relationships. The questions take about one and a half hours, but you can have a break in the middle if you would like one. A research worker will come to do the questions with you and explain any difficult words. You will not need to read them on your own.

After 6 months we will come back to ask the questions again, to see if anything has changed. Over the next year, we will come and see you two more times, to see how you are getting on, and to repeat the questions.

Each time we come we will give you a shopping voucher for £10 to thank you for your help.

We will also ask your carer some questions about what happened in the past and about the support you get now.

Treatment Groups



After our first visit, half of the men will be offered a treatment group, run by their local psychologist. It will meet twice a week for six months. Most men say they find this treatment helpful and they don't want it to stop.

We may talk to you after the treatment to see what you thought about it, what worked well, what did not work so well, and what you think needs to change. We can do this interview online. If we do the interview online you can choose whether to have your camera on, or not.

Consent

You can decide whether you want to take part in this research. You do not have to do it.

If you want to take part now, you can change your mind later. You do not have to give us a reason.

What will you do with my data?

We will write down your name, age, and telephone number and then give it a code number, like 001. Only the research team will know this is you.

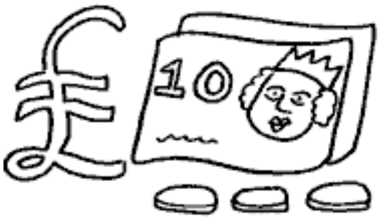
We will store your information with the code number, so no one will know what you said, apart from the research team.

Everything you tell us will be private. But if you tell us you are at risk of harm, or someone else is at risk of harm, we have to tell someone, like your care manager.

Can I withdraw?

Yes you can withdraw, that means leave the research. If you decide to withdraw from the study, we would like to keep the data that we have already collected. However, you can ask us not to do this.

Who is paying for the study?



This study is being paid for by the National Institute for Health Research.

What will happen to the results of this study?

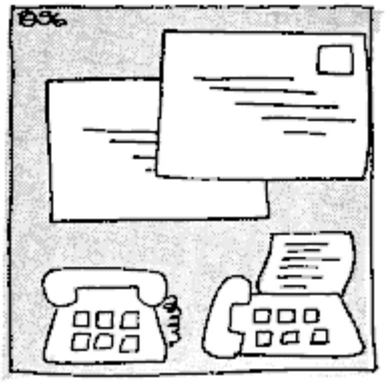
We will write some reports that may go into a journal (like a magazine for people who work in health services or universities). Your name will not be used. No one will know you took part.

Who checks the research is run properly?

Some people from NIHR check that we are running the research properly. They will check to make sure we are following the rules.

Also, all research is checked by a Research Ethics Committee, who make sure we are treating you right. This study was checked by ___XXXXXXXXX___Research Ethics Committee.

Complaints



If you want to complain, please speak to a member of the research team first.

If you want to speak to someone else we can arrange that for you. For example, you could talk to the Patient Advice and Liaison Service:
(insert local number for PALS)

Questions?

If you have questions, you can speak to the Chief Investigator who is in charge of the research.

Professor Glynis Murphy,
Chief Investigator
Tel: [redacted]
Email: [redacted]

She works at:
Tizard Centre,
Cornwallis North East
University of Kent
Canterbury
Kent CT2 7NS

Thank you for taking the time to read this Information Leaflet

Appendix F: Consent form

PARTICIPANT CONSENT FORM

(Version 0.1 – 28 Jan 2021)

Title of the project: RCT of group CBT for men with intellectual and/or developmental disabilities and harmful sexual behaviour: the HaSB-IDD trial

Participant Identification Number ☐

	Please initial in the box
I have read the Information Sheet (Version XXXXXX) for the above study. I have asked all my questions, and have had these answered.	☐
I understand what the research is about and what I will do in it.	☐
I understand I don’t have to take part and I can withdraw later without giving a reason.	☐
I understand that my information will be private but may be checked by people paying for the research.	☐
I understand that if I say I am at risk of harm, or someone else is at risk of harm, the research team	☐

have to tell someone, like my care manager.

I understand that if I want to withdraw from the study, the researchers would like to keep the information that they have already collected. I can tell them not to do this, but this might not be possible. ☐

I understand that if I am asked for an interview, it will be recorded, and if I agree to this, I can choose to have the video camera off. ☐

I agree to take part in this study. ☐

Your details

Print your name:

Signature:

Date:

Address:

Tel:

Name of person who explained the study:

Signature:

Date:

Appendix G: Interview Schedule

HASB-IDD; Process Evaluation:
Interview Schedule for men (v1.2, 13.11.23)

Interviews with Client Participants

Arranging the Interview

This might be face to face or online, but the principles remain the same

- Interviews to be conducted at therapy base, residential service or online:
- Ensure a room is available
- Ensure privacy
- Clients to be interviewed on their own unless they would like someone else present (if accompanied, ensure the person understands their role)

Preparation for Interview

- Ask participants to bring any materials they may like to discuss
- Book audio recorder (or record online)
- Arrange cash and receipt system for participants payment and in case need to reimburse travel costs (not needed if online)
- Check the name of the group with therapists (it might have been called Friday group or men's Group or something – very unlikely called SOTSEC-ID group)

Introductions

[After settling in, getting agreement for recording, switching recorder on and checking it is working:]
Hi my name is *[say name]* and as you know I want to ask you what you think about the (SOTSEC ID) group work that you and [psychological therapists in the group] have been doing (make sure they understand which specific group you are talking about).

Are you still happy to take part? *[CHECK CONSENT]*

If yes:
That's great. I'm really interested in what you think. Don't worry about speaking your mind. What you have to say is really important because you are the expert here!
I won't keep you for too long today. I'd like to talk with you for about forty-five minutes. So, we will finish *[provide an anchor point such as, 'before lunch,' or show the finish time on a clock]*. If you would like to stop before then, just let me know. We can stop any time you would like to.
[EXPLAIN RIGHT TO WITHDRAW]

I'm going to use this *[show recording device]* to record what we are saying. This will help me to remember everything you say to me today. When we have finished our meeting today, I will listen to the recording and type it up on my computer. When I type what you have said, I won't use anyone's name, so nobody will know who said what. This makes it easier to be honest without worrying about hurting anyone's feelings. I won't tell [psychological therapist)s)] what you have said.

I will ask you about the work you have been doing within the groups with therapists (names) and how you have felt about it. We don't have to talk today about your past or your problems. This is not a therapy session. You can choose what you tell me and you can decide not to answer questions. We can stop at any time, just tell me.

Demographic information

Before we begin with that, I'd like to ask you a couple of questions about you.

- What is your age?
- What is your (ethnic) background?

Researcher to complete.
Site code:
Number of sessions completed:

Topic Guide

1. ***Broad Overview of Group and Feedback***

1.1 What did you get to do/get up to in the [name of group]?

Prompt if needed:

- Did you enjoy the what you've been doing?
- What did/did not enjoy about it?

2. ***Goals/Expectations of Change*** *[Ensure focus is on SOTSEC ID and not previous therapy]*

3.1 Why did you get involved in [name of group]?

Prompt: Did you think that things would change because of doing the group?
Prompt: Did you want to make a change in your life? What type of change?
Prompt: Did someone say that you should get involved in the group? How did they do that?

We will come back to changes again later, ok?

3. ***Process of SOTSEC ID*** *[Ensure focus is on SOTSEC ID and not previous therapy]*

3.1 How often did you attend [name of group]?

3.2 How long were the group sessions?

Prompt: Was that too much or not enough?
Prompt: Would more or fewer sessions have been better?

The next questions are related to the material covered in the group.

3.3 Think back to the information regarding **relationships**, what did you learn?
Prompt: Has this work on relationships been helpful or unhelpful? If so, how?
Prompt: How might this help you with new relationships?

3.4 Think back about the work you did around your **thoughts about sex**, what did you learn?
Prompt: Has this work on thoughts been helpful or unhelpful? If so, how?
Prompt: Have you noticed any changes in your thoughts or feelings towards sex? If so, what changes did you notice?

3.5 Think back about the work you did on **victim empathy** (how the victim felt), what did you learn?
Prompt: Has this work on how the victim felt been helpful or unhelpful? If so, how?

3.6 Did you develop a **plan to help you stop offending in the future**? What things did you say can help you to stop offending? What else did you plan about living a **good life**?
Prompt: How helpful was it to make these plans?
Prompt: Do you think you can stick to the plans? What will help? What will get in the way?

Refer to topics covered in the intervention (session examples: developing victim empathy)

3.7 Do you think it is likely you will do any of these things again? (the things that got you in trouble/re-offending)
Prompt: If no, What parts of the group helped? How will your plans help with this?
Prompt: If yes, why might it happen again?

Session examples: “changing the way you think about things”, “understanding how you feel about things”, and “learning about why you offend” (Actual session titles ‘Recognizing, identifying and labelling emotions to others’; ‘Understanding the relationship between thoughts, feelings and behaviours’)

4. ***Helpful Aspects*** *[Ensure focus is on SOTSEC ID and not previous therapy]*

4.1 What are the things you liked most about attending [name of group]?
Prompt: What is the best thing(s) about the group?
Prompt: What did you get out of the group?

4.2 Did you get on with the people who ran the [name of group]? What did you like about them?

4.3 Did you get on with the other group members? What did you like about them? Did you make a friend from the group?

4.4 Do you miss going to the [name of group]? What do you miss?

4.5 Are you in touch with anyone from the group? (if remain an inpatient adapt phrasing)

5. ***Concerns/worries/barriers*** *[Ensure focus is on SOTSEC ID and not previous therapy]*

5.1 What was the worst thing about the [name of group]?
Prompt: What was the hardest/most difficult thing about the group?

5.2 Were you worried or upset during sessions? What happened?

[If yes] Prompt: What has made you worried/upset?

6. ***Change in problems*** *[Ensure focus is on SOTSEC ID and not previous therapy]*

6.1 You said you wanted X change, has this happened since finishing [name of group]?
Prompt: Did you change for the good?
Prompt: Has any other change happened?
Prompts:

- Do you think it has made any difference?
- What are the differences you have noticed?

6.2 Impact on broader life *[Ensure focus is on SOTSEC ID and not previous therapy]*

Prompts:

- Has X change made a difference to what you do in your day/ evening/ weekends?
- Have your relationships with other people changed? Have things changed in how you get on with people? If not, why not?
- What changes do you feel there has been in your life after the group?
- How have things changed?
- How have you managed to do that?

How do you feel about that?

6.3 Do you have any plans around X change after the group?
Prompt: Has being a member of the group helped with those plans?

7 **Finishing the interview**

Is there anything else you would like to say?

Is there anything I have forgotten to ask you?

Thank you for speaking to me today, it is a great help.

Now I will go away and look at the things you have said, as well as the things that other people who have done different groups have said. We will use the information to find out what people think about the groups. We will write a report and tell you about what we found; if you would like to know.

Would you like a copy of the report?

[CHECK FOR DISTRESS]
Are you feeling okay?
If “no” -
Would you like to speak to anyone about what we have talked about? Can I help with that?
Thanks again for your help with this project.

Appendix H: Thematic analysis codebook

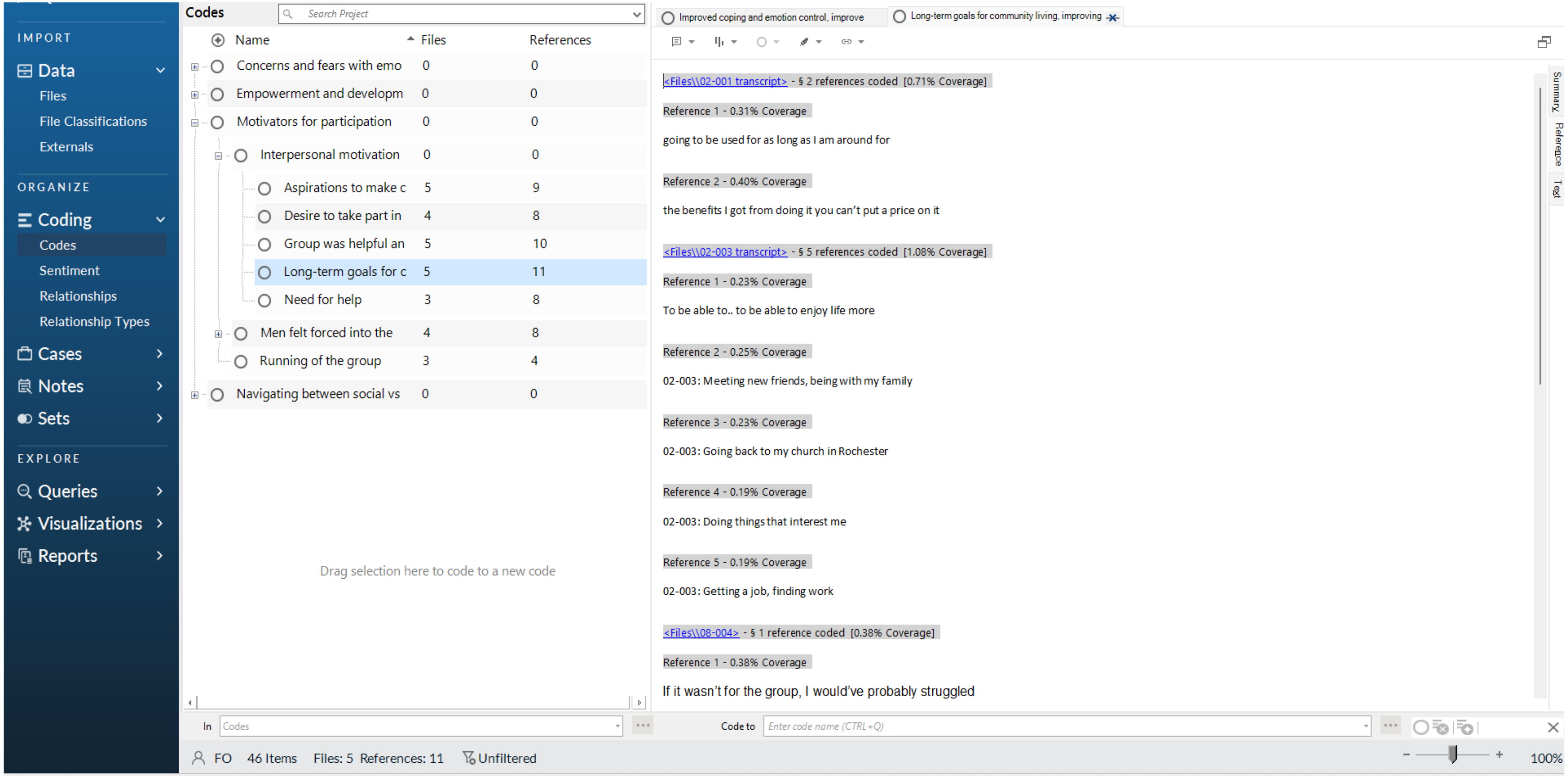
Name	Description
Concerns and fears with emotional vulnerability	
Fears and concerns with sharing about index offence	
Intensity of the content	
Concerns about the unknown	
Victim empathy content seen as difficult	
Less enjoyable and difficult aspect of the group	
Empowerment and development of self-efficacy	
Opportunity for transformation and personal growth	
Group facilitated reflections	
Group providing a second chance	
Improved coping and emotion control, improved relationships, greater confidence in public	
Positive changes as a result of attending the group	

Name	Description
Skill development as a result of the group	
Skills learnt important for relapse prevention	
Reflective learning and educational growth	
New learnings and knowledge	
Consent primary learning of relationship content	
Relationship content solely heterosexual	
Sex module seen as impactful	
Victim empathy content seen as useful	
Risk reduction	
Motivators for participation	
Interpersonal motivation	
Aspirations to make changes and achieve goals	
Desire to take part in the group	
Group was helpful and useful	
Long-term goals for community living, improving relationships, and work	

Name	Description
Need for help	
Men felt forced into the group	
Part of treatment	
Running of the group	
Navigating between social vs individual needs	
Learning needs differences	
Difficulties to remember content	
Pace of content	
Processing of information difficulties	
Recall and memory difficulties	
Need for connectedness	
Enjoyable aspects of the group	Ability to have people who you can 'relate to'
Group dynamics seen as positive	
Staff were positively impactful on the experience of the group and recovery	
Preferences for sessions	
Group dynamics seen as difficult	

Name	Description
Individual session preference	
Refresher for sessions	
Thoughts on length and number of sessions	

Appendix I: Examples of participant comments with corresponding codes



Name	Files	References
Concerns and fears with emo	0	0
Empowerment and developm	0	0
Motivators for participation	0	0
Interpersonal motivation	0	0
Aspirations to make c	5	9
Desire to take part in	4	8
Group was helpful an	5	10
Long-term goals for c	5	11
Need for help	3	8
Men felt forced into the	4	8
Running of the group	3	4
Navigating between social vs	0	0

○ Improved coping and emotion control, improve

○ Long-term goals for community living, improving

<Files\\02-001 transcript> - § 2 references coded [0.71% Coverage]

Reference 1 - 0.31% Coverage

going to be used for as long as I am around for

Reference 2 - 0.40% Coverage

the benefits I got from doing it you can't put a price on it

<Files\\02-003 transcript> - § 5 references coded [1.08% Coverage]

Reference 1 - 0.23% Coverage

To be able to.. to be able to enjoy life more

Reference 2 - 0.25% Coverage

02-003: Meeting new friends, being with my family

Reference 3 - 0.23% Coverage

02-003: Going back to my church in Rochester

Reference 4 - 0.19% Coverage

02-003: Doing things that interest me

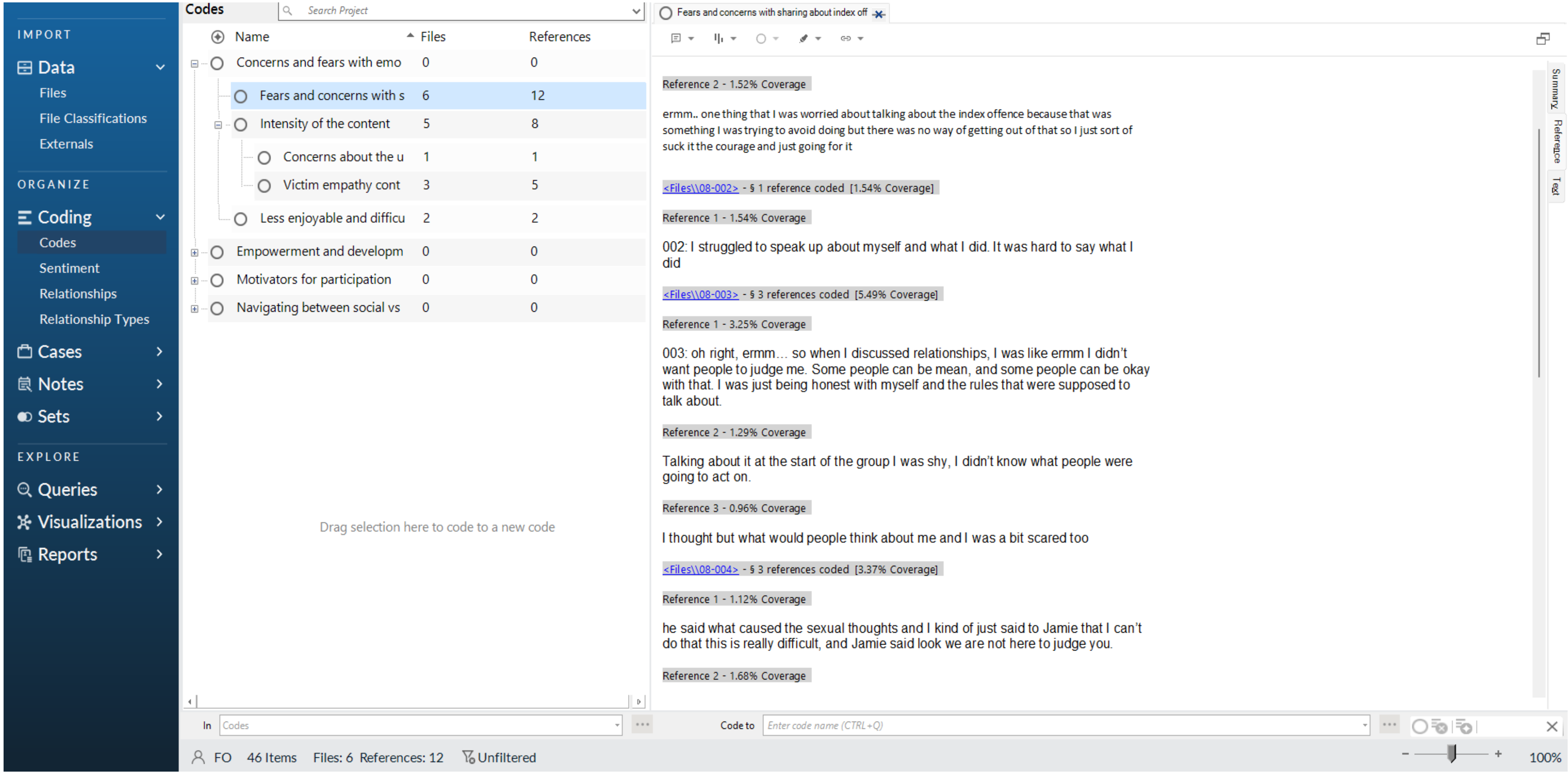
Reference 5 - 0.19% Coverage

02-003: Getting a job, finding work

<Files\\08-004> - § 1 reference coded [0.38% Coverage]

Reference 1 - 0.38% Coverage

If it wasn't for the group, I would've probably struggled



Codes

Name	Files	References
Concerns and fears with emo	0	0
Fears and concerns with s	6	12
Intensity of the content	5	8
Concerns about the u	1	1
Victim empathy cont	3	5
Less enjoyable and difficu	2	2
Empowerment and developm	0	0
Motivators for participation	0	0
Navigating between social vs	0	0

Fears and concerns with sharing about index off

Reference 2 - 1.52% Coverage

ermm.. one thing that I was worried about talking about the index offence because that was something I was trying to avoid doing but there was no way of getting out of that so I just sort of suck it the courage and just going for it

<Files\\08-002> - § 1 reference coded [1.54% Coverage]

Reference 1 - 1.54% Coverage

002: I struggled to speak up about myself and what I did. It was hard to say what I did

<Files\\08-003> - § 3 references coded [5.49% Coverage]

Reference 1 - 3.25% Coverage

003: oh right, ermm… so when I discussed relationships, I was like ermm I didn’t want people to judge me. Some people can be mean, and some people can be okay with that. I was just being honest with myself and the rules that were supposed to talk about.

Reference 2 - 1.29% Coverage

Talking about it at the start of the group I was shy, I didn’t know what people were going to act on.

Reference 3 - 0.96% Coverage

I thought but what would people think about me and I was a bit scared too

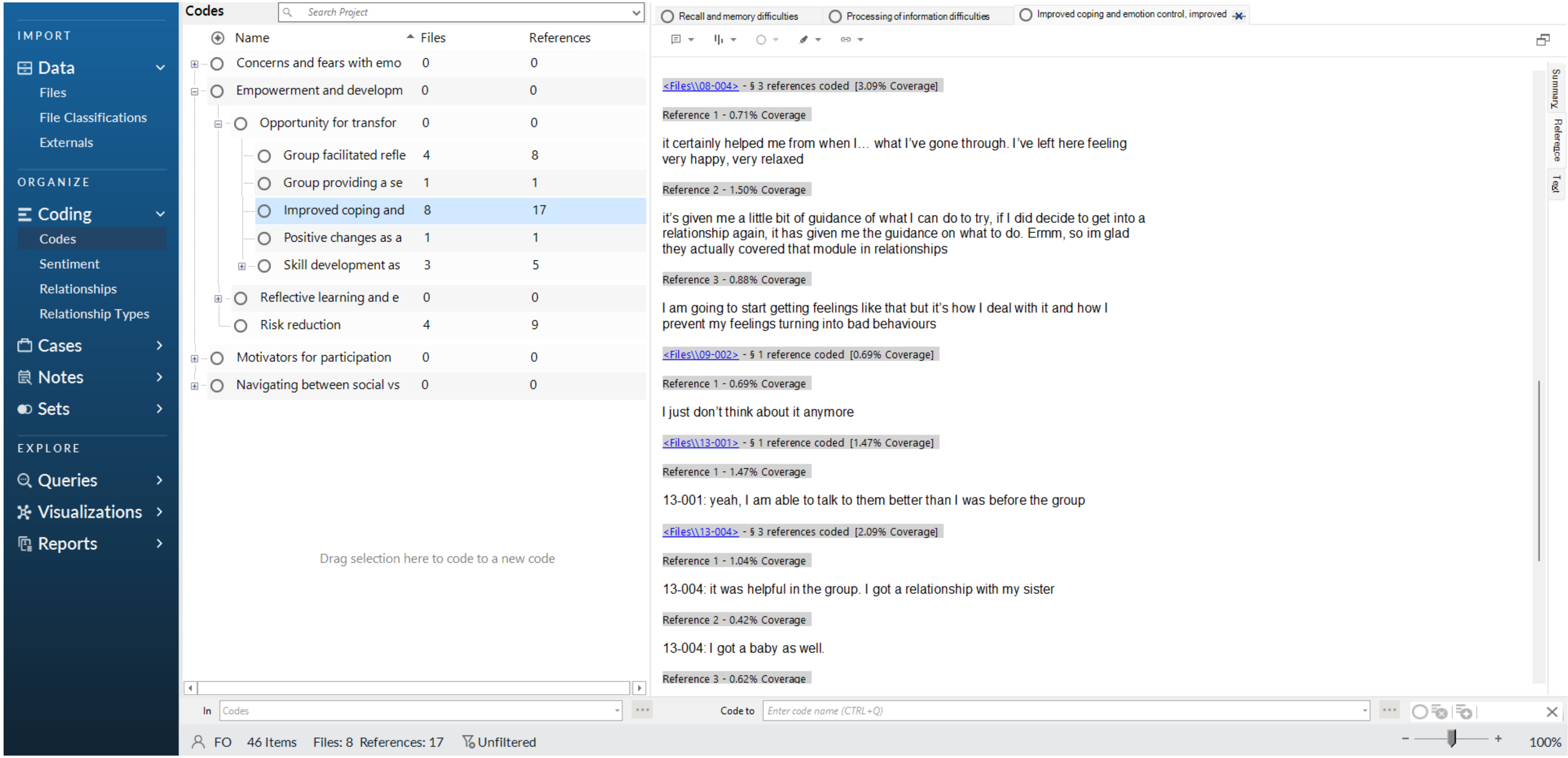
<Files\\08-004> - § 3 references coded [3.37% Coverage]

Reference 1 - 1.12% Coverage

he said what caused the sexual thoughts and I kind of just said to Jamie that I can’t do that this is really difficult, and Jamie said look we are not here to judge you.

Reference 2 - 1.68% Coverage

FO 46 Items Files: 6 References: 12 Unfiltered



Name	Files	References
Concerns and fears with emo	0	0
Empowerment and developm	0	0
Opportunity for transfor	0	0
Group facilitated refle	4	8
Group providing a se	1	1
Improved coping and	8	17
Positive changes as a	1	1
Skill development as	3	5
Reflective learning and e	0	0
Risk reduction	4	9
Motivators for participation	0	0
Navigating between social vs	0	0

○ Recall and memory difficulties ○ Processing of information difficulties ○ Improved coping and emotion control, improved

<Files\\08-004> - § 3 references coded [3.09% Coverage]

Reference 1 - 0.71% Coverage

it certainly helped me from when I… what I've gone through. I've left here feeling very happy, very relaxed

Reference 2 - 1.50% Coverage

it's given me a little bit of guidance of what I can do to try, if I did decide to get into a relationship again, it has given me the guidance on what to do. Ermm, so im glad they actually covered that module in relationships

Reference 3 - 0.88% Coverage

I am going to start getting feelings like that but it's how I deal with it and how I prevent my feelings turning into bad behaviours

<Files\\09-002> - § 1 reference coded [0.69% Coverage]

Reference 1 - 0.69% Coverage

I just don't think about it anymore

<Files\\13-001> - § 1 reference coded [1.47% Coverage]

Reference 1 - 1.47% Coverage

13-001: yeah, I am able to talk to them better than I was before the group

<Files\\13-004> - § 3 references coded [2.09% Coverage]

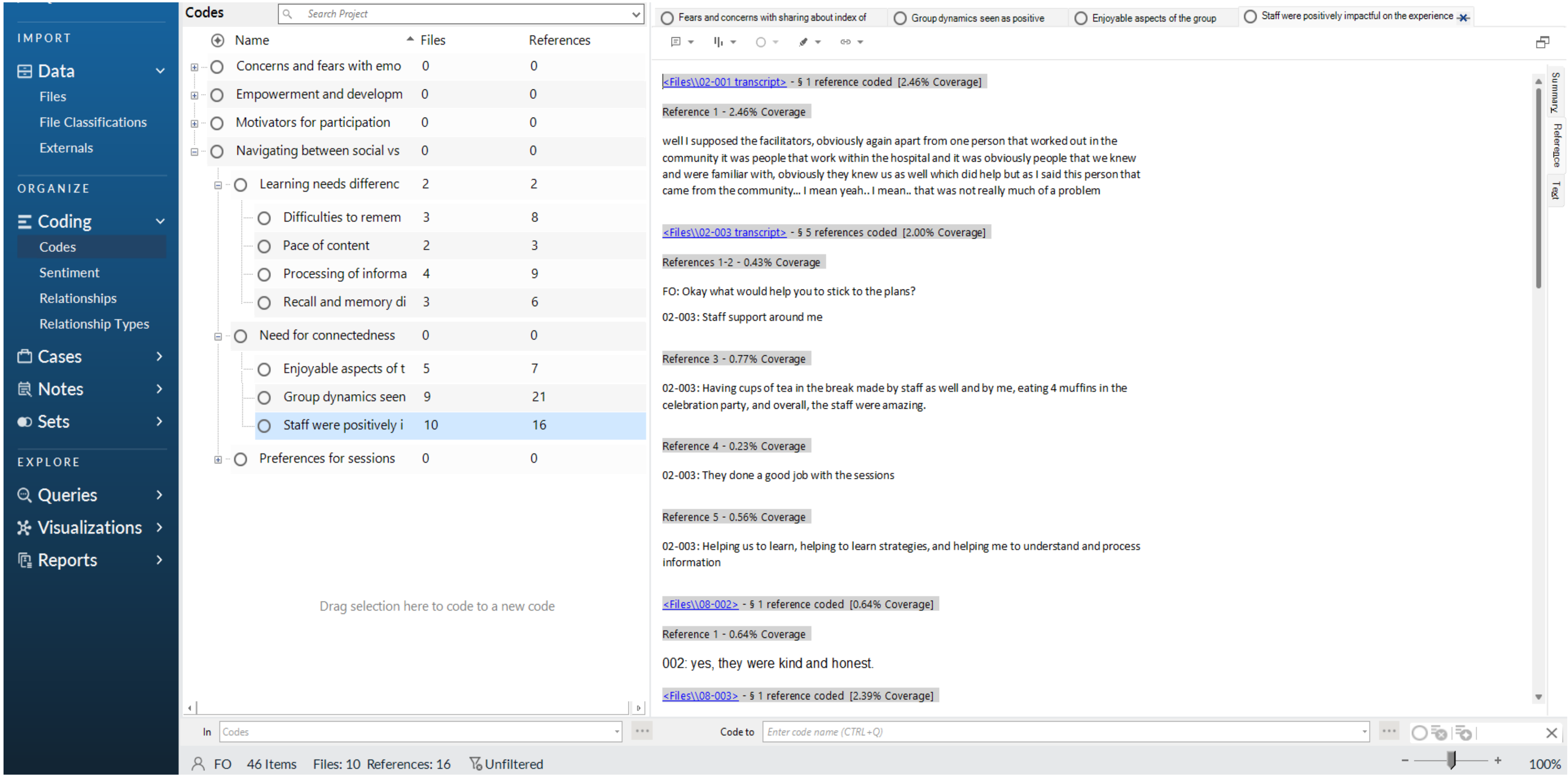
Reference 1 - 1.04% Coverage

13-004: it was helpful in the group. I got a relationship with my sister

Reference 2 - 0.42% Coverage

13-004: I got a baby as well.

Reference 3 - 0.62% Coverage



Name	Files	References
Concerns and fears with emo	0	0
Empowerment and developm	0	0
Motivators for participation	0	0
Navigating between social vs	0	0
Learning needs differenc	2	2
Difficulties to remem	3	8
Pace of content	2	3
Processing of informa	4	9
Recall and memory di	3	6
Need for connectedness	0	0
Enjoyable aspects of t	5	7
Group dynamics seen	9	21
Staff were positively i	10	16
Preferences for sessions	0	0

<Files\\02-001 transcript> - § 1 reference coded [2.46% Coverage]

Reference 1 - 2.46% Coverage

well I supposed the facilitators, obviously again apart from one person that worked out in the community it was people that work within the hospital and it was obviously people that we knew and were familiar with, obviously they knew us as well which did help but as I said this person that came from the community... I mean yeah.. I mean.. that was not really much of a problem

<Files\\02-003 transcript> - § 5 references coded [2.00% Coverage]

References 1-2 - 0.43% Coverage

FO: Okay what would help you to stick to the plans?

02-003: Staff support around me

Reference 3 - 0.77% Coverage

02-003: Having cups of tea in the break made by staff as well and by me, eating 4 muffins in the celebration party, and overall, the staff were amazing.

Reference 4 - 0.23% Coverage

02-003: They done a good job with the sessions

Reference 5 - 0.56% Coverage

02-003: Helping us to learn, helping to learn strategies, and helping me to understand and process information

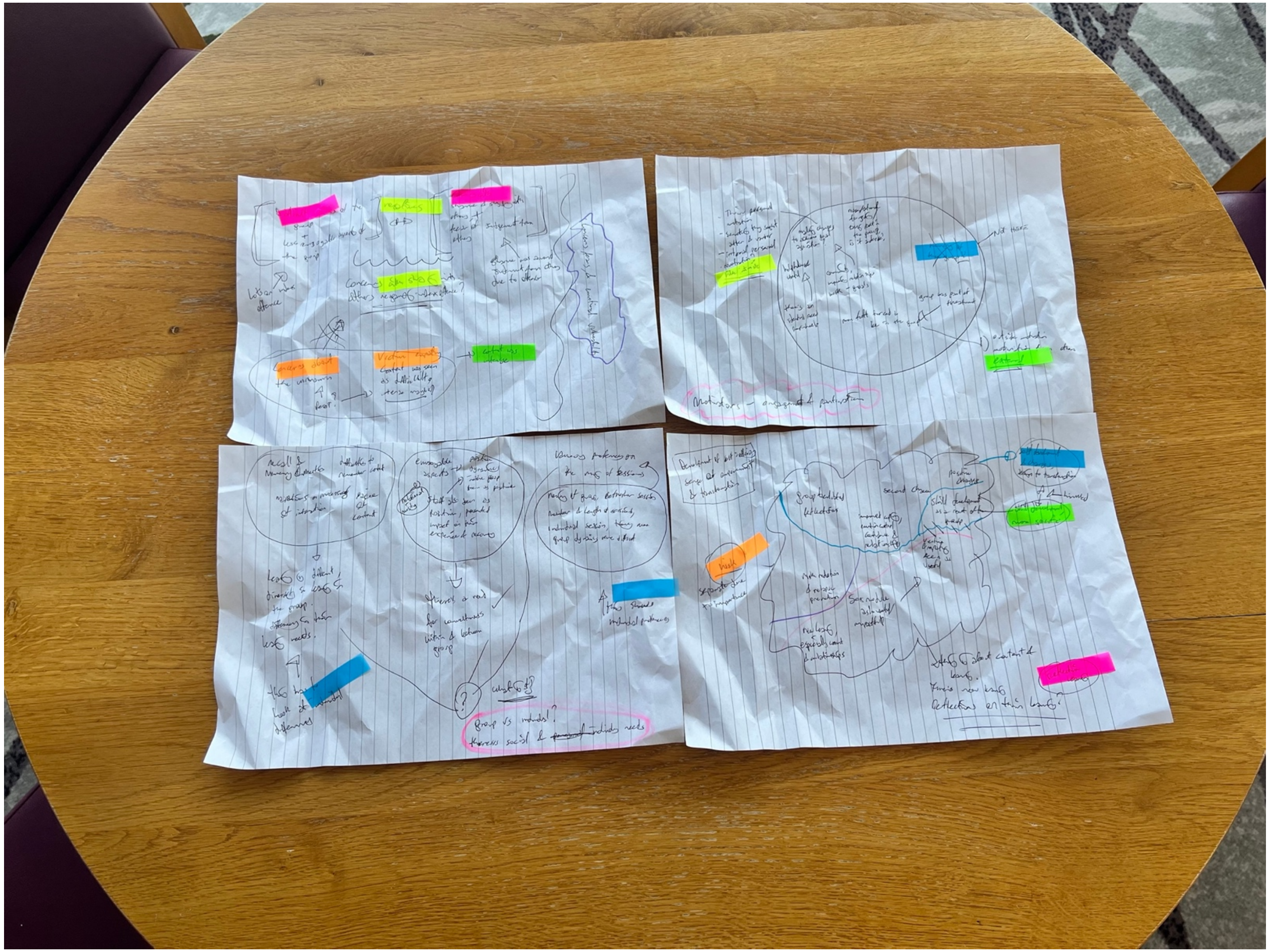
<Files\\08-002> - § 1 reference coded [0.64% Coverage]

Reference 1 - 0.64% Coverage

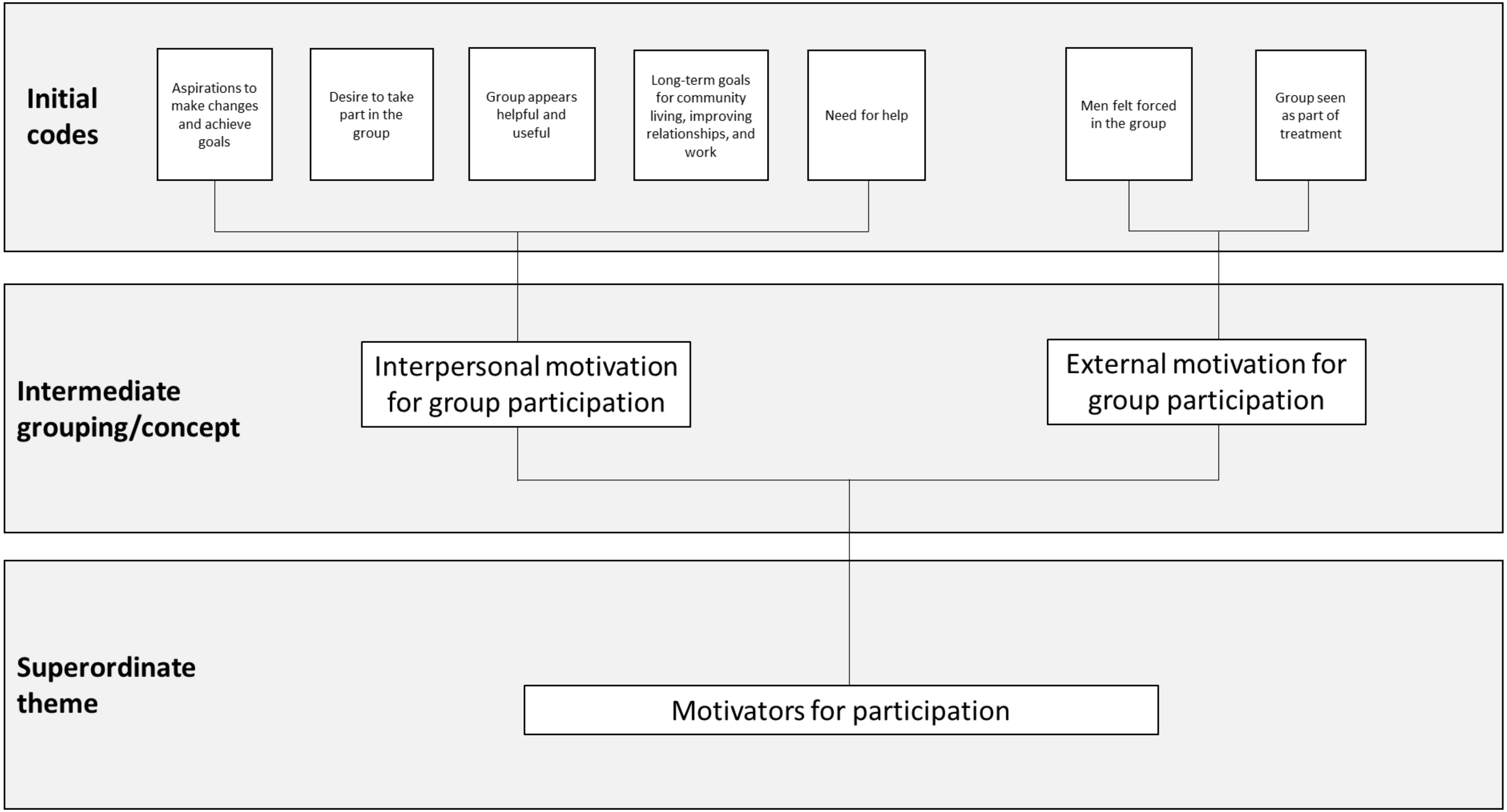
002: yes, they were kind and honest.

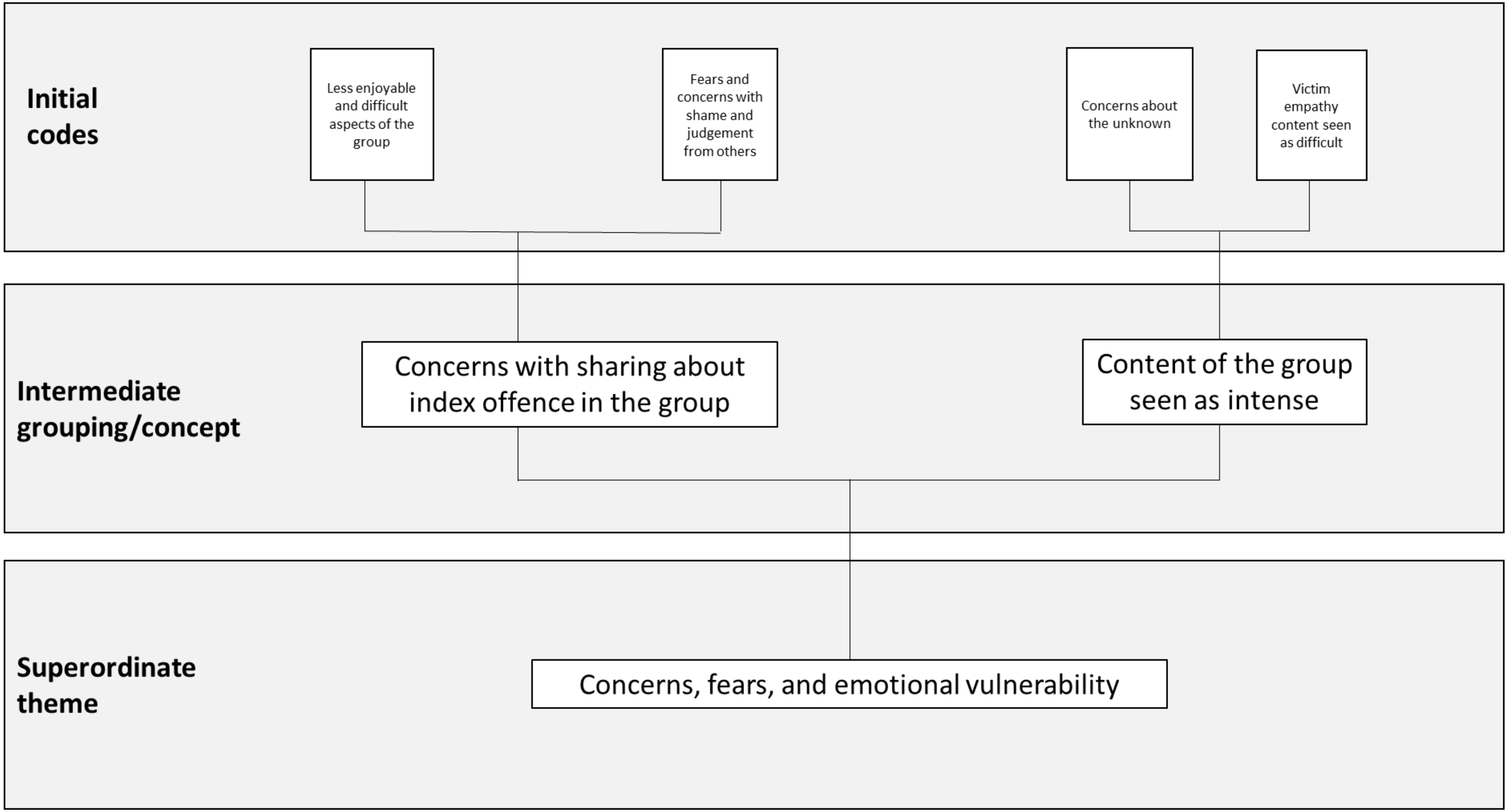
<Files\\08-003> - § 1 reference coded [2.39% Coverage]

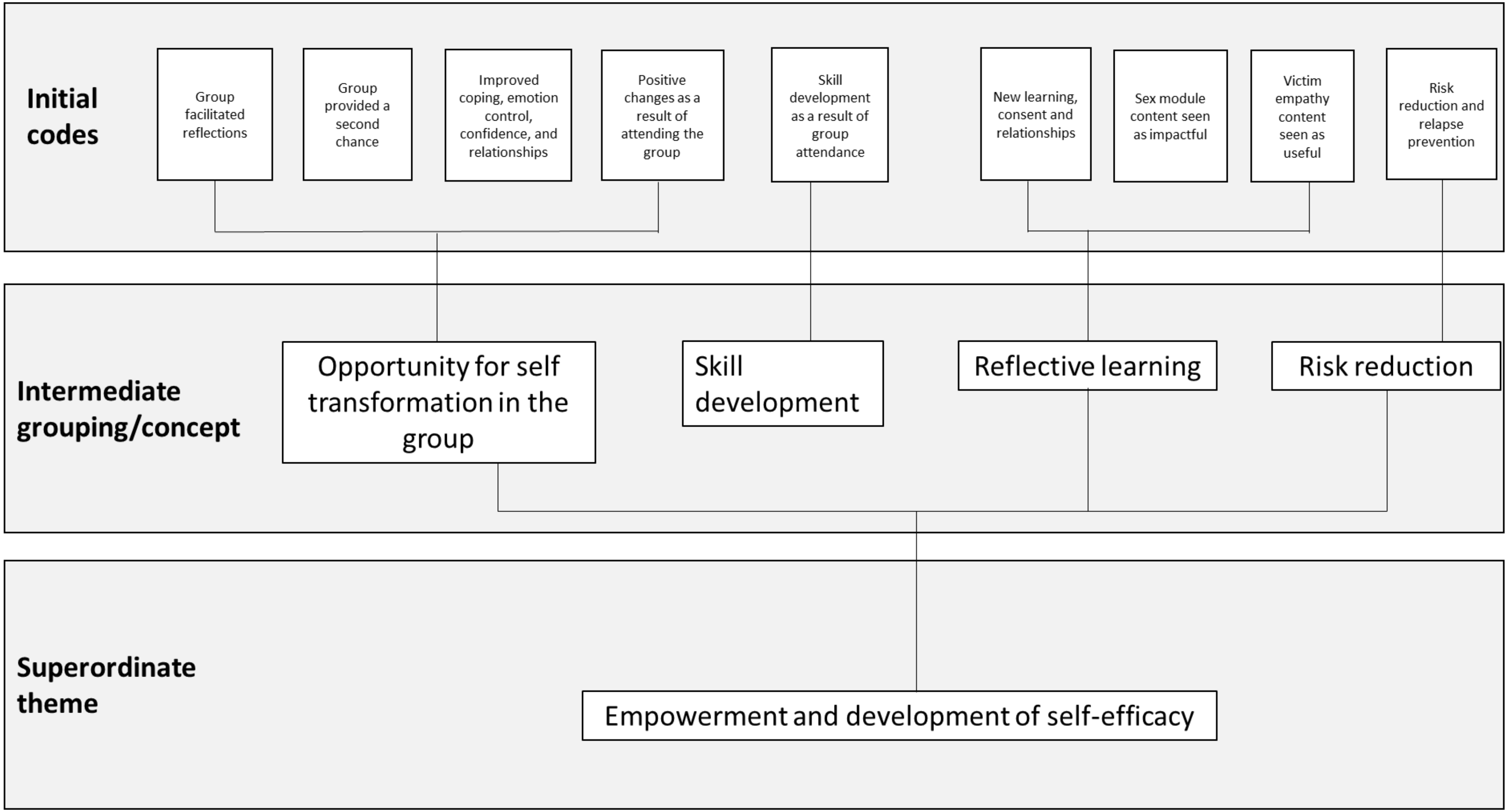
Appendix J: Mapping of initial codes to final themes

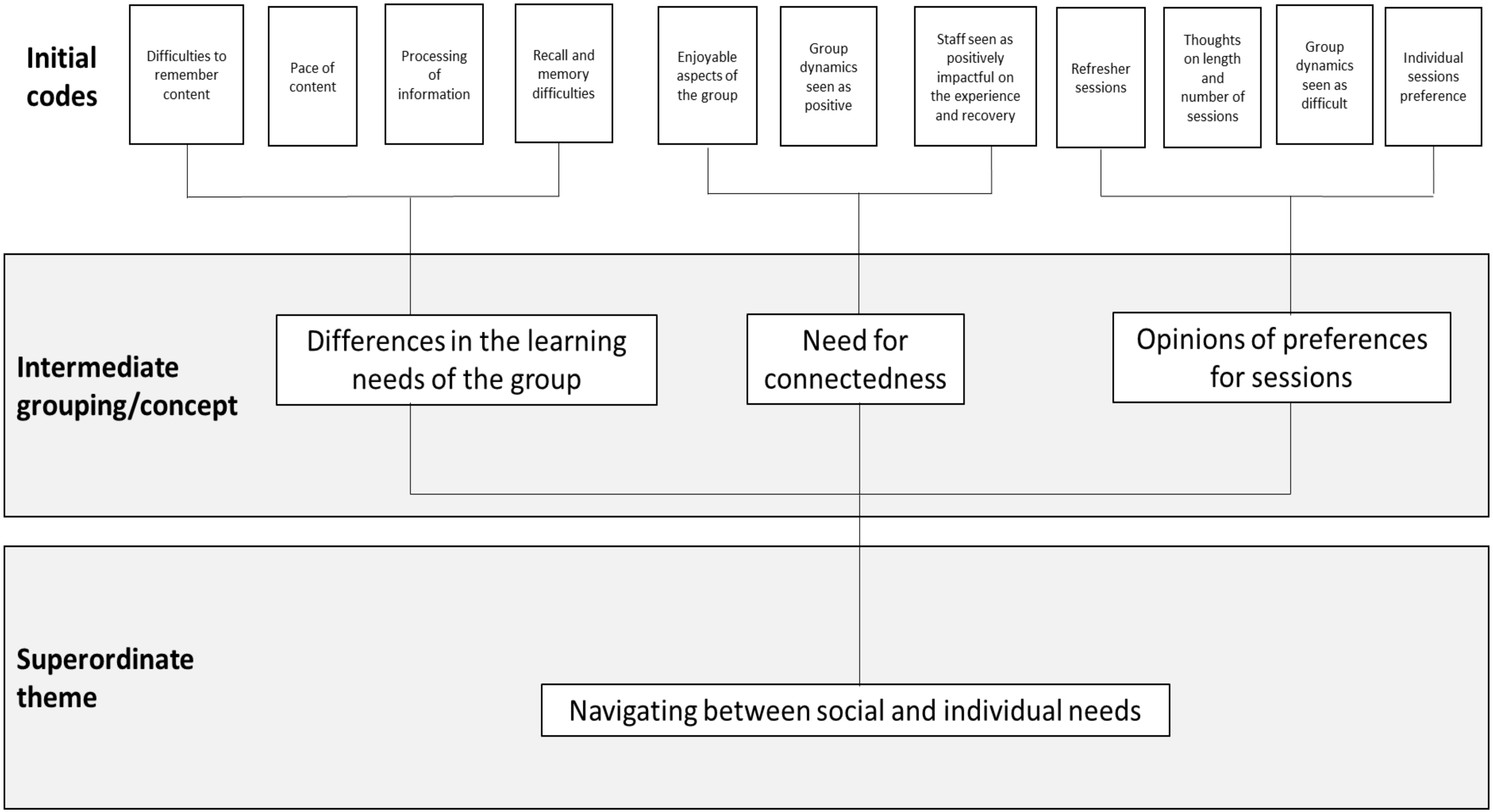


The following diagrams have been formatted for ease of reading.




Initial codes
Less enjoyable and difficult aspects of the group
Fears and concerns with shame and judgement from others
Concerns about the unknown
Victim empathy content seen as difficult
Intermediate grouping/concept
Concerns with sharing about index offence in the group
Content of the group seen as intense
Superordinate theme
Concerns, fears, and emotional vulnerability


Initial codes
Group facilitated reflections
Group provided a second chance
Improved coping, emotion control, confidence, and relationships
Positive changes as a result of attending the group
Skill development as a result of group attendance
New learning, consent and relationships
Sex module content seen as impactful
Victim empathy content seen as useful
Risk reduction and relapse prevention
Intermediate grouping/concept
Opportunity for self transformation in the group
Skill development
Reflective learning
Risk reduction
Superordinate theme
Empowerment and development of self-efficacy


Initial codes
Difficulties to remember content
Pace of content
Processing of information
Recall and memory difficulties
Enjoyable aspects of the group
Group dynamics seen as positive
Staff seen as positively impactful on the experience and recovery
Refresher sessions
Thoughts on length and number of sessions
Group dynamics seen as difficult
Individual sessions preference
Intermediate grouping/concept
Differences in the learning needs of the group
Need for connectedness
Opinions of preferences for sessions
Superordinate theme
Navigating between social and individual needs