Volume 1
Research Component

PSYCHOLOGICAL INTERVENTIONS IN FORENSIC SERVICES

By

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A thesis submitted in partial fulfilment to
The University of Birmingham
For the degree of
DOCTOR OF CLINICAL PSYCHOLOGY

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May 2014

OVERVIEW

This thesis is submitted to the University of Birmingham in partial fulfilment of the requirements for the degree of Doctorate of Clinical Psychology. The thesis comprises of two volumes which contain reports documenting research and clinical work carried out during training.

Volume I of the thesis is the research component and contains three papers. The first is a systematic review which examines the use of Dialectical Behaviour Therapy (DBT) applied in forensic services. A systematic search of databases highlighted thirteen studies suitable for the review that utilised DBT to target a range of psychosocial and behavioural variables in offending populations. Findings across studies were inconsistent and limited by a number of methodological issues, therefore it is not currently possible to determine the clinical utility of DBT when applied in forensic services.

The second paper is an empirical study which explores service user views of engagement in psychological interventions within medium security. Interviews with male service users residing in Medium Secure Units (MSU) were analysed using Interpretative Phenomenological Analysis (IPA). Two super-ordinate themes, along with subthemes, were selected to represent how participants appear to understand their initial and continued engagement in psychological interventions. *A game of two halves* represents a narrative and seemingly experiential difference between participants in terms of their engagement in psychological interventions. It reflects how participants understand their initial engagement as brought about by differences in personal motivations or goals, and the impact of these differing motivations on their level of engagement. *If you build it they will come* represents

reasons for continued engagement. It reflects how participants can receive multiple gains from the psychological environment, and if the psychological practitioner builds this environment of gains, participants are more likely to initially engage in a psychological intervention and remain engaged with it. Links are made with the current literature and implications and recommendations for clinical practice are made. Volume I also contains a public domain briefing paper, which provides an overview of the systematic review and empirical study.

Volume II is the clinical component and contains five Clinical Practice Reports (CPR) that were completed over the course of training. The reports represent clinical and empirical work carried out during placements in the specialties of adult mental health, Child and Adolescent Mental Health (CAMHS), older adult and Learning Disabilities (LD). CPR 1 presents a cognitive-behaviour and behavioural formulation of an adult male with Obsessive Compulsive Disorder (OCD). CPR 2 is a service evaluation utilising staff reflections of a formulation group within a Community Mental Health Team (CMHT). CPR 3 is a single-case experimental design, which evaluates a behavioural intervention with a boy with LD and behaviour that challenges. CPR 4 presents a case study of an older adult male with memory difficulties, which includes assessment, formulation, intervention and outcomes. CPR 5 is an abstract outlining an oral presentation of a case study. Assessment, formulation, intervention and outcome information about an adult male with LD, behaviour that challenges and forensic issues was presented.

DEDICATION

This thesis is dedicated to mental health service users, as a reminder that you are experts by experience, have valuable insights and strong capabilities for recovery.

ACKNOWLEDGEMENTS

There are a number of individuals that I would like to acknowledge without whom this journey would not have been possible. First and foremost I would like to thank my family and friends who have always believed in me and encouraged me to achieve my aspirations. I would like to thank my mother Caroline for her emotional support, understanding and creativity. My father Brian for stimulating conversation, knowledge and support with editing. My friend Fran for her kindness and special shared sense of humour in times of need. My fiancée Neil for most importantly being my rock, grounding me, reminding me of and sharing with me the important things in life. I would not have been able to do this without you.

I would also like to thank those involved in my clinical psychology training and research without whom this thesis would not have been possible. This includes the course team; my appraisal tutor; clinical supervisors; the services, teams and professionals involved in the research; and all my training comrades, who have shared with me the highs and lows of training; I feel so fortunate to have shared my journey with such a supportive and compassionate cohort. In particular, I would like to acknowledge Dr Richard Bennett, my research supervisor, who enabled and supported the development, undertaking, analysis and editing of the research. Thank you for your support and containment. Dr Ruth Fountain, my clinical supervisor, who undoubtedly enabled my access to services, worked hard to promote my project and recruit participants. Dr Elizabeth Newton, who kindly offered to support the analysis of the research and imparted her IPA wisdom. Asha Patel, my fellow trainee, for her understanding and endless support from conception to completion of this thesis. Lastly, but by no means least, I would like to greatly thank my participants. I feel privileged to have shared your voice and I hope that I have done justice to your experiences and views.

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Paper to be edited for submission to 'International Journal of Forensic Mental Health'

A SYSTEMATIC REVIEW OF DIALECTICAL BEHAVIOUR THERAPY AS APPLIED IN FORENSIC SERVICES

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Word count: 8645

Key words: Dialectical Behaviour Therapy, DBT, forensic, prison, secure service, offending behaviour

ABSTRACT

Background: Dialectical Behaviour Therapy (DBT) has been increasingly utilised in forensic services to target emotional dysregulation that may be linked with self-harm, suicide, offending behaviour, and institutional rule-breaking, yet no systematic review of empirical research in this area has been carried out.

Aim: To explore the nature and quality of research into the uses and effectiveness of comprehensive DBT and DBT skills training in forensic services.

Method: An electronic search for studies utilising DBT with a forensic sample was carried out using *PsycInfo, Scopus,* and *Web of Knowledge* databases. Reference lists of relevant retrieved papers were also examined.

Results: After application of exclusion criteria, a total of thirteen papers were reviewed. The interventions targeted a range of psychosocial variables related to emotions, personality, self-evaluation, psychopathology, coping strategies, self-harm/suicide, risk, and offending behaviour including institutional rule-breaking. They were broadly categorised into studies that specifically targeted individuals with Borderline Personality Disorder (BPD) in the criminal justice system, and studies that targeted the general offender population.

Conclusions: When similar outcomes were assessed across studies, there were no consistent improvements in any emotional, psychological, cognitive, interpersonal, or behavioural variables. Implications of methodology and study quality are highlighted and recommendations for future research are made.

1.0 INTRODUCTION

1.1 Overview of DBT

Dialectical Behaviour Therapy (DBT) was developed as a treatment approach for individuals with a history of self-harming and suicidal behaviours, and subsequently for individuals with a diagnosis of Borderline Personality Disorder (BPD; Linehan, 1993). DBT assumes a biosocial theory of BPD; difficulties are characterised by emotion dysregulation, resulting in behavioural, interpersonal and cognitive instability and identity disturbance, which are brought about by an interaction between a biological disposition for dysregulation and an invalidating environment (Linehan, 1993). DBT therefore aims to support change in adaptive emotional regulation and sense of self within an extensive, validating environment that consists of weekly individual therapy, group skills training and out-of-hours telephone coaching for approximately one year (Feigenbaum, 2010). The therapy relationship itself is viewed as very important in the process of creating a stable sense of self; time is therefore dedicated to this through case consultation, where the therapist is supported to maintain alliance in the face of potentially difficult client behaviours (Robins & Koons, 2000). As the name alludes, DBT is interested in facilitating change through a process of dialectical synthesis; that is, being able to bring together seemingly opposing states and positions (an in-depth explanation of this can be found in Linehan & Dexter-Mazza, 2008). The main dialectic in DBT is between acceptance and change, the synthesis of which requires both the therapist and the client to accept the client for who they are, whilst also recognising the potential and need for change (Dimeff & Linehan, 2001). This is facilitated through the synthesis of traditional and third wave CBT approaches, combining change strategies, such as problem-solving, and acceptance strategies, such as mindfulness (Lau & Mcmain, 2005).

1.2 DBT in forensic settings

There is a large evidence base supporting the use of DBT for individuals with BPD (Bohus et al., 2000, 2004; Linehan, Armstrong, Suarez, Allmon & Heard, 1991; Linehan et al., 2006; Linehan, Heard, & Armstrong, 1993; Linehan et al., 1999; Verheul et al., 2003). Given that up to 23% of prisoners are estimated to meet the criteria for BPD (NICE, 2007) and 26% of secure psychiatric admissions are for individuals with Personality Disorders (PD; Coid, Kahtan, Gault, & Jarman, 1999), there has been interest in the application of DBT in forensic settings to ensure that the complex needs of this client group are being addressed (Berzins & Trestman, 2004).

However, interest in the use of DBT more generally for individuals in the forensic population has arisen out of findings that emotional dysregulation is a common difficulty often implicated in offending behaviour (Day, 2009; Novaco, 2011; Roberton, Daffern, & Bucks, 2012; Stinson, Becker, & Sales, 2008) and self-harm and suicidal behaviours are highly prevalent in forensic services (Brooker, Sirdifield, & Gojkovic, 2007; Meltzer, Jenkins, Singleton, Charlton, & Mohammed, 2003; Ministry of Justice, 2013; Webb et al., 2012). In addition, individuals residing in forensic settings often have difficulties engaging in psychological treatment (Day, Casey, Ward, Howells, & Vess, 2013; Hodge & Renwick, 2003; Miller, 2012), which may be linked to inability and/or unwillingness to access, express, and reflect on their emotions with a therapist (Howells & Day, 2006). With an emphasis on the therapeutic alliance and specific skills for accessing and reflecting on emotional states (Swales & Heard, 2009), DBT may be well suited to enhance treatment engagement.

In summary, DBT is a treatment designed to provide individuals with complex needs the tools for effective management of emotions, cognitions and behaviours. In theory, DBT could benefit individuals in the criminal justice system who have difficulties with emotion

regulation and maladaptive coping, and whose offending behaviour may in some circumstances be linked to this.

1.3 Aim

The aim of this review is to explore the nature and quality of research into the uses and effectiveness of both comprehensive DBT, and DBT skills training, for forensic populations. Specifically, to describe the presenting issues that DBT has been used to treat and its effectiveness at producing meaningful change particularly in relation to offending behaviour.

2.0 METHODOLOGY

2.1 Study inclusion

Within forensic settings there are many service constraints often resulting in a necessity to adapt DBT (McCann, Ivanoff, Schmidt, & Beach, 2007). Linehan (1993) has highlighted that DBT is a flexible approach, and adaptations to suit different settings, such as ward-based crisis support instead of telephone consultation, have been effective in a range of services (Bloom, Woodward, Susmaras, & Pantalone, 2012; Dimeff & Koerner, 2007). Whilst there are mixed results with regard to the effectiveness of adaptations such as DBT skills training alone (Harley, Baity, Blais, & Jacobo, 2007; Harley, Sprich, Safren, Jacobo, & Fava, 2008; Nelson-Gray et al., 2006; Soler et al., 2009), this may reflect one of the most consistently used aspects of DBT in forensic settings, given that financial constraints often result in a preference for group-based interventions (HMPS, 2012). For these reasons it seemed pertinent to explore studies which had used comprehensive DBT programmes in a modified form, and DBT skills training alone, as long as the full skills training programme was adhered to. Full skills training is a necessity as without both acceptance and change modules the dialectical focus is missing and therefore would not be classified as DBT.

There are practical and ethical difficulties with conducting highly controlled research in forensic settings and on the very rare occasions that such research is carried out, it often loses its real-world significance (Hollin, 2008). The use of concurrent interventions appears to be the norm in forensic settings given the complexity of mental health issues and criminogenic need (Kjelsberg et al., 2006). As an example, to the author's knowledge there have been no forensic DBT studies carried out in which medication has been controlled. Therefore studies of varying quality and rigour were considered for inclusion in this review provided they met the inclusion criteria. In order to avoid publication bias, unpublished

studies and non-English studies were considered as long as they met the inclusion criteria. Assessment of quality was undertaken, in part with the research supervisor, to determine the validity and clinical utility of results.

2.1.1 Inclusion criteria

Table 1:

Inclusion/exclusion criteria

Inclusion	Exclusion
Reporting an empirical piece of research	A theoretical/conceptual paper or a review
Assessing the effectiveness of a comprehensive DBT programme, which includes skills training and DBT consistent individual therapy	Does not include all modules of skills training
Or assessing the effectiveness of a DBT skills training programme	Does not include all modules of skills training
	Explicitly assessing the effectiveness of DBT combined with another treatment modality or group programme
Utilising a forensic sample defined as all participants being either forensically detained whilst completing the intervention or in receipt of the intervention to address offending behaviour	
Including outcome date, i.e. statistical analysis of at least one dependent variable or qualitative analysis of feedback	

2.2 Search methods

An electronic search for papers published up to 3rd January 2014 using *PsycInfo*, *Scopus* and *Web of Knowledge* databases was carried out. The reference list of relevant conceptual/theoretical, review and empirical papers that were retrieved were further examined for other relevant papers. See Appendix 1 for the specific search criteria used for each database.

2.3 Data extraction

In line with Cochrane standards (Higgins & Deeks, 2008), the following information has been reported where available with respect of each study included; sample size; the nature of the intervention that was used and any comparison treatments; the dependent variables and measures used; possible sources of bias in the methodology; analysis; and outcomes including follow-up outcomes.

2.4 Assessment of quality

The Effective Public Health Practice Project (EPHPP) assessment tool (Thomas, 1998) has been recommended as one of the most effective tools for assessing the quality of papers in systemic reviews (Deeks et al., 2003). The tool allows the evaluation of quality based on a number of components regarding the likelihood of various forms of bias affecting internal validity. It provides an overall quality rating of strong, moderate, or weak. It has adequate content validity, construct validity and substantial inter-rater reliability (Thomas, Ciliska, Dobbins & Micucci, 2004). As there were a substantial amount of before-and-after studies included in this review, a modification was made to the tool to account for confounding variables that may affect the results of this type of study (see Appendix 2 for the

tool with added descriptions from its accompanying dictionary and highlighted additions). Whilst modifications to quality assessment tools are often made to increase suitability (University of Alberta Evidence & Practice Center, 2012), the validity of the modification made for the purpose of this review has not been assessed and therefore this is a limitation of the current review. As well as the EPHPP tool dictionary, scoring guidance was obtained from a Cochrane training handbook which refers to the use of the tool (Jackson, 2007) and a review using the tool conducted by its author (Thomas, Fitzpatrick-Lewis, Rideout, & Muresan, 2008).

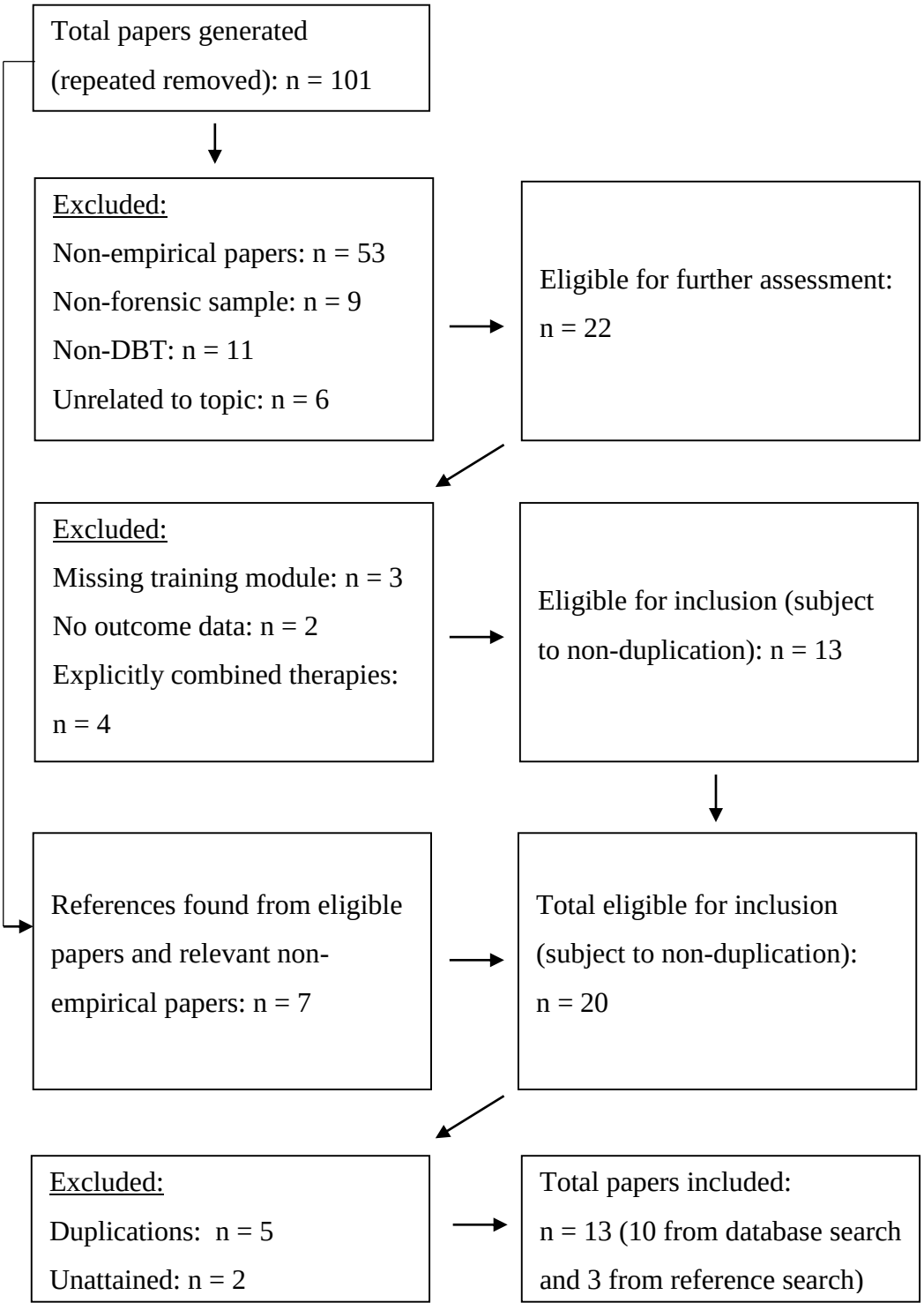
3.0 RESULTS

3.1 Search results

The database search generated a total of 101 papers (repetitions within and across search engines are excluded in this number), 22 of which were deemed eligible for a full-text review based on review of abstracts. Of these, 13 papers were deemed eligible for the review after application of inclusion/exclusion criteria. A review of the references of these papers and relevant theoretical/review papers resulted in a further 7 papers being identified which met the inclusion criteria. This resulted in a total of 20 papers eligible for inclusion in the review. However, 5 of these have been classified as duplications of papers already attained, such as; a follow-up report (Drake & Barnoski, 2006); a first-stage pilot of which results were later aggregated with a larger sample and subsequently published (Nee & Farman, 2005); case studies utilising the same data (Low, Jones, Duggan, MacLeod, & Power, 2001; Nee & Farman, 2007); and additional qualitative feedback (Sly & Taylor, 2003). These were considered part of the original study and therefore not subject to individual analysis, as is recommended by the Centre for Reviews and Dissemination (2008). A further 2 papers were unpublished (Gordon & Hover, 1998; Hover & Packard, 1998) and were unobtainable despite contact with the authors who could not locate the original articles due to length of time passed (G. Hover, personal communication, December 28, 2013). Hover also reported that Hover and Packard (1998) was unpublished due to non-significant findings. This resulted in a total of 13 papers, which have been included in this review (Barnoski, 2002; Blanchette, Flight, Verbrugge, Gobeil, & Taylor, 2011; Eccleston & Sorbello, 2002; Evershed et al., 2003; Gee & Reed, 2013; Low, Jones, Duggan, Power, & MacLeod, 2001; McCann & Ball, 1996; Nee & Farman, 2008; Pein et al., 2012; Rosenfeld et al., 2007; Shelton, Kesten, Zhang, &

Trestman, 2011; Shelton, Sampl, Kesten, Zhang, & Trestman, 2009; Trupin, Stewart, Beach, & Boesky, 2002). See Figure 1 for a diagrammatical process review.

Figure 1:



Process review

3.2 Overview of studies

The scope of the studies varied with many of the interventions targeting a range of psychosocial variables related to emotions, personality, self-evaluation, psychopathology, coping strategies, self-harm/suicide, risk, and offending behaviour, including institutional rule-breaking. These variables were targeted using both comprehensive DBT programmes and DBT skills training programmes, the definitions of which are outlined in Table 2. For the purpose of this review, they have been broadly categorised into studies that specifically targeted individuals with BPD in the criminal justice system, and studies that targeted the general offender population. Table 2 provides a descriptive account of each study, produced in line with guidance from Centre for Reviews and Dissemination (2008), and the study quality rating. The implications of quality assessment on study validity and utility are discussed in each chapter, and Appendix 3 details how the studies were assessed and rated using the EPHPP tool.

Studies defined as duplications i.e. additional analyses of the same data set, specific case studies from the original sample (defined as duplications by the Centre for Reviews and Dissemination, 2008) are included in Table 2 (non-highlighted) for the reader's reference. These are not typically discussed in the main body of the text as they do not contribute new findings, however, where new findings do emerge, i.e. in follow-up studies, this is discussed and study quality assessed. Qualitative data, including information from the only qualitative duplication study in this review (Sly & Taylor, 2003), is used to offer explanations and interpretations of quantitative research findings. This is one way of synthesising qualitative data highlighted by the Centre for Reviews and Dissemination (2008).

Table 2:

Summary of studies

Journal article and study number	Setting and referral criteria	Participant characteristics	Study design	Intervention	Outcomes	Overall quality rating
Study one **Low et al., (2001)**	High secure psychiatric hospital in UK BPD and currently engaging in self-harm	10 females, mean age 28.7	Before and after study	1 year of DBT: skills training (individual), individual therapy and telephone consultation	<u>Improvement at 6-month follow-up:</u> Self-harm (ward reported) ↓ RLI survival & coping beliefs subscale ↑ DES total score ↓ <u>Non follow-up maintained improvement:</u> BDI total score ↓ IVES impulsiveness subscale ↓ <u>No change:</u> SES total score IDAS depression & irritability subscales BSSI total score BHS total score	3: weak
Low et al., (2001)	As above	3 females from above sample, ages not reported	Case studies			

Study two **Nee & Farman (2008)** This paper aggregates results from two pilots, the first being Nee & Farman (2005)	Prisons in UK: two closed (life sentenced) and one allocation BPD, recently engaged in self-harm and at risk of committing a serious offence in the future	Females, age range 19-49 Short treatment group n=13 Long treatment group n=9 Control n=5	Before and after study Non-randomised controlled study Discourse analysis	DBT group skills training, individual therapy, telephone consultation using an answerphone system, and some case consultation Short treatment: 3-4 months Long treatment: 1 year Waiting list control	*Short treatment* <u>Improvement at the end of treatment:</u> Rosenberg self-esteem scale total score ↑ LCQ total score ↑ RLI survival & coping beliefs & moral objections subscales ↑ BSI total score ↓ Eysenck impulsivity scale ↓ DES total score ↓ CAQ distress subscale ↓ <u>Trend towards improvement:</u> ECQ benign control ↑ & emotional inhibition ↓ PFQ shame & guilt subscales ↓ <u>No change:</u> ECQ rehearsal subscale STAXI total score	*Long treatment* <u>No difference between treatment & control group:</u> All self-report measures used in this study	3: weak
					<u>Not analysed:</u> Self-harm & lethality (ward recorded) Adjudications (ward recorded) <u>Qualitative:</u> Interviews gaining participant feedback		

Nee & Farman (2007)	As above	3 females from above sample, mean age 21.6	Case studies			
Study three **Evershed et al., (2003)**	High secure psychiatric hospital in UK PD with features of BPD	Adult males, ages not reported Treatment n=8 Control n=9	Before and after study Non-randomised controlled study (violence outcomes only)	18 months of DBT: group skills training, individual therapy, ward based coaching in place of telephone consultation and case consultation TAU: medication, group therapy and/or individual therapy (none specified)	<u>Improvement at the end of treatment:</u> BDHI-D overt & covert hostility subscales ↓ STAXI trait & anger out subscales ↓ NAS cognitive subscale ↓ <u>Trend towards improvement:</u> STAXI anger experience subscale ↓ <u>No change:</u> STAXI state, anger in & anger control subscales NAS arousal, behavioural & provocation subscales <u>Difference between treatment & control group at end of treatment:</u> Violence (ward recorded arguments, abuse, threats, damage to property & intimidation) severity in favour of treatment group <u>No difference between treatment & control group:</u> Violence (as above) frequency	3: weak

Study four **Gee & Reed (2013)**	Prison in UK Traits of BPD	Adult females, ages not reported Completers n=29 Non-completers n=33	Before and after study Qualitative, no method of analysis provided	2–20 months DBT group skills training, individual therapy, case consultation and skills coaching in place of telephone consultation	<u>Improvement at the end of treatment:</u> Adjudications (NOMS reported) 88% ↓ ACCT data (NOMS reported), 54% ↓ for all participants & 68% ↓ for completers CORE total score & risk score (37 participants), 68% & 61% achieved reliable ↓ respectively Matrix evidence evaluation questionnaires assessing perception of life, mental health & personal relationships subscales (26 participants), 54-64% reported improvement <u>Qualitative:</u> Questionnaire developed by authors gaining level of participant satisfaction	3: weak
Study five **Eccleston & Sorbello, (2002)**	Remand prison in Australia BPD, or difficulties exhibited by an individual with BPD, or a history of self-harm/ suicidal behaviours	Adult males, ages not reported Unit A (at risk of self-harm/suicide) n=6 Unit B (violent offenders) n=6 Unit C (vulnerable & first-time offenders) n=8 Unit D & E (under protection) n=9	Before and after study Qualitative, no method of data analysis provided	10 weeks of DBT group skills training, individual therapy provided on a needs only basis, debriefing seemingly in place of case consultation	<u>Improvement (no statistical analysis) at the end of treatment:</u> DASS total score, depression, anxiety & stress subscales ↓ for units B, C and E DASS total score & stress subscale ↓ for unit A DASS stress subscale ↓ for unit D <u>No change:</u> DASS depression subscale for unit D <u>Deterioration:</u> DASS depression & anxiety subscales ↑ for unit A DASS total score & anxiety subscale ↑ for unit D Themes identified from therapist notes Questionnaires developed by authors gaining participant and prison staff feedback	3: weak

Study six **McCann & Ball (1996)**	Secure psychiatric hospital in UK: intermediate and medium secure units Resident participants: at least 3 symptoms of BPD Staff participants: working in the above service, no other criteria given	<u>Residents:</u> Mixed genders, mean age 37.6 Aggregated treatment group n=21 Control group n=14 <u>Staff</u> Treatment group intermediate n=9 Treatment group medium n=10 Control group n=33	Before and after study	DBT group skills training, case consultation and ward staff modelling Intermediate unit: opportunity to attend 16 months Medium unit: opportunity to attend 10 months TAU: at a minimum this included group therapy (not specified)	<u>Improvement at the end of treatment:</u> BSI depression & hostility subscales ↓ for aggregated treatment group RWCS seeking social support subscale ↑ & blame of self subscale ↓ for aggregated treatment group GAS total score ↑ for aggregated treatment group GCQ engagement subscale ↑, avoidance & conflict subscales ↓ for intermediate treatment group GCQ conflict subscale ↓ for control group MBI (staff outcomes) emotional exhaustion ↓ & personal accomplishment ↑ for intermediate treatment group and depersonalisation ↓ for both treatment groups <u>Trend towards improvement:</u> BDI total score ↓ for treatment group <u>No change:</u> RWCS problem focused, blame of others & avoidance subscales BSI paranoia & psychoticism subscales BDHI anger & hostility subscales GCQ all subscales for medium treatment group GCQ engagement & avoidance subscales for control group MBI (staff outcomes) emotional exhaustion & personal accomplishment for control group & medium treatment group, & depersonalisation for control group	3: weak

Study six continued					<u>Not reported:</u> Regressions (ward recorded, not defined) Incidents (ward recorded assaults, suicidal behaviour, property loss, contraband & fire setting) STAXI STAI PANAS CALPAS CCS	
Study seven **Barnoski (2002)** Drake & Barnoski (2006)	YOI mental health unit in USA Programme was fully integrated on the unit therefore all residents were potential participants Follow-up study, criteria as above	Adolescents of mixed gender, ages not reported Treatment n=42 Control n=116 Treatment n=63, mean age 14 Control n=65, mean age 15	Non-randomised controlled study	On-going ward based DBT: group skills training, individual therapy and case consultation Minimum 14 days stay on unit TAU: treatment not specified	<u>Difference between treatment & control group at 12-month follow-up:</u> Reconviction rates for felony offences in favour of the treatment group <u>No difference between treatment & control groups:</u> Total reconviction rates <u>No difference between treatment & control group at 18 or 36-month follow-up:</u> Reconviction rates (violent, felony & total)	3: weak 3: weak

Study eight **Rosenfeld et al., (2007)**	Outpatients on probation in two USA states History of stalking offences	Males, mean age 36.7 Treatment completers n=14 Treatment non-completers n=15 Control n=148 (data from stalking recidivism study)	Before and after study Non-randomised controlled study	4-6 months of DBT: group skills training, individual therapy, case consultation and telephone consultation Non-completers: less than 5 skills training sessions TAU: treatment not specified	<u>Difference between treatment & control group at the end of treatment:</u> Re-arrest rate for general offences in favour of treatment completers <u>Difference between treatment groups:</u> Re-arrest rate for stalking offences in favour of treatment completers <u>No difference between treatment groups:</u> Re-arrest rate for general offences <u>No change (completers):</u> SARA total score BPAQ total score EQ total score MEPS total score WAYS all subscales <u>Deterioration (completers):</u> STAXI anger expression subscale ↑ WBSI total score ↑	3: weak

Study nine **Blanchette et al., (2011)**	Four prisons in Canada, various security levels Programme was fully integrated on each unit therefore all residents were potential participants	94 females, mean age 32.4 Comparison group (for revocation rates only): all women released from Canadian prisons between 2002-2004	Before and after study	On-going ward based DBT: group skills training, individual therapy, ward based coaching in place of telephone consultation and case consultation Shortest duration between completing pre-and-post measures was 23 days	<u>Improvement at 3-year follow-up:</u> Revocation rates for a new offence 15%, compared to 28-29% in the comparison group <u>Improvement at 3-month follow-up:</u> Self-harm (ward reported) ↓ <u>Improvement at the end of treatment:</u> IFS total score, personal involvement & mental health issues subscales ↑ BPRS-E anxiousness/depression subscales ↓ SCL-90-R total score & somatization, obsessive compulsive, interpersonal sensitivity, depression, anxiety, phobic anxiety, psychoticism, paranoid ideation & hostility subscales ↓ WAYS confrontational coping & escape-avoidance ↓ POMS total score, depression & confusion subscales ↓ SCS total score ↑ <u>No change at 3-month follow-up:</u> Aggregated incidents (ward reported instigation of & victimisation in undefined incidents) BUT… <u>Trend towards improvement at 6-month follow-up</u> Aggregated incidents (ward reported instigation of & victimisation in undefined incidents, & self-harm) ↓	3: weak

Study nine continued Sly & Taylor (2003)	Resident participants: as above Staff participants: working in the above service, no other criteria given	Residents n=23 females from above sample, ages not reported Staff n=62, genders/ages not reported	Qualitative; content analysis		<u>No change at the end of treatment:</u> IFS daily living, interpersonal relations & institutional behaviour subscales BPRS-E total score, thinking disturbances, hostile/suspiciousness, & withdrawal/retardation subscales WAYS distancing, self-control, seeking social support, accepting responsibility, planful problem solving & positive reappraisal subscales POMS tension, anger, fatigue & vigour subscales BHS total score <u>Deterioration at 3-year follow-up</u> Total revocation rates 57%, compared to 37=38% in the comparison group Semi-structured interview and questionnaire developed by the authors to answer the following research questions: Are DBT goals understood and being achieved? Are the treatment materials and built-in assessment battery effective and informative? Is DBT accomplishing what it sets out to?	
Study ten **Pein et al., (2012)**	Secure psychiatric hospital in Germany Substance abusers	Genders not reported Treatment n=14, mean age 29.57 Control n=15, mean age 25.07	Before and after study	12 months of DBT: group skills training, individual therapy, extra mindfulness practice and individual nursing sessions TAU: treatment not specified	<u>Improvement at the end of treatment:</u> FOTRES dynamic risk ↓ for treatment group TL-D total score ↑ for treatment group FAIR total score ↑ for both groups <u>No change:</u> TMT-B total score for either group FWIT total score for either group FOTRES dynamic risk for control group TL-D total score for control group	3: weak

Study eleven **Trupin et al., (2002)**	YOI mental health unit and general offender units in USA Programme was fully integrated on the unit therefore all residents were potential participants	Females Mental health treatment group n=23, mean age 14.8 General offender treatment group n=22, mean age 15.5 General offender control group n=45, mean age 15.2	Before and after study Non-randomised controlled study (risk only)	10 months of DBT group skills training, case consultation, case management and ward based support rather than individual therapy or telephone consultation TAU: at a minimum occupation, education & substance programme (not specified)	<u>Improvement at the end of treatment:</u> Staff punishments (frequency of ward reported room confinement, suspension and suicide precaution levels) ↓ for mental health treatment group Rehabilitation (ward reported employment levels, educational achievement, completion of treatment programmes and transferral to an open unit) ↑ for mental health treatment group <u>No change:</u> Behavioural problems (frequency of ward reported aggression, para-suicidal acts and classroom disruption) for either treatment group <u>Deterioration</u> Staff punishments (frequency of ward reported room confinement, suspension and suicide precaution levels) ↑ for general offender treatment group <u>No difference between treatment & control groups at 90-day follow-up:</u> CRA total score	3: weak

Study twelve **Shelton et al., (2009)**	Three prisons in USA: male, female and YOI Impulsive behaviour	Male adults n=23 Female adults n=18 Male adolescents n=22 Aggregated mean age 28	Before and after study	16 weeks of DBT group skills training	<u>Improvement at unspecified follow-up period:</u> BPRS total score ↓ WAYS seeking social support, accepting responsibility & planful problem solving ↑ , & escape-avoidance ↓ PANAS negative affect subscale ↓ for adult males BPAQ ↓ physical aggression & ↑ anger management subscales for males <u>Non follow-up maintained improvement:</u> Disciplinary tickets for behavioural offences (ward reported frequency) ↓ <u>No change:</u> PANAS positive affect subscale PANAS negative affect subscale for adolescent males & females BPAQ verbal aggression & hostility subscales BPAQ physical aggression & anger management subscales for females BPRS hostility subscale OAS-M aggression & hostility subscales WAYS confrontational coping, self-control, positive reappraisal & distancing subscales	3: weak

Study twelve continued			Controlled clinical trial	8 weeks: individual coaching sessions, reported to be consistent with DBT, or individual case management sessions (not described)	<u>Difference between treatment & control group at 12-month follow-up:</u> PANAS positive affect subscale ↓ in favour of the control group <u>Non-maintained difference between treatment & control group:</u> BPRS ↓ in favour of the female & adolescent male treatment groups <u>No difference between treatment & control group:</u> All other measures described in the study	
Study thirteen **Shelton et al., (2011)**	Prison in USA Impulsive behaviour	26 males, mean age 17.92	Before and after study	16 weeks of DBT group skills training	<u>Improvement at the end of treatment:</u> Disciplinary tickets for behavioural offences (ward reported frequency) ↓ BPAQ physical aggression subscale ↓ <u>No change:</u> BPAQ total score, verbal aggression, hostility & anger management subscales OAS-M aggression & hostility subscales WAYS confrontational coping, seeking social support, accepting responsibility, planful problem solving, escape-avoidance, self-control & positive reappraisal subscales BPRS total score & hostility subscale PANAS negative & positive affect subscales <u>Deterioration:</u> WAYS distancing subscale ↑	3: weak

Key: BPD (Borderline Personality Disorder); DBT (Dialectical Behaviour Therapy); SES (Self Esteem Scale, Rosenberg, 1965); IDAS (Irritability, Depression and Anxiety Scale, Snaith & Zigmond, 1994); BDI (Beck Depression Inventory, Beck & Steer, 1987; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961, respectively); DES (Dissociative Experiences Scale, Bernstein & Putnam, 1986); RLI (Reasons For Living Inventory, Linehan, Goodstein, Nielson, & Chiles, 1983); BHS (Beck Hopelessness Scale, Beck, Weissman, Lester, & Trexler, 1974); BSSI (Beck Scale for Suicide Ideation, Beck, Kovacs, & Weissman, 1979); IVES (Impulsiveness, Venturesomeness and Empathy Scale, Eysenck & Eysenck, 1991); BSI (Borderline Syndrome Index, Conte, Plutchik, Karasu, & Jerrett, 1980); LCQ (Locus of Control Questionnaire, author/reference not provided); ECQ (Emotion Control Questionnaire, author/reference not provided); PFQ (Personal Feelings Questionnaire, author/reference not provided); STAXI (State-Trait Anger Expression Inventory, Spielberger, Reheiser, & Sydeman, 1995; Spielberger, Jacobs, Russell, & Crane, 1983, respectively) and STAXI-2, Spielberger, 1999); CAQ (Custodial Adjustment Questionnaire, author/reference not provided); PD (Personality Disorder); TAU (Treatment As Usual); BDHI-D (Buss-Durkee Hostility Inventory, Dutch Version, Lange et al., 1995); NAS (The Novaco Anger Scale, Novaco, 1980); ACE (Adults facing Chronic Exclusion); CORE (Clinical Outcomes in Routine Evaluation, author/reference not provided); ACCT (Assessment, Care in Custody and Teamwork); NOMS (National Offender Management Service); DASS (Depression, Anxiety and Stress Scale, Lovibond & Lovibond, 1995); RWCS (Revised Ways of Coping Scale, Vitaliano, Russo, Carr, Maiuro, & Becker, 1985); CALPAS (California Psychotherapy Alliance Scale, Gaston, 1991); GCQ (Group Climate Questionnaire, MacKenzie, 1981); CCS (Concerns about Change Scale, reference not provided); BSI (Brief Symptom Inventory, Derogatis & Melisaratos, 1983); GAS (Global Assessment Scale, Endicott, Spitzer, Fleiss, & Cohen, 1976); BDHI (Buss-Durkee Hostility Inventory, version not provided); STAI (State Trait Anxiety Inventory, Spielberger, Gorsuch, Lushene, Vagg, & Jacobs, 1970); PANAS (Positive and Negative Affect Scales, Watson, Clark, & Tellegen, 1988); MBI (Maslach Burnout Inventory, Maslach & Jackson, 1981); YOI (Young Offenders Institute); BPAQ (Buss-Perry Aggression Questionnaire, Buss & Perry, 1992); EQ (Empathy Questionnaire, Mehrabian & Epstein, 1972); MEPS (Means Ends Problem Solving Scale, Platt, Spivack, & Bloom, 1971); WBSI (White Bear Suppression Inventory, Wegner & Zanakos, 1994); WAYS (Ways of Coping Questionnaire, Folkman & Lazarus, 1988); SARA (Spousal Assault Risk Assessment, Kropp, Hart, Webster, & Eaves, 1995); IFS (Institutional Functioning Scale, questionnaire developed for the purpose of the study); BPRS-E (Expanded Brief Psychiatric Rating Scale, Lukoff, Nuechterlein, & Ventura, 1986) and BPRS (Brief Psychiatric Rating Scale, Overall & Gorham, 1962) respectively; SCL-90-R (Symptom Checklist-90-Revised, Derogatis, 1994); POMS (Profile of Mood States, McNair, Lorr, & Droppleman, 1972); SCS (Self-Control Schedule, Rosenbaum, 1980); FOTRES (Forensic Operationalized Therapy Risk Evaluation System, Urbaniok, 2007); TMT-B (Trail Making Test- Part B, Reitan, 1992); FWIT (Colour-Word Interference Test, Bäumler, 1985); FAIR (Frankfurt Attention Inventory, Moosbrugger & Oehlschlägel, 1996); TL-D (Tower of London Dutch Version, Tucha & Lange, 2004); CRA (Community Risk Assessment, author/reference not provided); OAS-M (Overt Aggression Scale – Modified, Coccaro, Harvey, Kupsaw-Lawrence, Herbert, & Bernstein, 1991)

4.0 HOW EFFECTIVE IS DBT AT TREATING DIFFICULTIES EXPERIENCED BY INDIVIDUALS WITH BPD INVOLVED IN THE CRIMINAL JUSTICE SYSTEM, AND AT PRODUCING MEANINGFUL BEHAVIOURAL CHANGE IN RELATION TO THEIR OFFENDING BEHAVIOUR?

Just under half of the studies identified utilised participants with a diagnosis of BPD or significant traits. This section describes the presenting issues that DBT programmes have targeted within this complex client group whose behaviours have ultimately resulted in forensic detainment. It also explores each programmes' effectiveness in light of the quality of the research. Where possible, attention is paid to changes in observable behavioural measures, such as decreases in post-discharge recidivism, frequency and type of adjudications and incident data for violence, fire-setting, contraband and general rule-breaking, which would be required to ascertain the effectiveness of DBT at reducing offending behaviour. Also to changes in self-reported measures of emotion, cognition and behaviour that are often implicated in offending behaviour, such as decreases in anger, aggression, hostility, impulsivity and improved self-control and adaptive coping. There are a number of emotional, cognitive, interpersonal and behavioural difficulties experienced by individuals with BPD that may not be directly associated with offending behaviour, but cause considerable distress to themselves and problems in the forensic setting, such as suicidality, dissociation, depression, anxiety, and low self-esteem, and therefore all outcomes presented are explored in this review.

4.1 Comprehensive DBT

All DBT programmes within this section consist of weekly skills training and DBT consistent individual therapy. All but one programme (Gee & Reed, 2013) reported on the use of out-of-hours crisis management/coaching, either telephone or ward-based. All but one programme (Low, et al., 2001) reported on the use of case consultation for therapists.

Low, et al., (2001; study one) found a significant decrease in self-harm occurring throughout one-year of DBT treatment continuing at six-month follow-up, for adult females (n = 10) with BPD in a high secure hospital, who were actively engaging in self-harm. This may be explained by the additional follow-up maintained improvement in survival and coping beliefs but, in particular dissociation, which is a significant risk factor for self-harm (Chapman, Gratz, & Brown, 2006; Gratz, Conrad, & Roemer, 2002; Klonsky, 2007; Low, Jones, MacLeod, Power, & Duggan, 2000), as no changes in another measure of suicidality (BSSI), hopelessness, self-esteem, or irritability, and non-maintained changes in depression and impulsivity were found. Unfortunately, the study did not explore the effects of the programme on other behaviours that may be of relevance within a high secure hospital, such as aggression towards others, which has been linked to self-harm (Yusainy, 2013).

Nee and Farman (2008; study two) found no difference on any of the numerous outcome measures used between a one-year DBT treatment group (n = 9) and a wait-list control group (n = 5). Participants were adult females with BPD residing in prison, who were actively engaging in self-harm/suicidal behaviours and at risk of committing a serious offence. The authors suggest that as all participants were on the same ward and staff were given basic DBT awareness training, the control group may have been inadvertently exposed to treatment. This has been shown to occur with mindfulness in a forensic setting, whereby non-participants were taught the skill by participants and a reduction in aggressive behaviour

was observed (Singh et al., 2011). If this is the case, then significant improvements in borderline features, impulsivity, anger, locus of control and self-esteem at six-month follow-up in both groups seems a positive result, although there were no changes on a number of other measures, including suicidality and overall adaptive coping. In addition, self-harm data were not analysed given the small amount of the data that were collected, but visual inspection highlights an increase in self-harm at the end of treatment and during follow-up. This may be explained by the authors' hypothesis that two participants experienced significant life events during follow-up and therefore skewed the data; or by observation that participants seemed to have had fairly low baseline incidents of self-harm, and DBT has not been found effective for individuals with low self-harm severity (Verheul et al., 2003).

In Nee and Farman's shorter three to-four month DBT programme (n =13), utilising the same referral criteria, they found significant improvements at the end of treatment in self-esteem, locus of control, survival and coping beliefs, moral objections to suicide, borderline features, dissociative experiences, custodial distress and impulsivity. No other improvements were found. Again, visual inspection shows an increase in self-harm during the first month which does later decrease, but it does not fall below pre-treatment levels. Unfortunately, adjudication data were not analysed or reported for either programme, therefore it is unclear whether the programmes had any effect on other behaviours.

Evershed et al., (2003; study three) found a significant difference in the anger outcomes (described below) of a DBT treatment group (n = 8) and an unmatched Treatment as Usual (TAU) control group (n=9) of adult males residing in a high security hospital with a diagnosis of PD and features of BPD. Subscales related to hostility, trait anger, frequency of outward expressions of anger assessed by the STAXI, and cognitive mediation of anger assessed by the NAS improved only in the treatment group, with no differences on other

subscales or another measure of hostility (BDHI-D). Effect sizes demonstrated stability or a small to large improvement across all measures for the treatment group and stability or a small to large deterioration for the control group at the end of treatment. However, there was no significant difference between groups during or at the end of treatment for frequency of observed violence. This may be explained by the lack of change on subscales measuring anger control, aggression, and impulsive responses, and calls into question the clinical utility of the programme. The authors did report a decrease in violence severity in favour of the treatment group, but this finding is questionable because the control group was not matched for violence severity scores initially, and their data were only analysed for the last six months of an eighteen-month DBT treatment.

Gee and Reed (2013; study four) assessed the effectiveness of a programme of DBT lasting up to twenty months, for adult females residing in prison with traits of BPD (n = 29), who attended at least one two-month block of treatment. They reported a reliable decrease in global psychological distress, particularly for those with the highest initial risk, and a general decrease in risk. Over half of the participants reported improvement in perception of their; lives (64%), mental health (56%), and personal relationships (54%). The authors report an average 54% decrease in the usage of ACCT assessments (used when an individual is deemed at risk of self-harm) across all participants including non-completers (n=62) and 68% decrease for completers from pre-to-post treatment. Compared to baseline, there was a 29.3% decrease in adjudications during the programme and 88% decrease at the end of the programme. Positive results are also reflected by high client satisfaction, with 98% finding the programme useful and helpful in some way. However, the results are difficult to interpret as self- and staff-report measures and adjudication data were an amalgamation of all participants who completed pre-post measures (n = 62), including those who did not even

complete one module of the programme. In addition, there is no statistical analysis of difference between pre-and-post test results and no follow-up data.

4.2 DBT skills training

Two studies assessing the effectiveness of DBT for individuals with BPD or significant traits and forensic histories are classified as skills training only because they do not include DBT consistent individual therapy. However, in Eccleston and Sorbello's (2002) study participants received counselling on a needs only basis; and in McCann and Ball's (1996) study therapists had case consultation and ward staff had some training to support skill enhancement.

Eccleston and Sorbello (2002; study five) found mixed results for males (n = 29) in a remand prison who had either a diagnosis of BPD, characteristics/difficulties associated with BPD or a history of self-harm/suicidal behaviours, undertaking ten-weeks of DBT skills training. Participants across all wards reportedly achieved lower stress scores at the end of treatment, but individuals deemed most at risk of suicide/self-harm achieved slight increases in depression and anxiety. Unfortunately, no statistical analysis was carried out on pre-post scores. The authors claim that such an increase could reflect an enhanced ability to identify emotions given that some of these individuals were low baseline scorers. However, inspection of the presented data by the author of this report highlighted that individuals who scored in the moderate to severe ranges at baseline also achieved increases in depression and anxiety scores. Enhanced emotional processing should lead to a decrease in depression if accompanied by emotion regulation skill use and it may increase depression if it is not accompanied by skill use (Feldman, Harley, Kerrigan, Jacobo, & Fava, 2009). Individual therapy and telephone consultation are used to hone the application and generalisation of

skills to the wider context of life (Linehan, 1993); therefore not having these components at all or consistently may have been detrimental to real-life skill application. The authors present only positive feedback from participants, facilitators and staff, which may represent a bias in participant reporting or in the authors' selection of participant comments given the seeming worsening of symptoms and a number of reported implementation difficulties.

McCann and Ball (1996; study six) found end of treatment improvement for self-reported depression, hostility (both assessed by BSI), blame of self and seeking social support in male and females (n = 21) with at least three traits of BPD. They were residing in a secure psychiatric hospital and attended ten to-sixteen months of DBT skills training. There was no significant maintained change for most other coping strategies or psychological symptoms of distress, or anger and hostility assessed by BDHI. Results for the PANAS, STAXI and STAI were not reported, indicating the possibility of non-significant findings. A TAU control group (n = 14) achieved no significant change, however, they were not matched at pre-treatment for hostility, depression or adaptive coping. Unfortunately, despite the authors reporting that they collected incident data including assaults, suicidal behaviour, contraband and fire setting, they did not present the results. Therefore it is assumed that no behavioural change occurred, including any decrease in offending behaviour.

At the end of the programme, staff on the intermediate ward (n = 9) reported that the treatment group were significantly more engaged in group therapy, less avoidant, and that there was less conflict between participants in therapy. Staff reported a significant decrease in their own emotional exhaustion and depersonalisation, and a significant increase in personal accomplishment. Staff on the medium ward (n =10) reported no group change, but a significant decrease in their feelings of depersonalisation. The control group staff (n = 33) reported that the group had less conflict in therapy but there were no significant changes in

their well-being. By the end of the programme, the treatment group (aggregated), but not the control group, were rated by staff as having improved global functioning, although pre-treatment data suggests this was already increasing. The difference in outcomes between treatment groups may be explained by a difference in level of training and support, as intermediate ward staff were reported to have a *"stable, consistent and positive"* (p. 17) relationship with the investigators, whereas the medium ward staff did not. Level of acuity and length of participant time in treatment may also have contributed to this in favour of the intermediate ward.

4.3 Conclusion

The studies reviewed in this section investigated the effectiveness of comprehensive DBT and DBT skills training at treating emotional, psychological and behavioural difficulties experienced by individuals with BPD or traits of BPD, whose behaviours have resulted in forensic detainment. Between them the studies explored the impact of the programme on a range of difficulties and programme implementation varied. Improved outcomes assessed by only one out of the six studies included, locus of control, borderline features, stress and self-blame. However, given that these outcomes were found in each case in only one study, each with significant methodological limitations, it is not possible to conclude that this represents a reliable result. When similar outcomes were assessed across studies, there were inconsistent results for dissociation, psychological distress, suicidality, self-esteem, depression, and adaptive coping. Given that the main aim of DBT is to facilitate behavioural change (Lynch, Chapman, Rosenthal, Kuo, & Linehan, 2006), it is unfortunate that little behavioural change was reported. Only study one, using a comprehensive programme found a statistically significant maintained decrease in self-harm, with other studies either not providing results or

not offering statistical analysis. There were even indications that self-harm increased in study two. In addition, the small sample size and low power in study one decreases the probability that their significant result equates to a true effect (Button et al., 2013).

Regarding the impact of DBT on variables assessed that may be more directly linked to offending behaviour, results were again inconsistent and/or potentially unreliable. Only study four assessed risk and this was not statistically analysed. Inconsistent results across, and between studies when they used different measures to assess the same construct, were found for hostility, anger and impulsivity. Even though data on offending behaviour, i.e. violence and adjudications, were collected in most studies, they were often not reported, possibly indicating lack of a significant result. In study three, violence did not decrease and the decrease in violence severity is questionable due to the non-matched control group. In study four where the number of adjudications decreased, there was no statistical analysis and an indication that the data included those who dropped out very early in the programme (less than four weeks). It is therefore unclear what this change is attributable to. Given the possible links between offending behaviour and anger (Cornell, Peterson, & Richards, 1999; Johansson & Kempf-Leonard, 2009; Joyce, Dillane, & Vasquez, 2013); impulsivity (Cornell, Peterson, & Richards, 1999; Komarovskaya, Loper, & Warren, 2007); hostility (Corapçioğlu & Erdoğan, 2004; Firestone, Nunes, Moulden, Broom, & Bradford, 2005; McNiel, Eisner, & Binder, 2003; Collie, Vess, & Murdoch, 2007); and classification of risk (Cooke, 1996), lack of reliable and consistent change in these outcomes may explain little behavioural change.

Positive and negative results across all studies are of limited value given a number of methodological limitations in addition to those already mentioned, which affect internal validity. All studies had a small sample size making it harder to obtain true significant results. There was either admission or indication of uncontrolled confounding variables

between and within groups which could explain any treatment effects, and/or a lack of control group to support the hypotheses that effects were associated with treatment. Follow-up periods tended to be short and data were either not consistently collected or not analysed for all outcome measures, limiting the ability to ascertain the real clinical utility of the results. Such limitations warranted a weak quality rating in all cases. Therefore at the current time it is not possible to determine whether comprehensive DBT or DBT skills training is effective at treating difficulties experienced by individuals with BPD and producing meaningful behavioural change, particularly in relation to offending behaviour.

5.0 HOW EFFECTIVE IS DBT AT REDUCING OFFENDING BEHAVIOUR IN THE GENERAL FORENSIC POPULATION?

A small majority of reviewed studies assessed the effectiveness of DBT at reducing offending behaviours, including institutional rule-breaking. This section explores the types of offending behaviours that have been targeted, the effectiveness of comprehensive DBT and DBT skills training at producing change in offending and the mechanisms by which this might be explained, in light of the quality of the evidence. Whilst most of these studies assess actual behaviour, one study included in this review (Pein et al., 2012) only assesses future risk of committing an offence.

5.1 Comprehensive DBT

All DBT programmes within this section consist of weekly skills training and DBT consistent individual therapy. All but one programme (Pein et al., 2012) reported on the use of out-of-hours crisis management/coaching, either telephone or ward-based, case consultation for therapists, and therapist and staff training. However, Pein et al., a non-English translated study, reported following the Colorado Mental Health Institute at Pueblo (CMHIP) forensic model (McCann, Ball, & Ivanoff, 2000), which does include case and telephone consultation, therefore this may be an issue of not reporting rather than missing components.

Barnoski (2002; study seven) found that at twelve-month follow-up, a treatment group of adolescents residing on a Young Offender Institute (YOI) mental health unit (n = 42) in which DBT was embedded, were significantly less likely to have been reconvicted for a felony (serious) offence, than a semi-matched TAU control group (n = 116). However, there was no difference in reconviction rates when all offences were analysed together. Drake and Barnoski (2006) conducted an extended follow-up (n = 63) using a specific subsection of the

original control group (n = 65) who were matched on more variables. They found that between 18 and 36 month follow-up, the treatment group re-offended (felony and violent) less at each time point than the control group, but these differences were not significant. The authors calculated the need for 150 participants in each group to achieve statistical significance and therefore a small sample size is likely to have affected the results. However, these insignificant results may be accounted for by a number of other factors; participants were only required to have stayed at the unit for fourteen days to be included in the analysis and there is no indication of average length of stay or how many residents actually participated in the therapy. Therefore the treatment group may not have been fully exposed to the core components of DBT or for a sufficient length of time to achieve long-term gains (Bloom et al., 2012).

Rosenfeld et al. (2007; study eight) assessed the effectiveness of four to six months of DBT in an outpatient setting for adult males with a history of stalking. The authors found that completers (n=14) were significantly less likely to be re-arrested for stalking offences than non-completers (n=15), although there was no difference between groups for general recidivism. The authors reported that completers had a significantly lower re-arrest rate than a non-matched TAU control group of individuals from a previous stalking recidivism study (Rosenfeld, 2003; n = 148). However, these results are questionable given that the follow-up period was different for all participants, with some only two months post-treatment.

Completers were using significantly more thought suppression and demonstrated a marginally significant increase in anger following completion of treatment. The authors present this as positive, suggesting that thought suppression is adaptive in a prison environment and that an increase in anger represents greater acknowledgement of anger expression. However, DBT has generally been found to decrease anger expression (Koons et

al., 2001; Neacsiu, Rizvi, & Linehan, 2010); and mindfulness should decrease thought suppression (Bowen, Witkiewitz, Dillworth, & Marlatt, 2007) through increased acceptance and tolerance (Marcks & Woods, 2005) and decreased experiential avoidance (Hooper, Villatte, Neofotistou, & McHugh, 2010). Therefore these findings are more likely to indicate worsening of self-reported symptoms. There were also no changes in any other self-report measure, including aggression, empathy, risk of spousal assault, or other adaptive coping. Nevertheless, results for all psychometric data is questionable given that 20% of participants achieved elevated deception scores which were not controlled for.

Blanchette, et al., (2011; study nine) found mixed results with regard to behavioural changes for females (n = 94) attending an average five-six months of DBT that was embedded in a forensic mental health unit. Within the three months after treatment, participants (n = 61) were significantly less likely to self-harm, but there was no difference in participant instigation of incidents (no definition provided) or victimisation of participants. At six-month post-treatment (n = 50), the authors found a non-significant improvement in participant instigation of incidents, however this included self-harm data. Unfortunately, they were unable to statistically analyse self-harm data alone as Cochran Q assumptions were not met. This means that it is not possible to determine the effect of the programme on other types of incidents or whether the programme had maintained changes in self-harm. In addition, self-harm was very low at baseline with only four individuals having incidents of self-harm in the three-month prior to treatment.

At three-year post-release (n = 85), 57% of participants had their release revoked, which the authors report as unfavourable compared to a general revocation rate of 37-38%. However, 28-30% of the general revocation rate is accounted for by the perpetration of new offences, but only 15% of the study treatment group were revocated for a new offence with

the rest for technical reasons. They suggest high revocation due to possible perceived likeliness of offending in this population. Also, parole officers' limited awareness of DBT, resulted in lack of DBT consistent follow-up support. Indeed, DBT outcomes are better when follow-up support is offered (Motto & Bostrom, 2001).

For those individuals who completed the vast numbers of psychometric tests and were therefore included in this part of the analysis (n = 59), there was evidence of significantly less psychological symptoms of distress and depression; no change for hopelessness, tension, anger, hostility, fatigue or vigour; and mixed results for coping and self-control. Staff reported that participants were significantly less anxious and depressed, had better overall mental health, and showed more personal involvement in activities. There was no change for staff reported thinking disturbances, hostility, withdrawal, daily living functioning, interpersonal relations or institutional behaviour. Effect sizes ranged from moderate to large. At follow-up (period not specified), participants who had been in the programme longer (length not specified) showed the greatest decrease in hopelessness and increase in institutional functioning, specifically in their institutional relationships and mental health, according to staff reports. However, these results are difficult to interpret for a number of reasons; some tests had poor internal consistency; generally two measures of the same construct produced different results; and at least twelve participants completed measures that were used to demonstrate post-outcomes during treatment. In addition, in the qualitative part of this study, staff reported that the assessment battery was difficult to understand for both participants and themselves, making it difficult to complete (Sly & Taylor, 2003).

Pein et al., (2012; study ten) found a significant reduction in dynamic offence-related risk factors (individually defined with assault, coercion, threats and blackmail being most commonly cited) for forensically detained substance-users (n = 14), at the end of twelve

months of forensic-adapted DBT. Five of the participants with antisocial personality traits (n = 9) showed clinically meaningful improvement based on assessment of reliable change. Participants also improved on a measure of executive functioning and one measure of attention and concentration, with a reliable improvement in half of the participants. However, they did not improve on a different measure of attention or a measure of information processing. Poor executive functioning has been linked with decreased motivation to attend treatment (Severtson, von Thomsen, Hedden, & Latimer, 2010) and poor treatment outcomes in forensic settings (Fishbein et al., 2009). If DBT can improve executive functioning then this may explain why it could enhance treatment engagement, as could be suggested in study six and study eleven. A non-matched TAU control group (n = 15) also showed improvement on one of the measures of attention, but not on any other cognitive measures or risk. However, most of the treatment group had PD with borderline/anti-social traits, in which violence (Swanson, Holzer, Ganju, & Tsutomu-Jono, 1997) and executive functioning deficits (Gvirts et al., 2012; Ruocco, 2005) are common, and none of the controls had PD, therefore may not have had significant difficulties in these areas to begin with.

5.2 DBT skills training

Three studies are classified as skills training only because they do not include DBT consistent individual therapy. However, case consultation and ward-based/individual skills coaching was provided in two studies (Shelton, et al., 2009; Trupin, et al., 2002).

Trupin, et al., (2002; study eleven) found a significant reduction in disciplinary tickets given for behavioural problems (aggression, para-suicidal acts and classroom disruption) over ten-months of DBT ward implementation for females (n = 23) residing on a Young Offender Institute (YOI) mental health unit. However, a similar unexplained reduction in behavioural

problems was found to occur over the year prior to DBT implementation, and there was no significant difference between these years. There was a significant decrease in staff use of punishments (defined by the authors as room confinement, suspension, and being placed on suicide precaution) during the DBT year compared to the year prior, which remained constant across the ten-months. The authors reported improved rehabilitation outcomes in favour of the DBT year, for example, increased engagement in education, employment and other interventions. Whilst this indicates that participants were receiving uncontrolled concurrent interventions that could have affected treatment outcome, DBT may have enhanced engagement with these interventions. Results were less positive for the females on a general unit (n = 22) who did not achieve a reduction in behavioural problems and there was a significant increase in staff use of punishments across the ten-months of DBT. Both treatment groups achieved a significant decrease in risk scores from pre-to-post measurement; however, there was no difference between the treatment groups and a TAU control group (n = 45) matched for risk, at ninety day follow-up.

It seems that the only meaningful significant difference found in this study was in relation to staff use of punishments, whereby staff working with individuals with mental health difficulties dealt less punishments subsequent to DBT implementation than staff working with individuals without mental health difficulties, who actually dealt more punishments during DBT. This may be explained by added staff support and involvement on the mental health ward; they received significantly more hours of DBT training (80:16); their training was conducted by Linehan; they were responsible for adapting the materials; and there was suggestion of non-adherence on the other unit. However, despite staff punishment decreasing when DBT was applied more appropriately, this did not correspond with meaningful clinical change in participant risk or behaviour. The authors argue that this may

be explained by a lack of reporting of behavioural problems in the year prior to DBT implementation when records were not being scrutinised.

Shelton, et al., (2009; study twelve) assessed the effectiveness of a programme of DBT - Corrections Modified (DBT-CM) for male (n = 23) and female (n = 18) adults, and adolescent males (n = 22), with impulsive behaviour problems detained in prison. Unfortunately a manual for DBT-CM has not been published, but like many of the other programmes in this review, it appears to consist of adaptations to language and exercises to make it more suitable for a forensically detained population.

After sixteen weeks of skills training, they found a significant reduction in number of disciplinary actions for behavioural offences across participants, but this was not maintained at six-month follow-up. This is surprising given that at either six or twelve month follow-up (not specified) there was a significant improvement in; negative affect for adult males; anger management; physical aggression (measured by the BPAQ) for males; overall psychopathology, although most significant for males; and there was evidence of some improved coping. However, there were no changes in; overall aggression measured by the OAS-M; verbal aggression measured by the BPAQ; or any measures of hostility. Given that adult males appeared to most improve, it may have been useful to analyse disciplinary actions by age and gender rather than across participants.

Following training there was random allocation to eight weeks of individual DBT skills coaching or individual case management sessions (control). There was no change in disciplinary actions, BPAQ, OAS-M or WAYS scores in either group. They found an additional significant difference between the treatment and control group, specifically for females and adolescents, with regard to overall psychopathology at six-month follow-up in favour of the treatment group, but this was not maintained at twelve-months. There was a

significant difference between groups for positive affect at six-month follow-up in favour of the control group who achieved a decrease in this score. Therefore a non-DBT element incorporated into DBT may still produce positive results. It appears that these individual sessions occurred immediately after completion of the skills group, therefore initial results presented above as follow-up effects of the skills training may be inclusive of the individual sessions and not a demonstration of the effectiveness of skills training alone.

Shelton, et al., (2011; study thirteen) again assessed the effectiveness of DBT-CM but for a different (D. Shelton, personal communication, October 8, 2013) adolescent male sample (n = 26) with impulsive behaviour problems detained in prison. At the end of treatment there was a significant decrease in self-reported physical aggression (BPAQ but not the OAS-M) and actual number of disciplinary tickets issued for behavioural offences. They report a significant increase in the use of distancing as a coping strategy, presenting this as a positive strategy within a stressful prison environment. However, distancing measured by the WAYS, is an avoidant approach associated with poorer recovery in distressing circumstances (Jenkins, 1997). Despite utilising a range of measures assessing hostility, anger, psychopathology, affect and coping, there were no other significant results. The authors report that this indicates an improvement in aggressive and impulsive behaviours. However, the type of disciplinary tickets were not analysed and therefore it is unclear whether aggressive and impulsive acts, as opposed to non-violent or premeditated acts, did decrease. In addition, there was no follow-up data and given that their previous study using this programme found that decreases in disciplines were not maintained at six months, the clinical utility of this study cannot be determined.

5.3 Conclusion

The studies reviewed in this section investigated the effectiveness of comprehensive DBT and DBT skills training at reducing actual or risk of offending behaviour, including institutional rule-breaking. Most of these studies also assessed other emotional and behavioural outcomes. Programme implementation varied and even though some studies used a forensically modified version of DBT, these were also different versions and are not necessary comparable.

All of the studies assessing recidivism used a comprehensive DBT programme and these studies covered male and female adults and adolescents. Most found mixed results when assessing general offending, but some evidence of effectiveness for specific offending, for example, stalking and felony offences. However, each of these studies had significant limitations, the first being their specific use of recidivism data. The use of reconviction rates as an evaluation of treatment success, as in study six, may be unreliable for a number of reasons (Cunneen & Luke, 2007; Friendship, Beech, & Browne, 2002; Francis & Crosland, 2002; Friendship, Thornton, Erikson, & Beech, 2001), with the most significant being that only two in one hundred crimes actually result in a conviction (Liebling, 2002). Data for arrests, which was used in study seven, may be considered more reliable than reconviction data (Maltz, 1984). Though, matched control groups (Friendship et al., 2002) and two years in the community is required for this to be a reliable indicator of recidivism (Friendship et al., 2002; Friendship & Falshaw, 2003), and groups were not matched and some participants were only living at liberty for two months. Revocation data, which were used in study eight, are also limited by factors such as a non-matched control group, possible regional variations in revocation (Baillargeon et al., 2009), and the potential for a revocation based on perceptions of "likely" rather than actual offending (Blanchette et al., 2011).

Three of the studies assessing institutional rule breaking used a DBT skills training programme and one used a comprehensive programme, again covering male and female adults and adolescents. Studies nine and eleven aggregated behavioural data, which included self-harm, and therefore it is not possible to ascertain whether aggression and disruptive behaviour actually decreased in the long-term. Studies twelve and thirteen looked purely at disciplinary tickets, but either did not assess follow-up data, or found that changes were not maintained at follow-up. Of the studies assessing risk of offending, all of which were different types, the comprehensive DBT programme produced no change for adult males in study eight and change which was not statistically compared to a matched control group in study ten. Similarly, the skills group in study eleven produced no difference in risk between treatment and control at follow-up for adolescent females.

When analysing self-reported outcomes, assessed by only one of the seven studies, the vast majority did not improve. Those that did were generally not assessed at follow-up and include psychological symptoms, distress, depression, and executive functioning. Given that these improvements were found in only one of the studies, they cannot be deemed reliable findings. Depending on measure used, inconsistent results across, and often within, studies were found for; self-control; anger; self-reported aggression; and coping strategies, regardless of age, gender and type of DBT programme. Interestingly, anger actually worsened in study eight and hostility was consistently found not to improve. Chronic anger (Cornell, Peterson, & Richards, 1999; Johansson & Kempf-Leonard, 2009; Joyce, Dillane, & Vasquez, 2013), hostility (Corapçioğlu & Erdoğan, 2004; Firestone, Nunes, Moulden, Broom, & Bradford, 2005; McNiel, Eisner, & Binder, 2003; Collie, Vess, & Murdoch, 2007), low self-control (Baron, 2003; Burton, Cullen, Evans, Alarid, & Dunaway, 1998; Vazsonyi, Pickering, Junger, & Hessing, 2001) and maladaptive coping (Hastings, Anderson, & Hemphill, 1997; Zamble &

Porporino, 1990) are risk factors for violence and offending behaviour. Therefore, the lack of consistent maintained behavioural change in terms of recidivism and institutional rule-breaking evidenced in the studies may be explained by lack of consistent maintained improvement in factors associated with offending.

In addition to the limitations already highlighted, a number of other factors limit the clinical utility of all results. Across all studies control groups were either absent or unmatched and/or there were confounding variables that were not controlled for, which limits the ability to state that DBT produced effective results. Reporting of insufficient or no follow-up data means that the long-term effects cannot be ascertained. Such limitations warranted a weak quality rating in all cases. As a result, it is currently not possible to determine whether comprehensive DBT or DBT skills training is effective at reducing offending behaviour in the general forensic population.

6.0 DISCUSSION

From examining the published literature, this is the first systematic review assessing the effects of comprehensive DBT and DBT skills training for a forensic population. Three similar reviews have been conducted. One is primarily based on anecdotal information and covers programmes only in North America (Berzins & Trestman, 2004); two review DBT for an adolescent sample, with one reviewing only two American studies (Carr, Fitzgerald, & Skonovd, 2011), and the other utilising Canadian research and including mainly non-forensic samples (Quinn & Shera, 2009). These reviews generally report very positive results for the use of DBT for a forensic population. However, their limitations include a lack of comprehensive systematic searching, or lack of reporting on this, no information about study selection, and no assessment of study quality. Therefore they are not systematic reviews (Shea et al., 2009).

Overall there was a lack of consistency with regard to outcomes assessed, measures used and programme protocols, making it impossible to find consistent results for any particular programme or outcome measure. Even interpretation of outcomes was different across some studies, for example, studies eight and thirteen reported respective increases in anger and thought suppression and use of distancing as positive results. It seems that many outcomes can be interpreted in different ways to fit different hypotheses despite other research not fully supporting it.

When similar outcomes were assessed (although not with the same measures), there were no consistent positive findings, i.e. all studies assessing the same outcome finding the same result, for any emotional, psychological, cognitive, interpersonal or behavioural variables for individuals with BPD or those in the general offending population. This was also the case when outcomes were examined based on participant age and gender. Contrary to

what might be expected when participants have complex needs, comprehensive DBT did not appear to be any more effective than skills training alone and programmes that lasted twelve months or more did not appear to be any more effective than programmes lasting six months or less. However, it is recognised that many of the skills training programmes incorporated other DBT components that are likely to have enhanced the effects of the group, such as out-of-hours coaching, therapist consultation and staff support.

In some studies it was possible to make a comparison between participant results and staff factors. Within studies, outcomes were better when facilitators and ward staff received more support, training and supervision, which is not surprising given that such support is in part designed to enhance staff motivation and commitment (Fruzzetti, Waltz, & Linehan, 1997). This was explicitly demonstrated in studies six and nine and implicitly in study two, as staff received little training and no external DBT supervision during the first stage of the pilot and participants achieved poorer results (Nee & Farman, 2005). Content analysis of feedback revealed that participants perceived a lack of confidence in tutors during this first stage of the pilot, which could have had an impact on their belief in the therapists' ability to support them. Good treatment of the therapist should support therapy progression (Swales & Heard, 2009) and there is empirical support for this in DBT (Miller, Rathus, & Linehan, 2006), as well as a suggestion that a small amount of training is not necessarily better than none (McCann et al., 2007). Five of the studies in this review did not comment on whether staff or therapist training occurred at all, with some also not commenting even on the use of supervision. It is hoped that this is a product of poor reporting as even when there is much invested in training and consultation, as in study three (evidenced in Laishes, 2002), staff still felt that more could be done to select, support, and train them (Sly & Taylor, 2003). In addition to this, no studies presented adherence data, with most appearing not to assess

fidelity to the model. There is some evidence to suggest that outcomes are likely to be improved when DBT therapists adhere to the treatment manual (Dimeff & Linehan, 2008).

Most studies reported adaptations to the skills training sessions, primarily simplified language and examples or exercises more suited to a secure environment with individuals of particular ages and genders. There were very few specific details about these changes and whilst three studies created a new manual based on these adaptations, they have not been published. As a result, it would not be possible to replicate the treatment provided. Nevertheless, programme adaptations did not appear to make any difference to outcomes. This may be explained by additional qualitative data that supplemented study nine, which indicated that many participants felt that the programme was still difficult, even with adaptations, and both staff and participants wanted simpler language, exercises and treatment tools (Sly & Taylor, 2003).

6. 1 Clinical Implications

An important finding that has implications for clinical practice is that outcomes appear to be enhanced by intensive and continual DBT consistent staff training and support. Given the financial and time implications of delivering such a comprehensive treatment, and therefore the importance of ensuring that it is clinically and cost effective, forensic services considering a DBT intervention should ensure that sufficient time and resource can be given to initial and ongoing staff training, supervision and assessment of model fidelity. This should be consistent for all staff involved, across all wards/units offering the intervention and even when DBT skills training is offered alone. If staff make adaptations to the programme to account for gender, age, comprehension levels and circumstance, which appears to be important given that many staff and participants felt that DBT language and exercises were

irrelevant and difficult to grasp, adherence to the model and its core concepts should be maintained. Research highlights that improvements in DBT therapist practice requires intense effort due to the complexity of the DBT programme and client groups that it is designed to treat, and that multiple approaches to staff support are required to enhance therapist effort (McCann, Ivanoff, Schmidt, & Beach, 2007). Swales (2010) provides an overview of training and support that may enhance integrity and continual commitment to DBT, which includes intensive 8-month training, protective time for weekly team consultation which adheres to the DBT model, regular adherence feedback and the development of plans to address this.

The finding that many treatment effects were not followed-up or for a sufficient time, or that effects were not maintained at follow-up, highlights the need for forensic services considering a DBT intervention to ensure sufficient time and resource for follow-up investigations, even if clients leave the service. In addition, providing or supporting additional intervention if positive outcomes are not maintained. If the forensic service cannot provide the time and resource for staff and clients that is highlighted, the DBT intervention is less likely to produce clinically significant long-lasting results, may not be cost-effective and is unlikely to ensure equivalent treatments for all individuals in receipt of the intervention.

6. 2 Recommendations for future research

Future research would benefit from sounder methodology, which includes larger sample sizes, randomisation to matched control groups, control of confounding variables and adequate follow-up periods. As well as addressing methodological concerns, future research would benefit from consensus and consistency in terms of outcomes assessed and measures used, meaningful direction of change, and programme protocols, so that treatments and treatment effects could be compared and a more robust set of findings established.

Assessment of adherence is also important to ensure that research is measuring what it intends to measure; a DBT programme. A combination of outcomes, such as participant feedback, psychometric data, institutional behaviour, long-term recidivism, post-discharge progress and cost-effectiveness could provide a more holistic way to assess the real clinical utility of DBT when it is provided to individuals in the criminal justice system (Friendship, Falshaw, & Beech, 2003).

6.3 Review limitations

There are limitations to the current review that impact the validity of the conclusions made, which are primarily related to the obtaining of papers and the assessment of study quality. Whilst three databases deemed appropriate for psychological research were searched, in addition to references of relevant papers identified, other databases, including those specific to forensic or nursing journals, such as CINAHL, may have revealed other relevant papers that have consequently been missed.

Publication bias is a consistent issue in systemic reviews (Centre for Reviews and Dissemination, 2008). Whilst contact with authors of two unpublished studies was made, it was not possible to obtain the papers in question or sufficient detail about them to assess their quality and include them in the review. There are likely to be a number of other unpublished studies that have not been possible to include, which may have affected the conclusions of this review.

A consistent limitation of systematic reviews is that reporting issues rather than validity issues are often reflected in assessments of quality (University of Alberta Evidence & Practice Center, 2012). The EPHPP quality assessment tool was selected because it is less dependent on reporting than other tools, for example, it does not assume that blinding did not

occur when it has not been reported and therefore lack of information about blinding warrants a moderate rather than weak rating (Deeks et al., 2003). However, there is still inevitably reliance on reporting in other areas, such as selection methods and confounding variables, and as a result the studies reviewed may have greater strength and rigour than outlined.

7.0 REFERENCES

Baillargeon, J., Williams, B. A., Mellow, J., Harzke, A. J., Hoge, S. K., Baillargeon, G., & Greifinger, R. B. (2009). Parole revocation among prison inmates with psychiatric and substance use disorders. *Psychiatric Services*, 60(11), 1516–1521. doi:10.1176/appi.ps.60.11.1516

Barnoski, R. P. (2002). *Preliminary findings for the juvenile rehabilitation administration's dialectic behavior therapy program*. (Report No. 02-07-1203). Washington, USA: Washington State Institute for Public Policy.

Baron, S. W. (2003). Self-control, social consequences, and criminal behavior: street youth and the general theory of crime. *Journal of Research in Crime and Delinquency*, 40(4), 403–425. doi:10.1177/0022427803256071

Bãumler, G. (1985). *Farbe-Wort-Interferenztest*. Göttingen, Germany: Hogrefe.

Beck, A. T., Kovacs, M., & Weissman, A. (1979). Assessment of suicidal intention: The scale for suicide ideation. *Journal of Consulting and Clinical Psychology*, 47(2), 343–352. doi:10.1037/0022-006X.47.2.343

Beck, A. T., & Steer, R. A. (1987). *BDI, Beck depression inventory: Manual*. San Antonio, USA: Psychological Corp.

Beck, A. T., Ward, C. H., Mendelson, M. M., Mock, J. J., & Erbaugh, J. J. (1961). An inventory for measuring depression. *Archives of General Psychiatry*, 4(6), 561–571. doi:10.1001/archpsyc.1961.01710120031004

Beck, A. T., Weissman, A., Lester, D., & Trexler, L. (1974). The measurement of pessimism: The hopelessness scale. *Journal of Consulting and Clinical Psychology*, 42(6), 861–865. doi:10.1037/h0037562

Bernstein, E. M., & Putnam, F. W. (1986). Development, reliability, and validity of a dissociation scale. *The Journal of Nervous and Mental Disease*, 174(12), 727–735. doi:10.1097/00005053-198612000-00004

Berzins, L. G., & Trestman, R. L. (2004). The Development and Implementation of Dialectical Behavior Therapy in Forensic Settings. *International Journal of Forensic Mental Health*, *3*(1), 93–103. doi:10.1080/14999013.2004.10471199

Blanchette, K., Flight, J., Verbrugge, P., Gobeil, R., & Taylor, K. (2011). *Dialectical Behaviour Therapy within a womens structured living environment.* (Report No. R-241). Ontario, Canada: Correctional Service of Canada.

Bloom, J. M., Woodward, E. N., Susmaras, T., & Pantalone, D. W. (2012). Use of dialectical behavior therapy in inpatient treatment of borderline personality disorder: A systematic review. *Psychiatric Services*, 63(9), 881–888. doi:10.1176/appi.ps.201100311

Bohus, M., Haaf, B., Simms, T., Limberger, M. F., Schmahl, C., Unckel, C., & Linehan, M. M. (2004). Effectiveness of inpatient dialectical behavioral therapy for borderline personality disorder: A controlled trial. *Behaviour Research and Therapy*, 42(5), 487–499. doi:10.1016/S0005-7967(03)00174-8

Bohus, M., Haaf, B., Stiglmayr, C., Pohl, U., Böhme, R., & Linehan, M. M. (2000). Evaluation of inpatient dialectical-behavioral therapy for borderline personality disorder: A prospective study. *Behaviour Research and Therapy*, 38(9), 875–887. doi:10.1016/S0005-7967(99)00103-5

Bowen, S., Witkiewitz, K., Dillworth, T. M., & Marlatt, G. A. (2007). The role of thought suppression in the relationship between mindfulness meditation and alcohol use. *Addictive Behaviors*, 32(10), 2324–2328. doi:10.1016/j.addbeh.2007.01.025

Brooker, C., Sirdifield, C., & Gojkovic, D. (2007). *Mental health services and prisoners: An updated review.* Lincoln: Centre for Clinical and Academic Workforce Innovation.

Burton, V. S., Cullen, F. T., Evans, T. D., Alarid, L. F., & Dunaway, R. G. (1998). Gender, self-control, and crime. *Journal of Research in Crime and Delinquency*, 35(2), 123–147. doi:10.1177/0022427898035002001

Buss, A. H., & Perry, M. P. (1992). The aggression questionnaire. *Journal of Personality and Social Psychology*, 63(3), 452–459. doi:10.1037/0022-3514.63.3.452

Button, K. S., Ioannidis, J. P. A., Mokrysz, C., Nosek, B. A., Flint, J., Robinson, E. S. J., & Munafò, M. R. (2013). Power failure: Why small sample size undermines the reliability of neuroscience. *Nature Reviews Neuroscience*, 14(5), 365–376. doi:10.1038/nrn3475

Carr, L., Fitzgerald, T., & Skonovd, N. (2011). *Dialectical behavior therapy: Evidence for implementation in juvenile correctional settings*. California, USA: California Department of Corrections and Rehabilitation.

Centre for Reviews and Dissemination. (2008). *Systematic reviews: CRD's guidance for undertaking reviews in health care.* York: University of York.

Chapman, A. L., Gratz, K. L., & Brown, M. Z. (2006). Solving the puzzle of deliberate self-harm: The experiential avoidance model. *Behaviour Research and Therapy*, 44(3), 371–394. doi:10.1016/j.brat.2005.03.005

Coccaro, E. F., Harvey, P. D., Kupsaw-Lawrence, E., Herbert, J. L., & Bernstein, D. P. (1991). Development of neuropharmacologically based behavioral assessments of impulsive aggressive behavior. *The Journal of Neuropsychiatry and Clinical Neurosciences*, 3(2), S44–51. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed

Coid, J., Kahtan, N., Gault, S., & Jarman, B. (1999). Patients with personality disorder admitted to secure forensic psychiatry services. *The British Journal of Psychiatry*, 175(6), 528–536. doi:10.1192/bjp.175.6.528

Collie, R. M., Vess, J., & Murdoch, S. (2007). Violence-related cognition. In T. A. Gannon, T. Ward, A. R. Beech, & D. Fisher (Eds.), *Aggressive Offenders' Cognition: Theory, Research and Practice* (pp. 180–197). West Sussex: John Wiley & Sons.

Conte, H. R., Plutchik, R., Karasu, T. B., & Jerrett, I. (1980). A self-report borderline scale: Discriminative validity and preliminary norms. *The Journal of Nervous and Mental Disease*, 168(7), 428–435. doi:10.1097/00005053-198007000-00007

Cooke, D. J. (1996). Predicting offending in prison: The predictive validity of the prison behaviour rating scales. *Legal and Criminological Psychology*, 1(1), 65–82. doi:10.1111/j.2044-8333.1996.tb00307.x

Corapçioğlu, A., & Erdoğan, S. (2004). A cross-sectional study on expression of anger and factors associated with criminal recidivism in prisoners with prior offences. *Forensic Science International*, 140(2-3), 167–174. doi:10.1016/j.forsciint.2003.11.019

Cornell, D. G., Peterson, C. S., & Richards, H. (1999). Anger as a predictor of aggression among incarcerated adolescents. *Journal of Consulting and Clinical Psychology*, 67(1), 108–115. doi:10.1037/0022-006X.67.1.108

Cunneen, C., & Luke, G. (2007). Recidivism and the effectiveness of criminal justice interventions: Juvenile offenders and post release support. *Current Issues in Criminal Justice*, 19, 197-210. Retrieved from: http://sydney.edu.au/law/criminology//journal/index.shtml

Day, A. (2009). Offender emotion and self-regulation: Implications for offender rehabilitation programming. *Psychology, Crime & Law*, *15*(2-3), 119–130. doi:10.1080/10683160802190848

Day, A., Casey, S., Ward, T., Howells, K., & Vess, J. (2013). *Transitions to better lives: Offender readiness and rehabilitation*. Devon: Willian Publishing.

Deeks, J. J., Dinnes, J., D'Amico, R., Sowden, A. J., Sakarovitch, C., Song, F., Petticrew, M., Altman, D. G. (2003). Evaluating non-randomised intervention studies. Health Technology Assessment, 7(27), 1–173. doi:10.3310/hta7270

Derogatis, L. R. (1994). *Symptom checklist-90-revised: Administration, scoring and procedures manual* (3rd ed.). Minneapolis, USA: National Computer Systems, Inc.

Derogatis, L. R., & Melisaratos, N. (1983). The Brief Symptom Inventory: an introductory report. *Psychological Medicine*, 13(3), 595–605. doi:10.1017/S0033291700048017

Dimeff, L. A., & Koerner, K. (2007). *Dialectical behavior therapy in clinical practice: Applications across disorders and settings*. New York, USA: Guilford Press.

Dimeff, L., & Linehan, M. M. (2001). Dialectical behavior therapy in a nutshell. *The California Psychologist*, 34, 10–13. Retrieved from http://www.dbtselfhelp.com/DBTinaNutshell.pdf

Dimeff, L. A., & Linehan, M. M. (2008). Dialectical behavior therapy for substance abusers. *Addiction Science & Clinical Practice*, 4(2), 39–47. doi:10.1151/ascp084239

Drake, E., & Barnoski, R. (2006). *Recidivism findings for the juvenile rehabilitation administration's dialectical behavior therapy program: Final report.* (Report No. 06-07-1201). Washington, USA: Washington State Institute for Public.

Eccleston, L., & Sorbello, L. (2002). The RUSH program – real understanding of self-help: A suicide and self-harm prevention initiative within a prison setting. *Australian Psychologist*, 37(3), 237–244. doi:10.1080/00050060210001706926

Endicott, J., Spitzer, R. L., Fleiss, J. L., & Cohen, J. (1976). The global assessment scale: A procedure for measuring overall severity of psychiatric disturbance. *Archives of General Psychiatry*, 33(6), 766. doi:10.1001/archpsyc.1976.01770060086012

Evershed, S., Tennant, A., Boomer, D., Rees, A., Barkham, M., & Watson, A. (2003). Practice-based outcomes of dialectical behaviour therapy (DBT) targeting anger and violence, with male forensic patients: a pragmatic and non-contemporaneous comparison. *Criminal Behaviour and Mental Health*, 13(3), 198–213. doi:10.1002/cbm.542

Eysenck, H. J., & Eysenck, S. (1991). *Impulsiveness, venturesomeness and empathy scale*. London: Hodder & Stoughton.

Feigenbaum, J. (2010). Self-harm – The solution not the problem: The dialectical behaviour therapy model. *Psychoanalytic Psychotherapy*, 24(2), 115–134. doi:10.1080/02668731003707873

Feldman, G., Harley, R., Kerrigan, M., Jacobo, M., & Fava, M. (2009). Change in emotional processing during a dialectical behavior therapy-based skills group for major depressive disorder. *Behaviour Research and Therapy*, 47(4), 316–321. doi:10.1016/j.brat.2009.01.005

Firestone, P., Nunes, K. L., Moulden, H., Broom, I., & Bradford, J. M. (2005). Hostility and recidivism in sexual offenders. *Archives of Sexual Behavior*, 34(3), 277–283. doi:10.1007/s10508-005-3116-8

Fishbein, D., Sheppard, M., Hyde, C., Hubal, R., Newlin, D., Serin, R., & Alesci, S. (2009). Deficits in behavioral inhibition predict treatment engagement in prison inmates. *Law and Human Behavior*, 33(5), 419–435. doi:10.1007/s10979-008-9163-7

Folkman, S., & Lazarus, R. S. (1988). Coping as a mediator of emotion. *Journal of Personality and Social Psychology*, 54(3), 466–475. doi:10.1037/0022-3514.54.3.466

Francis, B., & Crosland, P. (2002). *The Police National Computer and the Offenders Index: Can they be combined for research purposes?* London: Home Office.

Friendship, C., Beech, A. R., & Browne, K. D. (2002). Reconviction as an outcome measure in research. A methodological note. *British Journal of Criminology*, 42(2), 442–444. doi:10.1093/bjc/42.2.442

Friendship, C., & Falshaw, L. (2003). Evaluating groupwork in prisons. In G. J. Towl (Ed.), *Psychology in prisons* (pp. 52-63). Leicester: The British Psychological Society and Blackwell Publishing Ltd.

Friendship, C., Falshaw, L., & Beech, A. R. (2003). Measuring the real impact of accredited offending behaviour programmes. *Legal and Criminological Psychology*, 8(1), 115–127. doi:10.1348/135532503762871282

Friendship, C., Thornton, D., Erikson, M., & Beech, A. (2001). Reconviction: A critique and comparison of two main data sources in England and Wales. *Legal and Criminological Psychology*, 6(1), 121–129. doi:10.1348/135532501168235

Fruzzetti, A. E., Waltz, J. A., & Linehan, M. M. (1997). Supervision in dialectical behavior therapy. In C. E. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 84–100). New Jersey, USA: John Wiley & Sons Inc.

Gaston, L. (1991). Reliability and criterion-related validity of the California psychotherapy alliance scales - patient version. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 3(1), 68–74. doi:10.1037/1040-3590.3.1.68

Gee, J., & Reed, S. (2013). The HoST programme: A pilot evaluation of modified dialectical behaviour therapy with female offenders diagnosed with borderline personality disorder. *European Journal of Psychotherapy & Counselling*, 15(3), 233–252. doi:10.1080/13642537.2013.810659

Gordon, A., & Hover, G. (1998). The twin rivers sex offender treatment program. In W. L. Marshall., Y. M. Fernandez., S. M. Hudson., & T. Ward (Eds.), *Sourcebook of treatment programs for sexual offenders* (pp. 1-16). New York, USA: Plenum Press.

Gratz, K. L., Conrad, S. D., & Roemer, L. (2002). Risk factors for deliberate self-harm among college students. *American Journal of Orthopsychiatry*, 72(1), 128–140. doi:10.1037/0002-9432.72.1.128

Gvirts, H. Z., Harari, H., Braw, Y., Shefet, D., Shamay-Tsoory, S. G., & Levkovitz, Y. (2012). Executive functioning among patients with borderline personality disorder (BPD) and their relatives. *Journal of Affective Disorders*, 143(1-3), 261–264. doi:10.1016/j.jad.2012.05.007

Harley, R. M., Baity, M. R., Blais, M. A., & Jacobo, M. C. (2007). Use of dialectical behavior therapy skills training for borderline personality disorder in a naturalistic setting. *Psychotherapy Research*, 17(3), 351–358. doi:10.1080/10503300600830710

Harley, R., Sprich, S., Safren, S., Jacobo, M., & Fava, M. (2008). Adaptation of dialectical behavior therapy skills training group for treatment-resistant depression. *The Journal of Nervous and Mental Disease*, 196(2), 136–143. doi:10.1097/NMD.0b013e318162aa3f

Hastings, T., Anderson, S. J., & Hemphill, P. (1997). Comparisons of daily stress, coping, problem behavior, and cognitive distortions in adolescent sexual offenders and conduct-disordered youth. *Sexual Abuse: A Journal of Research and Treatment*, 9(1), 29–42. doi:10.1177/107906329700900103

Higgins, J. P. T., & Deeks, J. J. (2008). Selecting studies and collecting data. In J. P. T. Higgins & S. Green (Eds.), *Cochrane handbook for systematic reviews of interventions* (pp.151-183). West Sussex: The Cochrane Collaboration & John Wiley & Sons Ltd.

HMPS. (2012). *Offender behaviour programmes*. Retrieved from http://www.justice.gov.uk/offenders/before-after-release/obp

Hodge, J. E., & Renwick, S. J. (2003). Motivating mentally disordered offenders. In M. McMurran (Ed.), *Motivating offenders to change: A guide to enhancing engagement in therapy* (pp. 221–234). West Sussex: John Wiley & Sons.

Hollin, C. R. (2008). Evaluating offending behaviour programmes: Does only randomization glister? *Criminology and Criminal Justice*, 8(1), 89–106. doi:10.1177/1748895807085871

Hooper, N., Villatte, M., Neofotistou, E., & McHugh, L. (2010). An implicit versus an explicit measure of experimental avoidance. *International Journal of Behavior Consultation and Therapy*, 6(3), 233–245. Retrieved from: http://www.academia.edu

Hover, G. (December, 2013). Personal communication.

Hover, G., & Packard, R. L. (1998, November). *The evaluation of DBT skills in a forensic setting: Sex offenders, pedophiles and rapists*. Paper presented at the Annual American Association of Behavior Therapy Convention, USA.

Howells, K., & Day, A. (2006). Affective determinants of treatment engagement in violent offenders. *International Journal of Offender Therapy and Comparative Criminology*, 50(2), 174–186. doi:10.1177/0306624X05281336

Jackson, N. (2007). *Handbook for systematic reviews of health promotion and public health interventions*. Manchester: Cochrane Public Health Group.

Jenkins, S. R. (1997). Coping, routine activities, and recovery from acute distress among emergency medical personnel after a mass shooting incident. *Current Psychology*, 16(1), 3–19. doi:10.1007/s12144-997-1012-1

Johansson, P., & Kempf-Leonard, K. (2009). A gender-specific pathway to serious, violent, and chronic offending? Exploring Howell's risk factors for serious delinquency. *Crime & Delinquency*, 55(2), 216–240. doi:10.1177/0011128708330652

Joyce, C. J., Dillane, J., & Vasquez, E. A. (2013). The role of anger in offending: a grounded theory analysis of mentally disordered patients. *The Journal of Forensic Psychiatry & Psychology*, 24(2), 247–268. doi:10.1080/14789949.2013.773454

Kjelsberg, E., Hartvig, P., Bowitz, H., Kuisma, I., Norbech, P., Rustad, A. B., Seem, M., & Vik, T. G. (2006). Mental health consultations in a prison population: A descriptive study. *BMC Psychiatry*, 6(1), 27. doi:10.1186/1471-244X-6-27

Klonsky, E. D. (2007). The functions of deliberate self-injury: A review of the evidence. *Clinical Psychology Review*, 27(2), 226–239. doi:10.1016/j.cpr.2006.08.002

Komarovskaya, I., Loper, A. B., & Warren, J. (2007). The role of impulsivity in antisocial and violent behavior and personality disorders among incarcerated women. *Criminal Justice and Behavior*, 34(11), 1499–1515. doi:10.1177/0093854807306354

Koons, C. R., Robins, C. J., Lindsey Tweed, J., Lynch, T. R., Gonzalez, A. M., Morse, J. Q., Bishop, G. K., Butterfield, M. I., Bastian, L. A. (2001). Efficacy of dialectical

behavior therapy in women veterans with borderline personality disorder. *Behavior Therapy*, 32(2), 371–390. doi:10.1016/S0005-7894(01)80009-5

Kropp, P., Hart, S., Webster, C., & Eaves, D. (1995). *The spousal assault risk assessment (SARA).* British Columbia, Canada: British Columbia Institute Against Family Violence.

Laishes, J. (2002). *The 2002 mental health strategy for women offenders.* Canada: Correctional Service Canada.

Lange, A., Pahlich, A., Sarucco, M., Smits, G., Dehghani, B., & Hanewald, G. (1995). Psychometric characteristics and validity of the Dutch adaptation of the buss-durkee hostility inventory (the BDHI-D). *Behaviour Research and Therapy*, 33(2), 223–227. doi:10.1016/0005-7967(94)00043-J

Lau, M. A., & Mcmain, S. F. (2005). Integrating mindfulness meditation with cognitive and behavioural therapies: The challenge of combining acceptance- and change-based strategies. *Canadian Journal of Psychiatry*, 50(13), 863–869. Retrieved from http://www.proquest.com/

Liebling, A. (2002). The uses of imprisonment. In S. Rex., & M. Tonry (Eds.), *Reform and punishment: The future of sentencing* (pp. 105-137). Devon: Willian Publishing.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, USA: Guilford Press.

Linehan, M. M, Comtois, K. A., Murray, M. A., Brown, M. Z., Gallop, R. J., Heard, H. L., Korslund, K. E., Tutek, D. A., Reynolds, S. K., & Lindenboim, M. S. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs. therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry*, 63(7), 757–766. doi:10.1001/archpsyc.63.7.757

Linehan, M. M., & Dexter-Mazza, E. T. (2008). Dialectical behavior therapy for borderline personality disorder. In D. H. Barlow (Ed.), *Clinical handbook of psychological disorders: A step-by-step treatment manual* (pp. 365–420). New York, USA: Guilford Press.

Linehan, M. M., Goodstein, J. L., Nielson, S. L., & Chiles, J. L. (1983). Reasons for staying alive when you are thinking of killing yourself: The reasons for living inventory. *Journal of Consulting and Clinical Psychology*, 51(2), 276–286. doi:0022-006X/83/5102-0276500.75

Linehan, M. M., Schmidt, H., Dimeff, L. A., Craft, J. C., Kanter, J., & Comtois, K. A. (1999). Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. *The American Journal on Addictions*, 8(4), 279–292. doi:10.1080/105504999305686

Linehan, M. M., Armstrong, H. E., Suarez, A., Allmon, D., & Heard, H. L. (1991). Cognitive-behavioral treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 48(12), 1060–1064. doi:10.1001/archpsyc.1991.01810360024003

Linehan, M. M., Heard, H. L., & Armstrong, H. E. (1993). Naturalistic follow-up of a behavioral treatment for chronically parasuicidal borderline patients. *Archives of General Psychiatry*, 50(12), 971–974. doi:10.1001/archpsyc.1993.01820240055007

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the depression anxiety stress scales (DASS) with the beck depression and anxiety inventories. *Behaviour Research and Therapy*, 33(3), 335–343. doi:10.1016/0005-7967(94)00075-U

Low, G., Jones, D., Duggan, C., MacLeod, A., & Power, M. (2001). Dialectical behaviour therapy as a treatment for deliberate self-harm: Case studies from a high security

psychiatric hospital population. *Clinical Psychology & Psychotherapy*, 8(4), 288–300. doi:10.1002/cpp.287

Low, G., Jones, D., Duggan, C., Power, M., & MacLeod, A. (2001). The treatment of deliberate self-harm in borderline personality disorder using dialectical behaviour therapy: A pilot study in a high security hospital. *Behavioural and Cognitive Psychotherapy*, 29(01), 85–92. doi:10.1017/S1352465801001096

Low, G., Jones, D., MaCleod, A., Power, M., & Duggan, C. (2000). Childhood trauma, dissociation and self-harming behaviour: A pilot study. *British Journal of Medical Psychology*, 73(2), 269–278. doi:10.1348/000711200160363

Lukoff, D., Nuechterlein, K. H., & Ventura, J. (1986). Appendix A: Manual for expanded brief psychiatric rating scale (BPRS). *Schizophrenia Bulletin*, 12(4), 594–602. doi:10.1093/schbul/12.4.578

Lynch, T. R., Chapman, A. L., Rosenthal, M. Z., Kuo, J. R., & Linehan, M. M. (2006). Mechanisms of change in dialectical behavior therapy: Theoretical and empirical observations. *Journal of Clinical Psychology*, 62(4), 459–480. doi:10.1002/jclp.20243

MacKenzie, K. R. (1981). Measurement of group climate. *International Journal of Group Psychotherapy*, 31(3), 287–295. Retrieved from: http://www.proquest.com/

Maltz, M. D. (1984). Recidivism. Florida, USA: Academic Press.

Marcks, B. A., & Woods, D. W. (2005). A comparison of thought suppression to an acceptance-based technique in the management of personal intrusive thoughts: A controlled evaluation. *Behaviour Research and Therapy*, 43(4), 433–445. doi:10.1016/j.brat.2004.03.005

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. *Journal of Organizational Behavior*, 2(2), 99–113. doi:10.1002/job.4030020205

McCann, R. A., & Ball, E. M. (1996). *The effectiveness of Dialectical Behavioral Therapy with forensic inpatients: A preliminary analysis*. Colorado, USA: Colorado Mental Health Institute Pueblo.

McCann, R. A., Ball, E. M., & Ivanoff, A. (2000). DBT with an inpatient forensic population: The CMHIP forensic model. *Cognitive and Behavioral Practice*, 7(4), 447–456. doi:10.1016/S1077-7229(00)80056-5

McCann, R. A., Ivanoff, A., Schmidt, H., & Beach, B. (2007). Implementing Dialectical Behavior Therapy in Residential Forensic Settings with Adults and Juveniles. In L.A. Dimeff & K. Koerner (Eds.), *Dialectical behavior therapy in clinical practice: Applications across disorders and settings* (pp. 112–144). New York, USA: Guilford Press.

McNair, D. M., Lorr, M., & Droppleman, L. F. (1972). *Manual for the profile of mood states*. California, USA: Educational and Industrial Testing Services.

McNiel, D. E., Eisner, J. P., & Binder, R. L. (2003). The relationship between aggressive attributional style and violence by psychiatric patients. *Journal of Consulting and Clinical Psychology*, 71(2), 399–403.

Mehrabian, A., & Epstein, N. (1972). A measure of emotional empathy. *Journal of Personality*, 40(4), 525–543. doi:10.1111/j.1467-6494.1972.tb00078.x

Meltzer, H., Jenkins, R., Singleton, N., Charlton, J., & Mohammed, Y. (2003). *Non-fatal suicidal behaviour among prisoners*. London: Office for National Statistics.

Miller, S. (2012). *Understanding non-engagement in offender behaviour programmes*. Edinburgh: Scottish Prison Service.

Miller, A. L., Rathus, J. H., & Linehan, M. M. (2006). *Dialectical behavior therapy with suicidal adolescents*. New York, USA: Guilford Press.

Moosbrugger, H., & Oehlschlägel, J. (1996). *Frankfurter Aufmerksamkeits-Inventar (FAIR)*. Bern, Switzerland: Verlag Hans Huber.

Motto, J. A., & Bostrom, A. G. (2001). A randomized controlled trial of post-crisis suicide prevention. *Psychiatric Services*, 52(6), 828–833. doi:10.1176/appi.ps.52.6.828

Neacsiu, A. D., Rizvi, S. L., & Linehan, M. M. (2010). Dialectical behavior therapy skills use as a mediator and outcome of treatment for borderline personality disorder. *Behaviour Research and Therapy*, 48(9), 832–839. doi:10.1016/j.brat.2010.05.017

Nee, C., & Farman, S. (2005). Female prisoners with borderline personality disorder: Some promising treatment developments. *Criminal Behaviour and Mental Health*, 15(1), 2–16. doi:10.1002/cbm.33

Nee, C., & Farman, S. (2007). Dialectical behaviour therapy as a treatment for borderline personality disorder in prisons: Three illustrative case studies. *Journal of Forensic Psychiatry & Psychology*, 18(2), 160–180. doi:10.1080/14789940601104792

Nee, C., & Farman, S. (2008). Treatment of borderline personality disorder in prisons: Findings from the two dialectical behaviour therapy pilots in the UK. In J. Hagen, & E. Jensen, (Eds.), *Personality disorders: new research* (pp. 107–121). New York: NOVA Publishers.

Nelson-Gray, R. O., Keane, S. P., Hurst, R. M., Mitchell, J. T., Warburton, J. B., Chok, J. T., & Cobb, A. R. (2006). A modified DBT skills training program for oppositional defiant adolescents: Promising preliminary findings. *Behaviour Research and Therapy*, 44(12), 1811–1820. doi:10.1016/j.brat.2006.01.004

NICE. (2007). *Borderline personality disorder: Treatment and management*. (CG78). London: National Institute for Health and Care Excellence

Novaco, R. W. (1980). *Novaco anger scale*. California, USA: University of California.

Novaco, R. W. (2011). Anger dysregulation: driver of violent offending. *Journal of Forensic Psychiatry & Psychology*, 22(5), 650–668. doi:10.1080/14789949.2011.617536

Overall, J. E., & Gorham, D. R. (1962). The brief psychiatric rating scale. *Psychological Reports*, 10(3), 799–812. doi:10.2466/pr0.1962.10.3.799

Pein, A., Kliemann, A., Schlafke, D., Kupke, F., Wettermann, A., Tardel, D., & Fegert, M. (2012). Do antisocial substance abusers benefit from DBT-F? *Nervenheilkunde: Zeitschrift Fur Interdisziplinaere Fortbildung*, 31(1-2), 30–32. Retrieved from http://www.apa.org/pubs/databases/psycinfo/index.aspx

Platt, J. J., Spivack, G., & Bloom, M. (1971). *Means-ends problem-solving procedure (MEPS): Manual and tentative norms*. Philadelphia, USA: Hahnemann Medical College and Hospital.

Quinn, A., & Shera, W. (2009). Evidence-based practice in group work with incarcerated youth. *International Journal of Law and Psychiatry*, 32(5), 288–293. doi:10.1016/j.ijlp.2009.06.002

Reitan, R. M. (1992). *Trail making test: Manual for administration and scoring*. Arizona, USA: Reitan Neuropsychology Laboratory.

Roberton, T., Daffern, M., & Bucks, R. S. (2012). Emotion regulation and aggression. *Aggression and Violent Behavior*, 17(1), 72–82. doi:10.1016/j.avb.2011.09.006

Robins, C. J., & Koons, C. R. (2000). Efficacy of dialectical behavior therapy in women veterans with borderline personality disorder. In A. N. Sabo & L. Havens (Eds.), *The real world guide to psychotherapy practice* (pp. 237–266). Massachusetts, USA: Harvard University Press.

Rosenbaum, M. (1980). A schedule for assessing self-control behaviors: Preliminary findings. *Behavior Therapy*, 11(1), 109–121. doi:10.1016/S0005-7894(80)80040-2

Rosenberg, M. (1965). *Society and the adolescent self-image*. New Jersey, USA: Princeton University Press.

Rosenfeld, B. (2003). Recidivism in stalking and obsessional harassment. *Law and Human Behavior*, 27(3), 251. doi:10.1023/A:1023479706822

Rosenfeld, B., Galietta, M., Ivanoff, A., Garcia-Mansilla, A., Martinez, R., Fava, J., Fineran, V., & Green, D. (2007). Dialectical behavior therapy for the treatment of stalking offenders. *International Journal of Forensic Mental Health*, 6(2), 95–103. doi:10.1080/14999013.2007.10471254

Ruocco, A. C. (2005). The neuropsychology of borderline personality disorder: A meta-analysis and review. *Psychiatry Research*, 137(3), 191–202. doi:10.1016/j.psychres.2005.07.004

Severtson, S. G., von Thomsen, S., Hedden, S. L., & Latimer, W. (2010). The association between executive functioning and motivation to enter treatment among regular users of heroin and/or cocaine in Baltimore, MD. *Addictive Behaviors*, 35(7), 717–720. doi:10.1016/j.addbeh.2010.02.012

Shea, B. J., Hamel, C., Wells, G. A., Bouter, L. M., Kristjansson, E., Grimshaw, J., Henry, D., & Boers, M. (2009). AMSTAR is a reliable and valid measurement tool to assess the methodological quality of systematic reviews. *Journal of Clinical Epidemiology*, 62(10), 1013–1020. doi:10.1016/j.jclinepi.2008.10.009

Shelton, D. (October, 2013). Personal communication.

Shelton, D., Kesten, K., Zhang, W., & Trestman, R. (2011). Impact of a dialectic behavior therapy - corrections modified (DBT-CM) upon behaviorally challenged incarcerated male adolescents. *Journal of Child and Adolescent Psychiatric Nursing*, 24(2), 105–113. doi:10.1111/j.1744-6171.2011.00275.x

Shelton, D., Sampl, S., Kesten, K. L., Zhang, W., & Trestman, R. L. (2009). Treatment of impulsive aggression in correctional settings. *Behavioral Sciences & the Law*, 27(5), 787–800. doi:10.1002/bsl.889

Singh, N. N., Lancioni, G. E., Winton, A. S. W., Singh, J., Singh, A. N. A., & Singh, A. D. A. (2011). Peer with intellectual disabilities as a mindfulness-based anger and aggression management therapist. *Research in Developmental Disabilities*, 32(6), 2690–2696. doi:10.1016/j.ridd.2011.06.003

Sly, A. E., & Taylor, K. (2003). *Preliminary Evaluation of Dialectical Behavior Therapy within a Women's Structured Living Environment* (Report No. R- 145). Ontario, Canada: Correctional Service of Canada.

Snaith, R. P., & Zigmond, A. S. (1994). *The hospital anxiety and depression scale with the-irritability depression-anxiety scale and the Leeds situational anxiety scale*. Windsor: NFER-NELSON Publishing Company Ltd.

Soler, J., Pascual, J. C., Tiana, T., Cebrià, A., Barrachina, J., Campins, M. J., Gich, I., & Pérez, V. (2009). Dialectical behaviour therapy skills training compared to standard group therapy in borderline personality disorder: A 3-month randomised controlled clinical trial. *Behaviour Research and Therapy*, 47(5), 353–358. doi:10.1016/j.brat.2009.01.013

Spielberger, C. D. (1999). *State-trait anger expression inventory 2: STAXI-2 manual*. Florida, USA: Psychological Assessment Resources Inc.

Spielberger, C. D., Gorsuch, R. L., Lushene, P. R., Vagg, P. R., & Jacobs, A. G. (1970). *State-trait anxiety inventory*. California, USA: Consulting Psychologists Press.

Spielberger, C. D., Jacobs, G., Russell, S., & Crane, R. S. (1983). Assessment of anger: The state-trait anger scale. In J. N. Butcher, & C. D. Spielberger (Eds.), *Advances in Personality Assessment* (pp. 161-190). New Jersey, USA: Psychology Press.

Spielberger, C. D., Reheiser, E. C., & Sydeman, S. J. (1995). Measuring the experience, expression, and control of anger. *Issues in Comprehensive Paediatric Nursing*, 18(3), 207–232. doi:10.3109/01460869509087271

Stinson, J. D., Becker, J. V., & Sales, B. D. (2008). Self-regulation and the etiology of sexual deviance: Evaluating causal theory. *Violence and Victims*, 23(1), 35–51. doi:10.1891/0886-6708.23.1.35

Swales, M. A. (2010). Implementing DBT: selecting, training and supervising a team. *The Cognitive Behaviour Therapist*, 3(02), 71–79. doi:10.1017/S1754470X10000061

Swales, M. A., & Heard, H. L. (2009). *Dialectical Behaviour Therapy*. East Sussex: Routledge.

Swanson, J. W., Holzer, C. E., Ganju, V. K., & Tsutomu-Jono, R. (1997). Violence and psychiatric disorder in the community: Evidence from epidemiological catchment areas surveys. In American Psychiatric Association (Ed.), *Violent behavior and mental illness: A compendium of articles from psychiatric services and hospital and community psychiatry* (pp. 20–29). Washington, USA: American Psychiatric Pub.

Thomas, H. (1998). *Quality assessment tool for quantitative studies.* Toronto, Canada: Effective Public Health Practice Project, McMaster University.

Thomas, B. H., Ciliska, D., Dobbins, M., & Micucci, S. (2004). A process for systematically reviewing the literature: providing the research evidence for public health nursing interventions. *Worldviews on Evidence-Based Nursing*, 1(3), 176–184. doi:10.1111/j.1524-475X.2004.04006.x

Thomas, H., Fitzpatrick-Lewis, D., Rideout, E., & Muresan, J. (2008). *What is the effectiveness of community-based/primary care interventions in reducing obesity among adults in the general population?* Ontario, Canada: Public Health and Community Services & Effective Public Health Practice Project.

Trupin, E. W., Stewart, D. G., Beach, B., & Boesky, L. (2002). Effectiveness of a dialectical behaviour therapy program for incarcerated female juvenile offenders. *Child and Adolescent Mental Health*, 7(3), 121–127. doi:10.1111/1475-3588.00022

Tucha, O., & Lange, K. W. (2004). *The tower of London: Dutch version*. Göttingen, Germany: Hogrefe.

University of Alberta Evidence & Practice Center. (2012). *Validity and inter-rater reliability testing of quality assessment instruments* (Report No. 12-EHC039- EF). Maryland, USA: Agency for Healthcare Research and Quality.

U. K. Ministry of Justice. (2013). Safety in custody statistics quarterly update to 31 December 2012. Retrieved December 8, 2013, from https://www.gov.uk/government/publications/safety-in-custody

Urbaniok, F. (2007). *FOTRES: Forensic operationalized therapy/risk evaluation-system*. Bern, Switzerland: Zytglogge.

Vazsonyi, A. T., Pickering, L. E., Junger, M., & Hessing, D. (2001). An empirical test of a general theory of crime: A four-nation comparative study of self-control and the prediction of deviance. *Journal of Research in Crime and Delinquency*, 38(2), 91–131. doi:10.1177/0022427801038002001

Verheul, R., Bosch, L. M. C. V. D., Koeter, M. W. J., Ridder, M. A. J. D., Stijnen, T., & Brink, W. V. D. (2003). Dialectical behaviour therapy for women with borderline

personality disorder 12-month, randomised clinical trial in The Netherlands. *The British Journal of Psychiatry*, 182(2), 135–140. doi:10.1192/bjp.02.184

Vitaliano, P. P., Russo, J., Carr, J. E., Maiuro, R. D., & Becker, J. (1985). The ways of coping checklist: Revision and psychometric properties. *Multivariate Behavioral Research*, 20(1), 3–26. doi:10.1207/s15327906mbr2001_1

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology*, 54(6), 1063–1070. doi:10.2307/2137092

Webb, R. T., Shaw, J., Stevens, H., Mortensen, P. B., Appleby, L., & Qin, P. (2012). Suicide risk among violent and sexual criminal offenders. *Journal of Interpersonal Violence*, 27(17), 3405–3424. doi:10.1177/0886260512445387

Wegner, D. M., & Zanakos, S. (1994). Chronic thought suppression. *Journal of Personality*, 62(4), 615–640. doi:10.1111/j.1467-6494.1994.tb00311.x

Yusainy, C. (2013). *Overcoming aggression: Musing on mindfulness and self-control*. (PhD thesis, University of Nottingham). Retrieved from http://etheses.nottingham.ac.uk/3467/

Zamble, E., & Porporino, F. (1990). Coping, imprisonment, and rehabilitation some data and their implications. *Criminal Justice and Behavior*, 17(1), 53–70. doi:10.1177/0093854890017001005

Paper to be edited for submission to 'International Journal of Forensic Mental Health'

ENGAGEMENT IN PSYCHOLOGICAL INTERVENTIONS WITHIN MEDIUM SECURITY: A SERVICE USER PERSPECTIVE

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Word count: 7829

Key words: engagement, psychological intervention, medium security, psychosis, recovery model, Interpretative Phenomenological Analysis

ABSTRACT

Background: Individuals residing in medium secure settings are underrepresented in psychological research. Exploring such service user views may help psychological practitioners to understand and improve one of the fundamental difficulties in such settings, namely poor engagement.

Aim: To explore service user experiences and understandings of their engagement in psychological interventions within medium secure settings.

Method: Six individuals residing in medium secure settings who had participated in psychological interventions were interviewed about those experiences. Interpretative Phenomenological Analysis (IPA) guided the interview schedule, and the analysis and interpretation of interview content.

Results: Two themes were selected. 'A game of two halves' reflects how participants understand their initial engagement as having different goals, and how these differing goals impact on their level of engagement. 'If you build it they will come' reflects participants' accounts that when psychological practitioners build an environment in which they gain or benefit, such as being treated as a person developing hope and control, they are more likely to continue engaging.

Conclusions: Results support existing literature highlighting links between type of motivation, recovery style, and engagement. Results indicate that engagement may be enhanced when psychological practitioners use recovery-orientated principles. Implications for practice and future research are discussed.

1.0 INTRODUCTION

1.1 Service user views

National policy stipulates that service users should be involved in the development, implementation and evaluation of services and treatments provided (Department of Health, 2008, 2011, 2013). One of the ways this can be facilitated is by offering opportunities for service users to provide feedback about their service and treatment experience (Perkins & Goddard, 2005). This allows vital opinions and perspectives to be gained to inform person-centred needs-lead policy and procedure (Sheldon & Harding, 2010) and can be empowering for service users (Velpry, 2008). However, benefits are only likely to be gained if feedback results in actual service change, which does not always occur (Wensing & Elwyn, 2003). As psychological based treatments are considered to be reflective and evolving, based on empirical and practice-based evidence, psychological practitioners are in a prime position to investigate service user views and use the understanding that comes from this to ensure actual changes in psychological practice (Elliott, 2008). Gaining service user feedback is also in line with principles underpinning psychological interventions; collaboration and promotion of the valued role of the service user (Macran, Ross, Hardy, & Shapiro, 1999).

There is growing psychological research incorporating service user views (Elliott, 2008; Hodgetts & Wright, 2007), yet there are still many underrepresented individuals, such as those residing in forensic settings (Sheldon & Harding, 2010). Issues such as security and confidentially create significant barriers to conducting this type of research (Faulkner & Morris, 2003). However, it is such issues that make the gaining of service user views so important, as emphasis on risk policies and procedures and professionals' views, regularly take precedence over individuals' experiences (National Survivor User Network & WISH, 2011).

1.2 Engagement

Gaining service user feedback may help psychological practitioners and other service providers to understand and improve one of the fundamental difficulties encountered in a forensic mental health settings; poor engagement in treatment (Day et al., 2013; Hodge & Renwick, 2003). Whilst there is still debate as to what the term engagement encapsulates, Hall, Meaden, Smith, and Jones (2001) provide an interpretation of engagement that can be applied to psychological interventions. They suggest that good engagement is indicated by the client keeping their appointments, relating well to the practitioner, being open to discussing feelings and difficulties, perceiving the treatment as useful in some way, and their collaboration through agreement with and active involvement in the intervention within and outside therapeutic sessions. Unfortunately, having a forensic history has consistently been related to poor engagement (O'Brien, Fahmy, & Singh, 2009), suggesting that forensic clients are less likely to demonstrate these behaviours during treatment. In turn, this lack of engagement in psychological interventions is linked to poorer outcomes in forensic settings (Castro, Cockerton, & Birke, 2002; Long, Dolley, & Hollin, 2011; McCarthy & Duggan, 2010).

There are a number of service user, practitioner, therapy, system and environmental factors that appear to affect engagement in psychological interventions (Barrett et al., 2008). Therapeutic alliance, developed through aspects such as collaboration, bond, and goals, appears to be one important engagement prerequisite that has received much attention (Barrett et al., 2008; Castonguay, Constantino, & Holtforth, 2006; Constantino, Castonguay, Zack, & DeGeorge, 2010; Thompson & McCabe, 2012). The therapeutic alliance may be a representation of a secure attachment that is attuned and reciprocal and therefore provides a

secure base from which the client can explore different ways of being (Horvath & Greenberg, 1994; Horvath & Luborsky, 1993).

Motivation can be defined as an individual's unique *"considerations, commitments, reasons, and intentions to perform certain behaviors"* (p.103) and readiness to change as the individual's *"willingness, openness"* or *"preparedness"* (p. 104) to act on those intentions (DiClemente, Schlundt, & Gemmell, 2004). What appears to be particularly important for engagement in psychological interventions is the reason for motivation and readiness. For some, motivation is based on external pressures or coercion as opposed to an internal drive or desire for change, and this often has a detrimental effect on engagement, e.g., in some cases of individuals with eating disorders (DeJong, Broadbent, & Schmidt, 2012; Fassino, Pierò, Tomba, & Abbate-Daga, 2009) and substance users (Joe, Simpson, & Broome, 1998; Simpson, Joe, Rowan-Szal, & Greener, 1995). This is important when considering engagement in forensic populations, as they too often report feeling coerced into treatments (Cooke & Bailey, 2011; Wilkinson, 2008).

Internal motivation and readiness (Long et al., 2012; Rosen, Hiller, Webster, Staton, & Leukefeld, 2004) and therapeutic relationships (Sainsbury, Krishnan, & Evans, 2004; Yakeley & Wood, 2011) appear to be implicated in general treatment engagement in forensic settings, with some arguing that the development of alliance aids readiness (Tetley, Jinks, Huband, Howells, & McMurran, 2012). Similar findings emerge when assessing engagement in psychological interventions within forensic settings (Hiller, Knight, Leukefeld, & Simpson, 2002; Howells & Day, 2007; Kozar & Day, 2012; McMurran & Ward, 2010; Polaschek & Ross, 2010), with a possible bidirectional association between motivation and alliance (Ross, 2008). To the author's knowledge, there are no studies that explore in depth (i.e. using interviews rather than questionnaires), forensically detained service user views of the

engagement process purely in relation to psychological interventions. Not only can this type of research help to identify how these service users understand their engagement, therefore highlighting possible ways to improve it, the process of giving precedence to lived experiences may enhance engagement in itself (Gillespie, Smith, Meaden, Jones, & Wane, 2004).

2.0 OBJECTIVES

The aim of this study is to explore service user experiences and understandings of their engagement in psychological interventions within a medium secure setting. The primary research question is as follows:

- How do service users understand and make sense of their engagement in psychological interventions within medium security?

Subsequent questions arising from this are:

- What do service users perceive as contributing to their initial and continued engagement in psychological interventions?
- What do service users perceive as hindering their overall engagement in psychological interventions?

As a secondary aim, it is hoped that this research will contribute to the meeting of quality standards and best practice guidance in secure services, in terms of user involvement in service development and improving aspects of their care (Department of Health, 2007; NHS England, 2013; Quality Network for Medium Secure Units, 2007).

3.0 METHODOLOGY

3.1 Interpretative Phenomenological Analysis (IPA)

A phenomenological epistemological position has been taken in relation to this research; knowledge is sourced from experience and experience is subjective (Larkin, Watts, & Clifton, 2006). IPA was chosen for this study because it uses this position to guide research questions, protocols, and analysis, and it is therefore important to explore how this shapes the current research before moving forward.

IPA does not search for truths, but is concerned with how people make sense of their experiences, which are unique and based in context (Larkin et al., 2006). In line with this, the research question is designed to gain knowledge about how a unique set of individuals make sense of a particular phenomenology, which is acquired through subjective accounts of their particular experiences. In addition, participants are positioning themselves and sense-making in relation to a particular environment, person, time point, and circumstance when taking part in the research. The researcher is also undergoing a process of meaning making through interpretation of phenomenology, therefore readings of the data reflect what appears to be significant and important to the participant in context as selected by the researcher (Larkin et al., 2006).

3.1.1 Self in context

As a result of the interpretative element of IPA, sensitivity to personal context is very important (Yardley, 2000), therefore I will offer some insight into how my personal context may affect this process. Context will be discussed again in the participant section of the method. I have trained and worked in the field of psychology for over ten years as a volunteer, assistant, and trainee psychologist. As an assistant psychologist I worked exclusively in

forensic settings, including one of the services in which participants were recruited. I have personal experience of engaging individuals like the participants in this study in psychological interventions within forensic settings. This includes experiences of positive engagement, non-engagement and disengagement. Whilst my years of experience in this field demonstrates my passion; my readings, teachings, and close experiences mean that I am also potentially biased as to the factors which both help and hinder the engagement process.

3.1.2 Credibility

In order to minimise the impact of the above bias and stay as true as possible to participants reflected experience, a number of other individuals supported the development and analysis of this study. Methods of triangulation, in this case investigator triangulation, are considered an effective way of establishing validity in qualitative studies (Bartlett & Canvin, 2003). The research supervisor and another trainee psychologist also analysed aspects of the data to support the development of the themes. The trainee psychologist involved in the analysis was conducting the other part of this two-way multi-perspective study, utilising psychologists' perspectives of engagement in medium security. Additional support from individuals outside forensic services was gained through analysis with qualitative researchers at University of Birmingham and with a credibility checking group of doctoral students using IPA. The final data set was reviewed by all persons highlighted. Verbatim extracts that support participants' voices within the interpretations are presented in the body of the text and subsequent appendices, in the hope that the reader can feel reassured that reflected experiences are presented (Smith, Flowers, & Larkin, 2009).

3.2 Ethical approval

Before commencement of this study, full ethical approval was obtained from a National Health Service (NHS) Research Ethics Committee (REC) of which members had specialist knowledge of research in forensic services (see Appendix 1). Subsequently, local ethical approval was obtained from trust level Research and Development (R&D) department and from the two sites at which the research was conducted, (see Appendix 2 and 3 respectively).

3.3 Participants

3.3.1 Selection

In line with qualitative research, eligibility was based on service user insight into the topic area (Flick, 2009). Eligible service users were males currently detained in an MSU, who were attending an individual or group programme of psychological intervention in the MSU, or who had done so in the previous year. Males represent a large majority of individuals detained in MSUs (Maden, Scott, Burnett, Lewis, & Skapinakis, 2004) and have been found to be less engaged in treatment than females within forensic settings (Garner, Knight, Flynn, Morey, & Simpson, 2007; Staton-Tindall et al., 2007), therefore their views may be considered more pertinent to explore at the onset of this type of research. Given the diversity in secure settings (National Public Health Service for Wales, 2006; Rutherford & Duggan, 2007), it was deemed appropriate to allow heterogeneity in terms of other factors such as age, diagnosis, and ethnicity.

For the safety, security, and well-being of service users and the researcher, and to avoid complications and potential biases in data collection, a number of exclusion criteria were applied. Service users were not eligible to take part if they:

- were awaiting trial
- were transferred prisoners
- were unable to work one-to-one with a female
- had previously worked with the researcher in any capacity
- were unable to sufficiently understand the nature of the study and the information provided to give informed consent
- did not speak English
- were going through active acute relapse
- were not settled in mood and mental state generally or on attempts to interview

3.3.2 Recruitment

Multidisciplinary Teams (MDTs) responsible for the care of service users detained at two medium secure units were approached and provided with study information (Appendix 4). A member of the team approached eligible service users to introduce the study and provide a participant information leaflet (Appendix 5). If an interest was expressed, the Responsible Clinician (RC) signed a consent form (Appendix 6) agreeing for the researcher to meet with the service user. A meeting was arranged with the service user in liaison with the nurse in charge, which included at least 24 hours for reflection. At the initial meeting the participant information leaflet was discussed and questions were answered by the researcher. If agreeable, an interview was arranged again in liaison with the nurse in charge, with at least 24 hours for further consideration.

3.3.3 Characteristics

Table 1 outlines participant demographics. Most had participated in a number of psychotherapeutic programmes during their medium secure residency, including individual and group work with assistants, trainees, and qualified psychologists. Participants were asked to talk about their experiences regarding one particular course of psychological intervention; however, they often made parallels with other psychology encounters.

Table 1:

Participant demographics

Name[1]	Age	Diagnosis	Ethnicity	Length of current admission[2]	Practitioner[3]	Mode of intervention[3]
Donald	23	Schizophrenia	White	9 months	Psychologist	Individual
Kyle	44	Schizophrenia	White	4 years	Assistant psychologist	Group
Roger	42	Schizophrenia	Black	5 years	Psychologist	Individual
Warwick	52	Delusional disorder	White	3 years	Assistant psychologist	Individual
Brian	31	Psycho-affective Disorder	Black	6 months	Psychologist	Individual
Cameron	28	Schizophrenia	White	1 year	Trainee psychologist	Individual

[1] Pseudonyms have been used to protect the identity of participants
[2] At the time of interview. This is the total time spent residing in any MSU during current admission, but not the total length of time residing in a MSU during lifetime.
[3] Primary experience discussed

3.4 Data collection

3.4.1 Interviews

Interviews with the researcher took place on the participant's residential unit in a designated interview room. Informed consent (Appendix 8) was gained from each participant prior to interview commencement. Participants were informed that the researcher was not part of their clinical or psychology team and was only affiliated with the MSU for the purpose of conducting research, which was to fulfil requirements of a Doctorate in Clinical Psychology. Participants were made aware that the researcher had a duty of care to provide a brief handover of their subjective mood and mental state to the nurse in charge at the end of the interview. It was explained that confidentiality would be maintained unless risk issues were presented.

Interviews were recorded on a trust encrypted digital voice recorder and immediately transferred to a password-protected computer on site. Participants were given a two-week reflection period at which point they were contacted by the researcher to ascertain if they still consented for their interview to be transcribed. After transcription, participants were given an opportunity to view their transcript and have parts of the interview removed before analysis or the whole interview withdrawn.

3.4.2 Interview schedule

Whilst there is an evidence base for a number of concepts that appear to be important in engagement, there is little consensus between researchers (O'Brien et al., 2009; Tetley, Jinks, Huband, & Howells, 2011), service users, and clinicians (Gillespie et al., 2004) as to what engagement actually means. IPA is well suited this to type of topic, as it does not require the participant to be directly asked about or talk about the concept in question, which

is instead answered through the analysis process (Smith et al., 2009). Therefore questions were not specific to engagement and were instead designed to facilitate discussion of participants' journey through their psychological intervention, with additional prompts when necessary to explore factors that seemed important to their engagement. Table 2 outlines the main interview questions and Appendix 7 contains the full interview schedule.

Table 2:

Main interview questions

Interview questions
Can you tell me about the reason you were asked to see a psychologist in the MSU?
Can you tell me about the first meeting you had with the psychologist?
What do you think helped your decision to see the psychologist regularly?
What can you say about the relationship between you and the psychologist?
Can you tell me about any times when it became too difficult or you felt like giving up?

3.4.3 Interviews in context

Thirteen service users were deemed suitable for participation by their clinical teams, but as can be seen in Table 1, only six participated. Whilst two service users experienced a relapse and therefore became ineligible to participate, five refused. Two cited unease at the use of a digital voice recorder and three reported that they were not interested in talking about

their experiences of psychological interventions. As individuals who typically do not engage well with services and professionals, it is inherently difficult to gain forensic participants for qualitative research (Adshead, 2003).

The richness and depth of interviews appeared variable depending on how participants engaged with a psychological practitioner as the researcher and the topic of the interview. At times, lack of engagement with questions felt like a reflection of a topic that was not of real interest or significance to some participants. On other occasions, it appeared as though participants may have been unable to fully articulate the depths of their experiences. Engagement with the topic and ability to communicate experience are essential in IPA (Brocki & Wearden, 2006).

Working as a psychological practitioner also appeared to impact on engagement in the interview. For example, some participants highlighted that issues such as type and amount of questions and trust were important for their engagement with a psychological practitioner, yet I came as a psychological practitioner asking many repetitive questions without many opportunities to develop trust. I strived for a balance between a student keen to gain a rich data set and a psychological practitioner showing sensitivity and flexibility.

As a result of differences in participants' level of articulation and/or engagement with the interview process, length of time varied between 20 and 70 minutes. Whilst inability to provide meaningful information has often been a criticism of qualitative research with forensic populations (Bartlett & Canvin, 2003), it should not be assumed that such individuals cannot provide *"reliable and complete accounts"* (Fallon, Bluglass, Edwards, & Granville, 1999, p. 25). Therefore all participants are considered to have provided personally meaningful responses regardless of the length or depth of their interviews and are therefore all represented in this study.

4.0 ANALYSIS

Whilst there is no set method for IPA analysis, Smith et al., (2009) outline a set of strategies that can guide the researcher through the inductive and iterative processes involved in IPA (Smith & Osborn, 2008). The verbatim transcript was read and re-read, along with the audio-recording, to bring the participant and tones of the interview to focus. Line-by-line noting was carried out, which involved making; descriptive comments, noting what is talked about by the participant; linguistic comments, noting how it is said, the language and tone; and conceptual comments. The latter are more interpretative as they explore how participants talk might relate to their overall understanding and sense-making. This was subsequently ordered into a series of objects of concern, i.e. overall things that seem important to the participant, and experiential claims, i.e. what these objects of concern might mean. See Appendix 9 for an extract of the initial noting stage. These objects and claims formed the basis of emergent themes, which are an interpretation of the way a participant understands the topic. Next, patterns across, and connections between, emergent themes were sought and brought together to create super-ordinate and sub-ordinate themes. See Appendix 10 for photographic representation of this process and Appendix 11 for an example of a table of themes for one participant. After carrying out this process on each transcript, the final stage required looking for patterns and connections across cases to develop the master themes that are presented in the results section.

5.0 RESULTS

Through the above process of attending to, describing and interpreting what was said and what was felt within interviews, two themes were selected from the data. These themes represent how the researcher understood service users' sense-making in relation to their engagement in psychological interventions within medium security.

Through the interview process it emerged that the interviewees were participating in psychological interventions to achieve particular goals; recovery or physical freedoms from hospital. This brought to the researcher's mind the image of football in which players participated in a game with the hope of scoring goals and therefore winning something of value to them. However, the researcher also developed a sense from the depth and tone of the interviews that some individuals' engagement was more active and others more passive. After reviewing the content of the interviews this appeared to correspond with their particular goals, with passive engagement appearing to be associated with the pursuit of a goal of physical freedom and active engagement with the pursuit of a goal of recovery. This further expanded the image of football in the researchers mind to one in which there were two parts to the game negated by players attitudes and interests. Standing on one half of the pitch, some players don't really have their heart in the game; they play for a reason/goal, e.g. financial incentive or transfers to better clubs, but with minimal effort and without much passion or vigour. On the other half, some players play with maximum effort and enthusiasm because the game has added personal value, it provides satisfaction, growth and self-enhancement that feels more important than the physical incentives. The first theme 'a game of two halves' therefore represents this narrative and seemingly experiential difference between participants in terms of their engagement in psychological interventions. It reflects how participants understand

their initial engagement as brought about by differences in personal motivations or goals, and the impact of these differing motivations on level of engagement.

The second theme 'if you build it they will come' represents reasons for continued engagement. It reflects how participants can receive multiple gains from the psychological environment, and if the psychological practitioner builds this environment of gains, participants are likely to come to an offer of psychological intervention and remain engaged with the process. Whilst the second is a theme in its own right, it also represents an apparent mechanism of change, whereby motivations and levels of engagement are enhanced through the facilitation of personally meaningful gains. These themes and their subthemes are further explained below. Appendix 12 and 13 provide the range of comments contributing to the each theme respectively.

5.1 A game of two halves

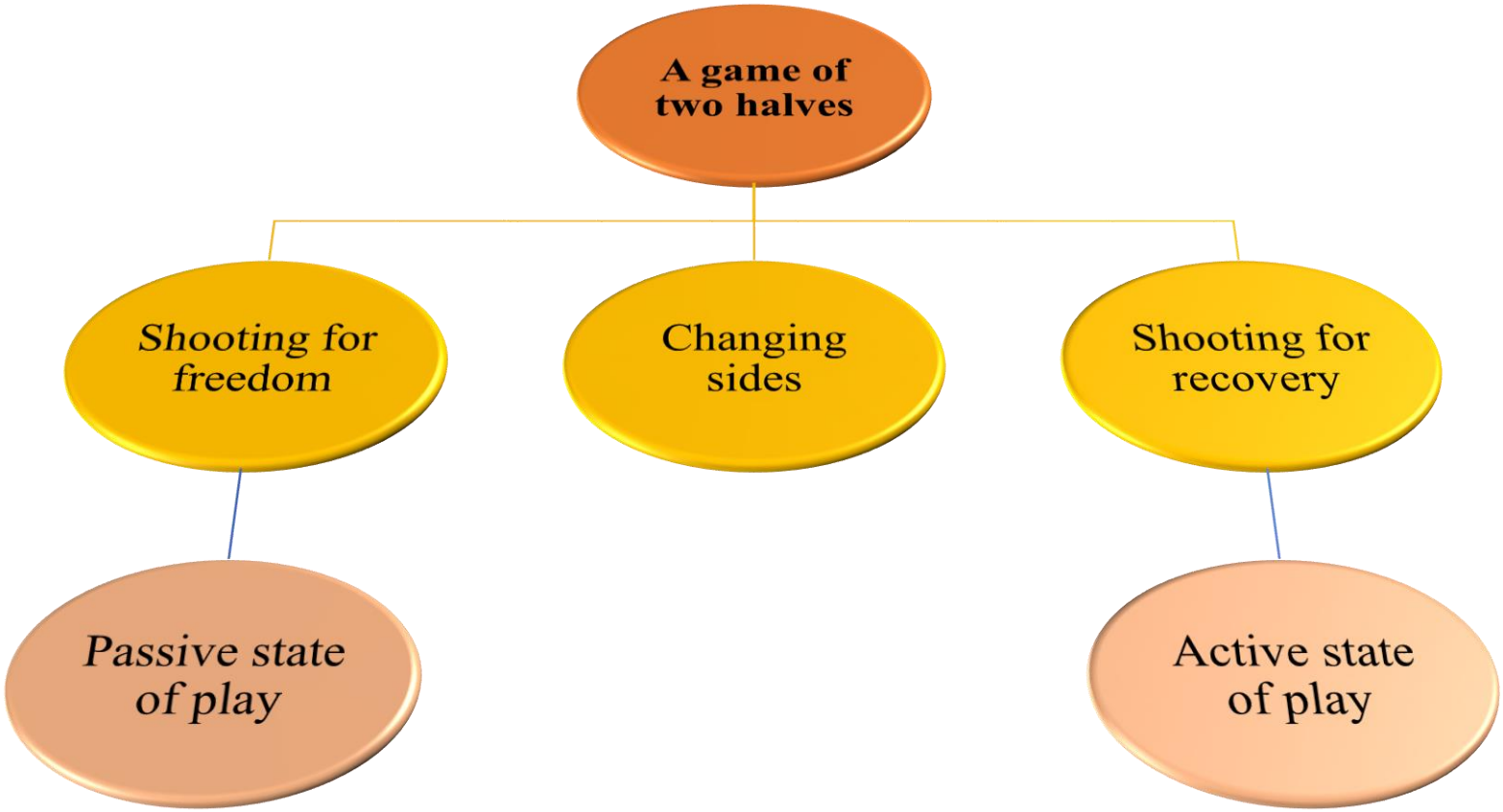
"It's just the overall goal really"

Participants appeared to understand their engagement as coming from personal motivations, which were pervasive throughout interviews. The content and tone of interviews indicated that participants' engagement could be characterised as having different levels of quality. At an interpretive level, motivational stance appeared to be linked to the quality of their engagement.

To explain this further, it could be considered that participants are involved in the same game on the same pitch, in that they are all detained in a forensic service and participating in psychological interventions. Whilst the game is the same, their goals are different and they appear to be engaged in different states of play depending on the goal that they are aiming for. Two participants' accounts are presented as examples of two different

goals and states of play. As will be explained within each subtheme, Warwick represents one half of the game; he is aiming purely for the goal of physical freedom through discharge and seemingly has a passive state of play in the psychological intervention as a result of this. Kyle represents the other half of the game; he is aiming for the goal of recovery and seemingly has an active state of play in the psychological intervention as a result of this. Some participants who initially only seemed to aim for the goal of physical freedom appeared to have a shift in mind-set as a result of the psychological intervention and therefore aimed also for the goal of recovery. This appeared to create a renewed vigour affecting their state of play in the psychological intervention so that they became more actively engaged. Brian's account will be utilised to represent this. A diagrammatical representation of this theme is provided by Figure 1.

Figure 1:



Theme 1: A game of two halves. This diagram illustrates the differing motivational stances that participants took towards their engagement in psychological interventions and the ways this appeared to affect their level of engagement in the intervention.

5.1.1 Shooting for freedom

When describing their initial motivations for attending a psychological intervention, most participants aimed purely for a goal of freedom from hospital life, namely discharge. Some participants understood their engagement as solely in pursuit of this goal and most participants felt that engagement in a psychological intervention was essential for discharge. This is illustrated below in Warwick's quotes:

> *Warwick: she was a psychologist and you have to see them, you had to do it…no one told me that I had to do it, but if I want to get out of the place, I have to do it.*
>
> ---
>
> *Warwick: [if leave or discharge was not affected by his attendance at psychology] I would chop it …not do it.*

As can be seen in Warwick's quotes above, he aims for the goal of physical freedom from hospital life. His comments reflect many participants' accounts of a seemingly unwritten rule that one would not be permitted to leave without having engaged in a psychological intervention. This could be interpreted as many participants understanding their initial engagement as shooting for a goal that they desire with a ball that they did not choose.

5.1.2 Shooting for recovery

In contrast, and in fewer numbers, some participants' descriptions of their motivations for attending psychological interventions suggested that they aimed for a wider goal of recovery. Some participants understood their engagement as in pursuit of this goal. This is illustrated below by Kyle:

Kyle: it's like load-shedding sometimes [by talking about problems during their psychological intervention]… it is to be grounded… I know I can find peace another day but just having that rest is important to gather, get your wits about you, and not be so much under pressure in your thinking. And therapy, that's what I think they bring, an opportunity to find some rest, and when you find some rest and slow down a bit, you got the opportunity to find real peace in your life and in some ways freedom. I know freedom doesn't start the day you walk through the door, it's much more than that, and so it's very valuable to listen as a group and as a hospital wide you know population to try and find freedom from whatever afflictions you've got…your outlook as well, what you're gonna do with your time when you are loose, so things that you learn day to day that make a difference for the future.

As can be seen in Kyle's quotes above, he aims for the goal of recovery. Recovery appears to mean psychological freedom from a pressured mind, which includes mental rest, relaxation and peace. By default this may aid discharge, but Kyle rarely talks about this throughout his interview, suggesting that he makes sense of his engagement as shooting for a personal goal of recovery above anything else.

5.1.3 Changing sides

Most participants' stories start in the same way as Warwick's, shooting for the goal of freedom, but as they unfold, some indicate an experiential shift in motivation and participation during the intervention. When thoughts about the purpose of psychological interventions expand, it appears that participants' field of vision also expands enabling them to consider another goal. The start of Brian's unfolding story is illustrated below:

Brian: the doctor recommended it [psychology] … [he did not think it was good advice] straight away, I seen them before and it never really made a difference…it's awkward you know sitting there talking about problems, it's hard.

Brian: I want to get out of here…I don't think I can unless I engage with it [psychology].

Brian's comments above reflect a stance we have already seen. However, his comments below relate to a change of position on whether seeing a psychological practitioner was good advice:

Brian: she's asking me about thoughts, feelings and I'm talking about my like you know illness, then she would give me advice how to control my thoughts and feelings like that, giving me advice on relapse, how to control anxiety, how to control thoughts and kind of like maintaining yourself in bad or even good situations…I try to use some of the techniques that I learn and they do work, I'm not sure, but they could help me.

When interpreting Brian's account as a whole, we can see that he makes sense of his initial engagement in a psychological intervention as aiming towards the goal of freedom through discharge. Yet, when he experienced other benefits, the psychological intervention provided him with hope for his mind, enabling him to also aim for a recovery goal. He therefore appears to make sense of his engagement as shooting towards two goals. Intervention and practitioner factors that support continued engagement, including the gain of hope, will be discussed in more detail in the next super-ordinate theme.

5.1.4 Passive state of play

At an interpretative level, the stance that participants adopted in relation to their motivation to attend psychological interventions appears to play a significant role in the

quality of their engagement with the process. Those participants who metaphorically aimed for physical freedom appeared to participate in passive states of play within their psychological interventions. Let us first consider the content, depth and tone of Warwick's account when discussing his psychological intervention below:

Charlotte: What were the not so good parts of the work with Ms Y?
Warwick: It went on a bit I must admit but it was alright wasn't too bad, I suppose there was too much hand outs, I only read half of it you know what I mean?
Charlotte: How come?
Warwick: ...I don't know, I just don't bother doing them.
Charlotte: What are they for?
Warwick: They're for when, how to cope with your emotions and stuff like that.
Charlotte: Did you find any of them helpful?
Warwick: I suppose so, but err, mm, I don't know like…
Charlotte: What ones did you find helpful?
Warwick: …err, I don't know what to say…
Charlotte: Apart from the hand-outs then, has there been anything else helpful about the sessions with Ms Y?
Warwick: err, it's helped me how to cope with my emotions and erm how to erm how to cope with erm mental health and stuff like that and not to fall into risk zones…
Charlotte: why is that helpful?
Warwick: ….I can't remember it too much, I don't know what to say….

In the above section of the interview, Warwick appeared as though he wanted to show his knowledge of the psychological work that he was undertaking. It evoked images of him sitting in a meeting attempting to demonstrate to his team that he is engaging with psychological work. However, his lack of depth and general struggle to answer questions could suggest that his state of play in the psychological intervention is fairly passive, whereby information is not retained or applied to self.

Warwick also commented in the interview that he does not consider himself to have a mental health issue, as is highlighted in the quote below:

> *Warwick: I don't class myself as having a mental illness so it's weird, they're [psychological practitioner] trying to make you feel better and you feel better anyway.*

As highlighted above, if Warwick does not position himself as having a psychological need or motivation, then we can see why he may be only passively engaged in the psychological intervention.

5.1.5 Active state of play

Those participants who metaphorically aimed for the goal of recovery appeared to participate in more enhanced states of play within their psychological intervention. Let us contrast Warwick's extract to the content, depth and tone of Kyle's account below:

> *Kyle: they do things like the WRAP[Wellness Recovery Action Planning] group, they give you your own very very tough folder, you know durable, so you can write down all your issues, relapse signatures, an what work you've done and what you find helpful, prompt list, notes, unhelpful thinking. You can build up a portfolio so that you and other people have got confidence that you're serious about recovery, not just owning it and putting it on the side and leaving it, but this is your life type moment. You can have it for years and I'm planning to do so just for my own attempts to find something material, something that I can change and grow on and work on.*

Similar to the rest of his interview, Kyle speaks with passion and vigour about his therapeutic work in the above extract. His description suggests an active state of play involving writing

his own detailed notes, applying information to himself, using information outside sessions and taking responsibility for this.

In contrast to Warwick, Kyle appears to position himself as an individual with a mental health difficulty, which he wants to explore with professionals, as is seen in the quote below:

> *Kyle: You can go too far with schizophrenia, it's not meant to be an indulgent thing, but I do like to talk freely with psychologists and therapists and doctors in general about schizophrenia and identity.*

Given that Kyle positions himself as having a psychological need and motivation, as highlighted in the above quote, we can see why he may be actively engaged in the psychological intervention. Not only that, but as his comment below suggests that he has scored a personally meaningful goal:

> *Kyle: it's a kind of freedom from entanglement really, a sort of moment of clarity during the interview [with the psychological practitioner], I look for those and thankfully they are there quite often and I can take a lot from them.*

Brian, like most participants, may not be as actively engaged in the process as Kyle, which will be seen in the short quote below. However, his change in stance towards his engagement in the psychological intervention appears to have facilitated an improved state of play in that he is now able to open up more during the intervention:

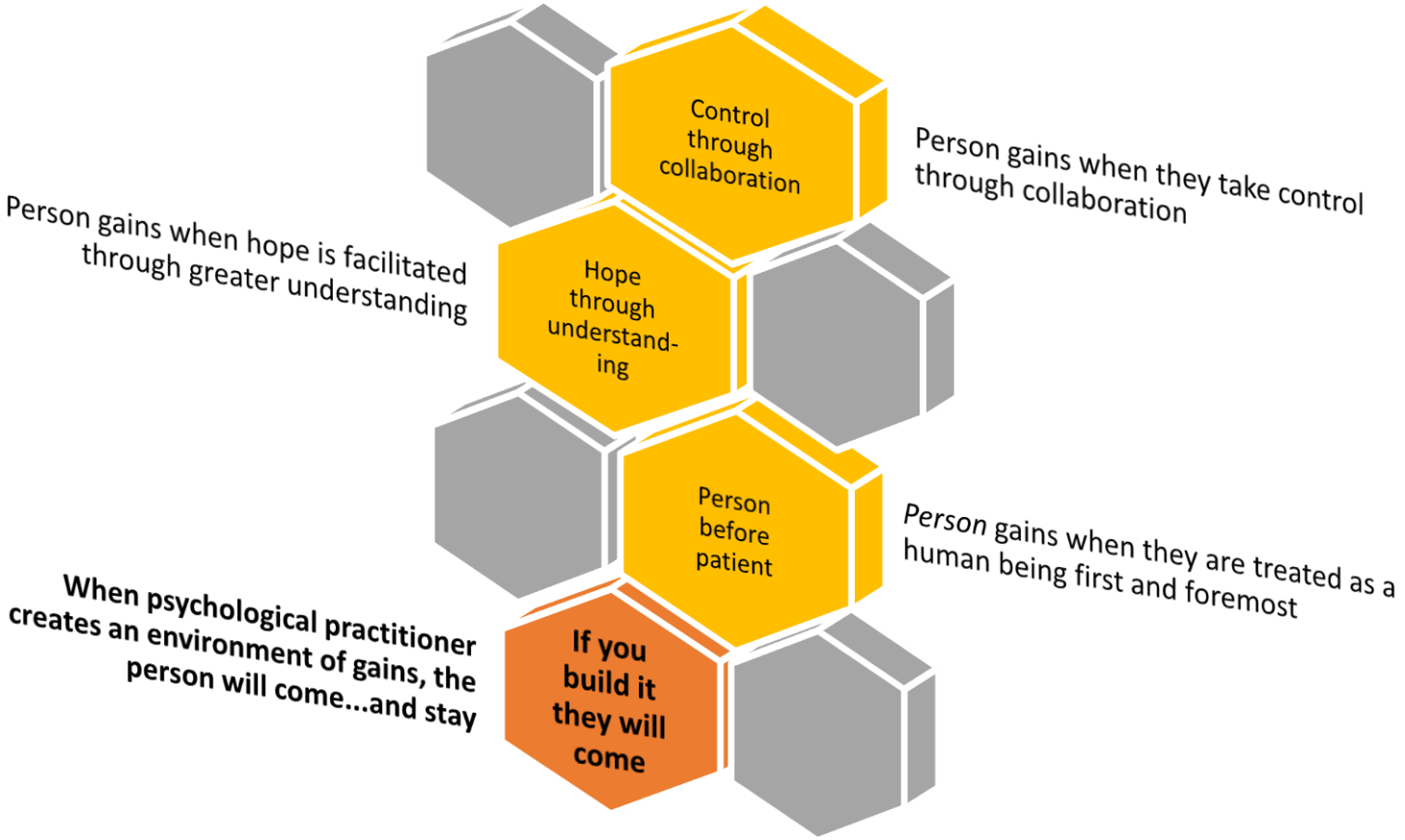
> *Brian: I built up trust in what she was asking me and how it was helping me…I could talk bit easier…talk more about problems.*

5.2 If you build it they will come

"Once you're doing it, you can see what it might be helping with"

Whilst working towards a personal goal appears to be essential for engagement in psychological interventions and also appears to impact level of engagement, participants' narratives also indicated influences of the intervention itself and the practitioner on their continued engagement. At an interpretative level, participants' accounts suggest that when a psychological practitioner creates an environment of gains/ benefits for them, such as being treated as a person, developing hope and having control, whilst working towards their ultimate goal, their engagement is likely to be enhanced. Most participants appeared to gain recognition as a person/human being, rather than as an offender/patient/client with mental health difficulties when the psychological practitioner treated them as people first and foremost. Hope, appeared to be another gain for participants, which occurred through the facilitation of greater understanding of self. As mentioned in the first super-ordinate theme, this not only aided continued engagement, but also allowed participants to gain an additional goal of recovery. Participants also appeared to achieve a gain of control when they were given opportunities for choice and collaboration within their psychological interventions. This facilitated them to engage in personally meaningful work and allowed some participants to take some control over their recovery. Participants explicitly indicated that if these factors, which have been summed as an environment of gains, is built, they will come - and stay. A diagrammatical representation of this theme is provided in Figure 2.

Figure 2:



Theme 2: If you build it they will come. This diagram illustrate how creating an environment of gains facilitates continued engagement.

5.2.1 Person before patient

Participants framed most positive experiences with a psychological practitioner in the context of their relational interactions. Half of the participants used the word friend to describe their relationships, as illustrated by Donald below.

> *Donald: it's like having a friend, talking to a friend.*

At an interpretive level, participants appeared to be describing relational interactions in which they were treated as a person rather than a patient/client/someone with a mental health difficulty. Warwick's comment below illustrates this:

> *Warwick: there's a lot more respect here than what I had there [prison]…she speaks to me as a person, it makes me feel like a human being, it's like when the sessions finish she will go on talking about oh how did you enjoy the match, stuff like that…if you didn't have no respect you wouldn't get nothing done.*

Warwick's description above highlights how he felt like a human being when the psychological practitioner didn't just want to talk to him about psychological work. He did not feel as though he was only viewed as a patient or a client of hers and this helped him to feel respected. Warwick's comment highlights that engagement is unlikely to occur if he does not feel respected as a human being.

These *person*-centred interactions appear to facilitate the development of trust, another seemingly important aspect of continued engagement for some participants. Brian's comment

below illustrates this when he spoke about one of the ways he was able to continue working with a psychological practitioner despite having initial difficulties trusting her:

> *Brian: well first of all you know through all that's happened, I never trusted nobody you know, I'm learning how to trust them... [He has learned to trust because] since we've been talking I haven't really had doctors on my back, we talk and she don't judge me for it and nobody else does either.*

Brian's above extract suggests that he was treated as a human being rather than being made to feel stigmatised and punished as an individual with a mental health difficulty. He explains that not being punished through judgement and indirectly receiving approval from others, aids his ability to trust the psychological practitioner and the process, and therefore continue engaging and sharing in his psychological intervention.

Warwick's quote below provides a contrast to the above position and indicates how some participants did not feel as though they have always been seen or treated as a human being first and foremost by a psychological practitioner:

> *Warwick: with the depot they keep giving me, it was making me tired and absent, I kept rubbing my hands like that [does motion of rubbing hands back and forward], I wasn't cold or nothing, I was rubbing me hands and all that lot…it [the depot] was making me a nervous wreck…and of course she's [psychological practitioner in first MSU] booked an interview room to come and see me with the mental health nurse, and I was too tired and I went to bed and they come round saying do you want to attend your sessions and I was nah I don't want to now...after that she got her own back by not doing any psychology work with me at all.*

Warwick's comment above could suggest that he felt that his human need to rest when he was emotionally and physically exhausted was not respected. He felt that he was punished by giving in to this need and not fulfilling the psychologist's need for him to be a compliant patient.

5.2.2 Hope through understanding

Most participants described gaining a better understanding of themselves and their mental health and/or offending behaviour throughout their psychological intervention, which they found to be a helpful part of the process that aided their engagement. At an interpretative level, four participants highlighted that these new understandings brought about some kind of acceptance of their past and difficulties, and importantly enabled them to gain hope for the future. This is illustrated by Roger as he explained why he continued to engage with the psychological practitioner:

> *Roger: I liked the sessions so I didn't mind seeing her again and again…I liked the classes and talking to her…I was having a better understanding of my problems, about my index offence, why I was brought [to the MSU], schizophrenia…it helped me come to terms with my index offence and why I might be thinking certain things…it helped me to understand why I got myself into trouble in the first place, why I got paranoid and if it happen again in the future… I've been more straight headed and problems I had in the past I will find easier to sort out in the future… if you get a better understanding you have freedom, you can get out of hospital and probably stay out.*

What we can see in Roger's description above is that the understanding he developed had personal meaning. It appeared to allow him to accept his difficulties whilst potentially seeing or feeling another way of being. He appeared to gain hope; having schizophrenia and

committing an offence does not mean that he is resigned to a life of continued difficulty and hospitalisation. At the start of Rogers quote he highlights that his engagement was supported by the development of this type of understanding, which gave him hope for the future.

The same can be inferred from Cameron's comment below:

> *Cameron: It [the psychological intervention] just helps you accept things more really, you can understand it more really, what's going on, what's happening….why things happen, so it gives you more understanding of what kind of things help and what kind of things don't help you…it gives you hope in the end and to get better and to get out and you know there's stuff like my family, and there's a hope for all of that and that it will all get on track…just through the whole progress, the progress as its gone on, like what we've discussed and how I have felt differently about things personally [gives him this hope]*.

In Cameron's extract above, he explicitly links understanding with acceptance and hope. Understanding does not appear to be just about the past for Cameron, but also understanding how things can be different in the future. The last sentence in this extract demonstrates multiple gains; Cameron has gained difference in his being through gaining understanding, which provides hope.

Three participants spoke about the impact of the hospital setting, either the physical nature of the environment or the impact of other people within that environment. At an interpretative level these can be viewed as affecting one's hope for the psychological intervention and their recovery. Kyle reflects below on what he thinks stops people from actively engaging in the recovery process, which includes psychological interventions:

Kyle: It can be a dreary experience being an inpatient, people wander off into their own comfort zones and sometimes they just want to be left alone… that's not good when you have an opportunity like that [psychological interventions] to sit there going through the motions.

We might interpret Kyle's comment above as suggesting that the mere act of being within a hospital environment can result in people feeling hopeless and therefore not actively engaging in processes that might support them to change their situation.

5.2.3 Control through collaboration

At an interpretative level, control appeared to be present within most participants' accounts, but was pervasive throughout two participants' narratives in particular. Control was framed in the context of choice and power within sessions, facilitated through collaboration and flexibility of the psychological practitioner. When this occurred, it enabled participants to gain by working on things that were important to them, so to see personally meaningful gains. This is illustrated in Kyle's quote below:

Kyle: thankfully the psychology groups are quite flexible, they sort of pick up and go with the ideation and they try and give me some sort of clarity.

Kyle's quote above suggests that he may understand that psychologists come with a structure and plan, but the psychologist's flexibility enabled him to have some control over the session content. This gave him an opportunity to talk about something that was important to him and he gained a psychological benefit from this.

Another gain appeared to be obtained by some participants when they were collaborated with; an increased desire and ability to take control over their recovery. This is illustrated by Cameron below:

> *Cameron: the fact that they've shown openness for me to have like more say in what happens that helps a lot… you're more likely to help yourself really if you've got more involvement in getting better… I suppose you look at the end goal really and what you want to get out of it, because you want, you don't want to be in here, you want to be out with your family so, you're helping yourself to get better by sticking to the course and making a full effort I suppose, a proper effort to get through it and help yourself in that way.*

Cameron's above explanation could suggest that control begets control; when he had some control in in his psychological intervention through a process of collaboration, he felt more able to look at what he wanted to achieve and take control of achieving this. Taking control of achieving this appeared to mean active participation and engagement in the psychological intervention.

At an interpretative level, frustrations raised within most participants' narratives could be attributable to times when they were not in a collaborative relationship with a psychological practitioner, but rather the practitioner had the control and agenda. Some participants disengaged in these instances and it is possible that this gave them back some control. Donald's quote below reflects a frustration that was also directly shared by Roger, and how this was overcome:

> *Donald: I have been examined by other psychologists in the past for a little while, just for one and two sessions, and these psychologists was just asking the same things…[this was] boring and irritating, I was frustrated…I stopped [the psychological intervention after these one or two sessions]… she [Dr Z] didn't ask me the same things all the time and I found it interesting…we talk about lots of things, discussed about the crime, being here and the past since I was a little child…she made me understand the serious of my crimes, in the beginning it [seriousness of crime] didn't matter to me too much, I thought it was something minor....I found this interesting, having a conversation about these things… I think in the future it will be different, I will think different about these things.*

Donald's quote above suggests that first impressions count. When the psychological practitioner was discussing things with him that were not important or interesting to him, in other words not collaborating with him on his interests and goals and enabling him choice over discussion during the first sessions, he disengaged. However, when he had the opportunity to discuss things that were of interest and importance to him, not only was his engagement maintained, but a change in anti-social attitude was facilitated. Donald now appears to have gained the ability to take some responsibility for and control over his actions in the future.

6.0 DISCUSSION

This research aimed to explore service user experiences and sense-making in relation to their engagement in psychological interventions within medium security. It could be interpreted that participants appeared to understand their engagement in psychological interventions as serving different goals. Their stance in relation to this appeared to play a significant role in the quality of their engagement in psychological interventions, with those individuals desiring the goal of recovery over physical freedom from hospital appearing to be more actively engaged. The environment that is created by psychological practitioners appears to have a significant role in participants continued engagement. They appear to understand their continued engagement as a result of gaining recognition as a human being first and foremost, hope, and control, which is developed though the intervention when they are treated as a person, and through the facilitation of understanding, and collaboration. This environment can also facilitate the development of a recovery-orientated goal in individuals who initially only aimed for a goal of physical freedom.

Providing this set of unique individuals with a voice allows only some experiences to be recounted and these interpretations should not be taken as an axiom of engagement in psychological interventions within medium secure settings. However, this glimpse of factors that appear to be important for the participants in this study provides one way of understanding some mechanisms of engagement, which when taken together with existing literature, can be used to inform clinical practice.

6.1 Links to literature

Whilst unintentional, all participants in this study had a diagnosis of a psychotic disorder. Recovery style in psychosis (McGlashan, Levy, & Carpenter, 1975) has been linked

to engagement in general treatment (Staring et al., 2006; Tait, Birchwood, & Trower, 2003) and psychological interventions (Jackson et al., 2001; Startup, Wilding, & Startup, 2006), with those adopting a 'sealing-over' style being less engaged than those with an integrative style. Sealing-over is an avoidant coping style, characterised by denial, minimisation, and/or lack of problem exploration (Greenfeld, Strauss, Bowers, & Mandelkern, 1989). It may be suggested that some participants' comments are reflective of this type, for example, Warwick, who denied having a mental health difficulty and did not wish to discuss problems during his psychological intervention. In turn he appeared to be only passively engaged in the intervention. Integration, on the other hand, is an adaptive coping style, characterised by interest and curiosity about the problem and a desire to make sense of it (Greenfeld et al., 1989). Kyle may reflect this style due to his acceptance of mental health difficulties and desire to explore and receive support with this. In turn he appeared to be actively engaged in the intervention. Recovery style lies on a continuum with oscillation between the two (Thompson, McGorry, & Harrigan, 2003), and research supports the idea that the psychological intervention can facilitate change in recovery style (Braehler et al., 2013; Jackson et al., 1998; Jackson et al., 2001; Mclnnis, Sellwood, & Jones, 2006). It could be suggested in the current research that engaging in psychological interventions enabled some individuals to move away from sealing-over. For example, Brian did not want to talk about his mental health initially, but recognised the importance of doing so over time, and this in turn aided his engagement. This research could be interpreted as offering some support to the existing literature in reporting an association between recovery style and engagement in psychosis, and that certain components of psychological interventions may support a shift in recovery style.

The finding that there are differing types of motivation that appear to affect level of engagement is also pertinent, as existing literature highlights better engagement when motivation is internal, such as desire to change, as opposed to external, such as coercion (Hiller et al., 2002; Joe et al., 1998; Rosen et al., 2004). The poor engagement of legally coerced individuals may be a result of them having less curiosity about their mental health and therefore lack of desire to explore this (Moore, Lumbard, Carthy, & Ayres, 2012) and/or lack of hope about their abilities within treatment (Hampton et al., 2011). Nevertheless, research suggests that regardless of initial motivation, participating in psychological interventions can increase internal motivation and subsequently enhance engagement (Baker & Hambridge, 2002; Prochaska & Levesque, 2002; Ryder, 1999). This also appears to be supported by the current study, which indicates that participation in psychological interventions can enable some individuals who are externally motivated to gain internal motivation, increase hope, enable possible shift in recovery style to one of more curiosity, and that providing internally motivated gains during the intervention can facilitate engagement.

This ability of the psychological practitioner to facilitate a shift in motivation and engagement may be explained by the application of Self-Determination Theory (SDT). This theory suggests that people have basic psychological needs for competence, autonomy, and relatedness (Ryan & Deci, 2000), and when these needs are supported, intrinsic motivation is enhanced (Deci & Ryan, 2012). Within a psychotherapy context, Ryan and Deci (2008) state:

> *"Regardless of their motivational starting point, SDT argues that an atmosphere of autonomy support, which has often been found to facilitate satisfaction of all three psychological needs, is critical to clients' active engagement and adherence."* [p. 187].

In their review of the literature, they evidence that when psychological interventions support self-determination through offering choice, minimising pressure, listening to, respecting, and working on personally meaningful goals within a relationship of relatedness, motivation and outcomes are enhanced. The current research supports this as it indicates that engagement is maintained, regardless of initial motivations, when the individual has some control and personal hope within a human relationship. This is further supported by the finding that intrinsic motivation and autonomy can be enhanced by a collaborative relationship.

The atmosphere of autonomy support that Ryan and Deci state satisfies the basic needs could be described as a recovery-orientated atmosphere (Abbott, 2008; Barker, 2012; Mancini, 2008). The recovery model focuses on positive identity and meaningful life alongside mental health, which the individual has hope for and control over, as opposed to cure and submission to drugs/health professionals akin to a medical model (Shepherd, Boardman, & Slade, 2008). Roberts and Wolfson (2006) describe the experience of recovering in this context as:

> *"Gaining a sense of self, of taking control and responsibility, often combining optimism for the future with acceptance of the past."* [p. 24]

A recovery-orientated environment fulfils this through a strengths-based focus, working on personally meaningful chosen goals, taking non-expert roles, collaboration, and promoting social inclusion and integration (Davidson, 2008). Deegan (1996), as an individual diagnosed with schizophrenia who has experienced recovery-orientated and medicalised environments, highlights that recovery can only occur within a mental health setting when professionals understand and treat service users as human beings first and foremost, allow

them to have a voice which they listen to and hear, support them to become self-determined through choice and power, and facilitate hope for a better more meaningful future.

It is argued that the basic needs of autonomy, competence, and relatedness are more likely to be fulfilled when professionals use these recovery-orientated practices (Mancini, 2008) and that these practices are likely to enhance internal motivation and subsequent therapeutic engagement (Abbott, 2008). The current research supports this and could indicate that engagement in psychological interventions is maintained and internal motivation enhanced when psychological practitioners enable relatedness, control, and competence by using recovery-consistent principles. These principles include treating individuals as people first and foremost, collaborating with them, facilitating their understanding of self, and enabling hope.

6.2 Clinical implications and recommendations

6.2.1 Translating insight into practice

Internal motivation is linked to readiness to change (Gavigan, 2001; Gavrilov-Jerković, 2007), and can not only aid engagement as suggested by the existing literature and the current research, it appears to be linked to better therapeutic outcomes than external motivation (Osbaldiston & Sheldon, 2003; Ryan, Plant, & O'Malley, 1995; Wild, Cunningham, & Ryan, 2006; Zeldman, Ryan, & Fiscella, 2004). Whilst external motivations are highly likely to draw forensic service users into attending psychological interventions, the intervention itself has the potential to develop and improve internal motivation and engagement (McMurran, 2002) and this was supported by the current research. Therefore it seems pertinent for psychological practitioners to understand motivation, so that methods and approaches can be tailored to the individuals current stance and level of readiness with the

view to enhance internal motivation and engagement with the process (Prochaska & Levesque, 2002). Motivational Interviewing (MI) techniques may be an ideal way for psychological practitioners to both assess and enhance motivation, readiness and engagement (Mann, Ginsberg, & Weekes, 2002).

As suggested by the current research and existing literature, recovery style may be an important aspect to assess when considering motivation and engagement in psychological interventions. However, there is conflicting evidence as to whether an integrative recovery style actually produces better outcomes (Jackson et al., 2001; Thompson et al., 2003). It has been argued that sealing-over can feel protective for some individuals (Tait, Birchwood, & Trower, 2004) and there is evidence suggesting that it can be associated with symptom reduction (Tait et al., 2003). It is therefore important for psychological practitioners to not only assess coping style, but also the function of the coping style, to ascertain in what ways the possible helpful aspects of it (e.g. avoiding being overwhelmed) may be gained in more adaptable ways (Gaudiano, & Busch, 2013).

In this study engagement and internal motivation was fostered through the use of recovery-focused practices, possibly as this aided the three basic needs of relatedness, competence and autonomy. Therefore to aid engagement and outcomes psychological practitioners are encouraged to adopt recovery principles in their therapeutic work. This being development of supportive equal relationships, with collaboration and a focus on goals that are person-specific and meaningful, to aid the individual in the development of a positive identity, valued living, hope for the future and autonomy and control. More important than any technique or model is working alongside the client listening to their preferences and working on their goals (Tilsen & Nylund, 2008). That said, there are approaches which emphasise collaboration and a client-centred position, which may be more likely to facilitate

engagement in forensic settings. For example, the Recovery Star to aid the identification of client-centred goals, support their autonomy and control in meeting these goals, and measure related outcomes (MacKeith, 2011). Acceptance and Commitment Therapy (ACT) could enable a focus on values and meaning rather than cure and symptom avoidance (Clarke, Oades, & Crowe, 2012). Solution Focused Therapy (SFT) could bring a focus on strengths, solutions and the capabilities of the person to empower and facilitate hope (Schott & Conyers, 2003).

The psychological practitioners alluded to in this study appear to already be using recovery principles and indeed they are now considered intrinsic to the psychologists' role (Professional Practice Board, 2008; Working Group on Psychological Health and Well-Being, 2009). Hence they are in a prime position to encourage its use in the wider forensic environment. This can be achieved by psychological practitioners attempting to instil core recovery values in others through general MDT working, supervision, reflective practice, training and involvement in service implementation (Drennan, Law, & Alred, 2012).

6.2.2 Furthering insight

Most of the engagement and outcome studies alluded to within this discussion did not utilise forensic samples. Given the lack of published psychological intervention outcome data from forensic services (Davies & Oldfield, 2009), one cannot make the assumption that any one type of motivation or form of engagement in psychological intervention is better than any other in forensic services, or that factors which appear to aid engagement with these individuals have any bearing on outcome. Quantitative research may be able to shed light on these issues by examining the relationship between types of motivation and level of engagement in psychological interventions within forensic settings; and the relationship

between level/type of engagement and any range of psychosocial outcomes. Keeping a recovery focus, indicators of quality of life such as employment, relationships, housing and attainment of personal goals set for treatment could be used as outcome measures (Slade, 2009). Within a forensic mental health setting, ward behaviour, frequency of hospitalisation and recidivism are also likely to be useful outcomes to assess (Friendship, Falshaw, & Beech, 2003).

6.3 Methodological considerations and recommendations

This study utilises a small homogenous sample of males with a psychotic disorder residing in medium security. Whilst this can be considered a limit to generalisability, IPA research is concerned with *"perspective rather than population"* and transferability (Smith et al., 2009, p. 49). Therefore it is hoped that the reader is able to apply the findings and their links to literature to their own setting and practice in a way that is helpful to them. Having said this, a number of important perspectives within forensic mental health are missing from this study. Future qualitative research could explore forensic services user views of engagement in psychological interventions utilising female participants, participants with personality disorders in medium security, and those residing in low and high secure care.

A positive aspect of this study was that participants were not self-selected and chosen simply because they were actively engaged in psychological interventions. This appeared to enable a range of views to be gained apparently covering those individuals who were passively and actively engaged and some discussion about occasions when a participant has disengaged. Nevertheless, participants were all engaged in psychological interventions on some level, either currently undertaking or having completed an intervention. Future research could expand on this by recruiting participants for whom engagement in psychological

interventions has been more difficult and who repeatedly disengage. This may enable further exploration of the disengagement process in psychological interventions within medium security. In addition, future research could explore the views of individuals who have never attempted to engage in psychological interventions so to understand these barriers.

As previously mentioned, the findings of this study are influenced by the interviews themselves and the specific analysis undertaken by the researcher. Whilst this is not a criticism, as IPA does not search for truth but for meaning and recognises that all sense-making is done in current context (Larkin et al., 2006), efforts were taken to increase credibility. As highlighted, this was carried out through supervision and peer support and by providing verbatim quotes. However, as the researcher is also a person-in-context it is inevitable that conceptions affect interpretations. It may be helpful for future qualitative research in this area to be carried out by other professionals and individuals without prior forensic experience so to maximum curiosity and minimise bias.

Some participants had an apparent difficulty engaging with the researcher and/or the topic of discussion. Future research in this area may benefit from a bolder design in which participants are interviewed on more than one occasion (Smith et al., 2009). This may serve a number of purposes; it may aid the development of trust and rapport, thereby supporting participants to further open up about their experiences; and it allows additional time to explore the views of those individuals who may be less articulate or in tune with their internal world.

7.0 REFERENCES

Abbott, P. (2008). Another step towards understanding recovery? Invited commentary on self-determination theory. *Advances in Psychiatric Treatment*, 14(5), 366–368. doi:10.1192/apt.bp.107.005157

Adshead, G. (2003). Do you feel lucky? In G. Adshead & C. Brown (Eds.), *Ethical issues in forensic mental health research* (pp. 11–29). London: Jessica Kingsley Publishers.

Baker, A., & Hambridge, J. (2002). Motivational interviewing: Enhancing engagement in treatment for mental health problems. *Behaviour Change*, 19(03), 138–145. doi:10.1375/bech.19.3.138

Barker, R. (2012). Recovery and risk: Accepting the complexity. In G. Drennan & D. Alred (Eds.), *Secure recovery: Approaches to recovery in forensic mental health settings* (pp. 23–40). Oxon: Routledge.

Barrett, M. S., Chua, W. J., Crits-Christoph, P., Gibbons, M. B., Casiano, D., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy*, 45(2), 247–267. doi:10.1037/0033-3204.45.2.247

Bartlett, A., & Canvin, K. (2003). User views and ethical issues in qualitative methods. In G. Adshead & C. Brown (Eds.), *Ethical issues in forensic mental health research* (pp. 58–71). London: Jessica Kingsley Publishers.

Braehler, C., Gumley, A., Harper, J., Wallace, S., Norrie, J., & Gilbert, P. (2013). Exploring change processes in compassion focused therapy in psychosis: Results of a feasibility randomized controlled trial. *British Journal of Clinical Psychology*, 52(2), 199–214. doi:10.1111/bjc.12009

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology & Health*, 21(1), 87–108. doi:10.1080/14768320500230185

Castonguay, L. G., Constantino, M. J., & Holtforth, M. G. (2006). The working alliance: Where are we and where should we go? *Psychotherapy*, 43(3), 271–279. doi:http://dx.doi.org/10.1037/0033-3204.43.3.271

Castro, M., Cockerton, T., & Birke, S. (2002). From discharge to follow-up: A small-scale study of medium secure provision in the independent sector. *The British Journal of Forensic Practice*, 4(3), 31–39. doi:10.1108/14636646200200019

Clarke, S., Oades, L., & Crowe, T. (2012). Recovery in mental health: A movement towards well-being and meaning in contrast to an avoidance of symptoms. *Psychiatric Rehabilitation Journal*, 35(4), 297–304. doi:10.2975/35.4.2012.297.304

Constantino, M. J., Castonguay, L. G., Zack, S. E., & DeGeorge, J. (2010). Engagement in psychotherapy: Factors contributing to the facilitation, demise, and restoration of the therapeutic alliance. In D. Castro-Blanco & M. S. Karver (Eds.), *Elusive alliance: Treatment engagement strategies with high-risk adolescents* (pp. 21–57). Washington, USA: American Psychological Association.

Cooke, K., & Bailey, D. (2011). Women's experience of forensic mental health services: Implications for practice. *The Journal of Mental Health Training, Education and Practice*, 6(4), 186–194. doi:10.1108/17556221111194527

Davidson, L. (2008). *Recovery: Concepts and application*. Devon: Devon Recovery Group. Retrieved from http://www.centreformentalhealth.org.uk/pdfs/recovery_concepts.pdf

Davies, J., & Oldfield, K. (2009). Treatment need and provision in medium secure care. *The British Journal of Forensic Practice*, 11(2), 24–31. doi:10.1108/14636646200900013

Day, A., Casey, S., Ward, T., Howells, K., & Vess, J. (2013). *Transitions to better lives: Offender readiness and rehabilitation*. Devon: Willian Publishing

Deci, E. L., & Ryan, R. M. (2012). Self-determination theory. In P. A. M. V. Lange, A. W. Kruglanski, & E. T. Higgins (Eds.), *Handbook of theories of social psychology: Collection volumes 1 & 2* (pp. 416–437). London: SAGE.

Deegan, P. E. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, 19(3), 73. Retrieved from: http://www.apa.org/pubs/journals/prj/

DeJong, H., Broadbent, H., & Schmidt, U. (2012). A systematic review of dropout from treatment in outpatients with anorexia nervosa. *International Journal of Eating Disorders*, 45(5), 635–647. doi:10.1002/eat.20956

Department of Health. (2007). *Best practice guidance: Specification for adult medium-secure services.* London: Department of Health.

Department of Health. (2008). *Real involvement: Working with people to improve health services*. London: Department of Health.

Department of Health. (2011). *No health without mental health: A cross-government mental health outcomes strategy for people of all ages.* London: Department of Health.

Department of Health. (2013). *The NHS Constitution.* London: Department of Health.

DiClemente, C. C., Schlundt, D., & Gemmell, L. (2004). Readiness and stages of change in addiction treatment. *American Journal on Addictions*, 13(2), 103–119. doi:10.1080/10550490490435777

Drennan, G., Law, K., & Alred, D. (2012). Recovery in the forensic organisation. In G. Drennan & D. Alred (Eds.), *Secure recovery: Approaches to recovery in forensic mental health settings* (pp. 55–72). Oxon: Routledge.

Elliott, R. (2008). Research on client experiences of therapy: Introduction to the special section. *Psychotherapy Research*, 18(3), 239–242. doi:10.1080/10503300802074513

Fallon, P., Bluglass, R., Edwards, B., & Granville, D. (1999). *Ashworth special hospital: Report of the committee of inquiry.* (Report No 4194-ii). London: Committee of Inquiry.

Fassino, S., Pierò, A., Tomba, E., & Abbate-Daga, G. (2009). Factors associated with dropout from treatment for eating disorders: A comprehensive literature review. *BMC Psychiatry*, 9, 67. doi:10.1186/1471-244X-9-67

Faulkner, A., & Morris, B. (2003). *User involvement in forensic mental health research and development.* Liverpool: NHS National Programme on Forensic Mental Health Research and Development.

Flick, U. (2009). *An Introduction to Qualitative Research*. London: SAGE.

Friendship, C., Falshaw, L., & Beech, A. R. (2003). Measuring the real impact of accredited offending behaviour programmes. *Legal and Criminological Psychology*, 8(1), 115–127. doi:10.1348/135532503762871282

Garner, B. R., Knight, K., Flynn, P. M., Morey, J. T., & Simpson, D. D. (2007). Measuring offender attributes and engagement in treatment using the client evaluation of self and treatment. *Criminal Justice and Behavior*, 34(9), 1113–1130. doi:10.1177/0093854807304345

Gaudiano, B. A., & Busch, A. M. (2013). Engaging people with psychosis in acceptance and commitment therapy and mindfulness. In E. M. J. Morris, L. C. Johns, & J. E. Oliver (Eds.), *Acceptance and commitment therapy and mindfulness for psychosis* (pp. 76–94). West Sussex: Wiley-Blackwell.

Gavigan, C. A. (2001). *Motivation for substance abuse treatment: The relationship between stages of change, intrinsic and extrinsic motivation, and treatment attendance* (PhD thesis, Fordham University). Retrieved from http://search.proquest.com/docview/251729535/abstract?accountid=8630

Gavrilov-Jerković, V. (2007). Relation between stages of change and motivation in the treatment of psychiatric patients. *Psihologija*, 40(2), 245–262. doi:159.947.5.072:616.89-052

Gillespie, M., Smith, J., Meaden, A., Jones, C., & Wane, J. (2004). Clients' engagement with assertive outreach services: A comparison of client and staff perceptions of engagement and its impact on later engagement. *Journal of Mental Health*, 13(5), 439–452. doi:10.1080/09638230400006767

Greenfeld, D., Strauss, J., Bowers, M., & Mandelkern, M. (1989). Insight and interpretation of illness in recovery from psychosis. *Schizophrenia Bulletin*, 15(2), 245–252. Retrieved from http://www.proquest.com/

Hampton, A. S., Conner, B. T., Albert, D., Anglin, M. D., Urada, D., & Longshore, D. (2011). Pathways to treatment retention for individuals legally coerced to substance use treatment: The interaction of hope and treatment motivation. *Drug and Alcohol Dependence*, 118(2–3), 400–407. doi:10.1016/j.drugalcdep.2011.04.022

Hiller, M. L., Knight, K., Leukefeld, C., & Simpson, D. D. (2002). Motivation as a predictor of therapeutic engagement in mandated residential substance abuse treatment. *Criminal Justice and Behavior*, 29(1), 56–75. doi:10.1177/0093854802029001004

Hodge, J. E., & Renwick, S. J. (2003). Motivating mentally disordered offenders. In M. McMurran (Ed.), Motivating offenders to change: A guide to enhancing engagement in therapy (pp. 221–234). West Sussex: John Wiley & Sons.

Hodgetts, A., & Wright, J. (2007). Researching clients' experiences: A review of qualitative studies. *Clinical Psychology & Psychotherapy*, 14(3), 157–163. doi:10.1002/cpp.527

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

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology*, 61(4), 561–573. doi:10.1037/0022-006X.61.4.561

Howells, K., & Day, A. (2007). Readiness for treatment in high risk offenders with personality disorders. *Psychology, Crime & Law*, 13(1), 47–56. doi:10.1080/10683160600869767

Jackson, H., McGorry, P., Edwards, J., Hulbert, C., Henry, L., Francey, S., Maude, D., Cocks, J., Power, P., Harrigan, S., & Dudgeon, P. (1998). Cognitively-oriented psychotherapy for early psychosis (COPE): Preliminary results. *The British Journal of Psychiatry*, 172(Suppl 33), 93–100. doi:10.1016/S0920-9964(97)82652-7

Jackson, H., McGorry, P., Henry, L., Edwards, J., Hulbert, C., Harrigan, S., Dudgeon, P., Shona, F., Maude, D., Cocks, J., & Power, P. (2001). Cognitively oriented psychotherapy for early psychosis (COPE): A 1-year follow-up. *British Journal of Clinical Psychology*, 40(1), 57–70. doi:10.1348/014466501163481

Joe, G. W., Simpson, D., & Broome, K. M. (1998). Effects of readiness for drug abuse treatment on client retention and assessment of process. *Addiction*, 93(8), 1177–1190. doi:10.1046/j.1360-0443.1998.93811776.x

Kozar, C. J., & Day, A. (2012). The therapeutic alliance in offending behavior programs: A necessary and sufficient condition for change? *Aggression and Violent Behavior*, 17(5), 482–487. doi:10.1016/j.avb.2012.07.004

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

Long, C. G., Banyard, E., Fox, E., Somers, J., Poynter, D., & Chapman, R. (2012). Barriers to treatment: Reasons for non-attendance in women's secure settings. *Advances in Dual Diagnosis*, 5(4), 154–163. doi:10.1108/17570971211281657

Long, C. G., Dolley, O., & Hollin, C. R. (2011). Women in medium secure care: Tracking treatment progress for changes in risk profiles and treatment engagement. *Journal of Psychiatric and Mental Health Nursing*, 18(5), 425–431. doi:10.1111/j.1365-2850.2010.01678.x

MacKeith, J. (2011). The development of the outcomes star: A participatory approach to assessment and outcome measurement. *Housing Care and Support*, 14(3), 98–106. doi:10.1108/14608791111199778

Macran, S., Ross, H., Hardy, G. E., & Shapiro, D. A. (1999). The importance of considering clients' perspectives in psychotherapy research. *Journal of Mental Health*, 8(4), 325–337. doi:10.1080/09638239917256

Maden, A., Scott, F., Burnett, R., Lewis, G. H., & Skapinakis, P. (2004). Offending in psychiatric patients after discharge from medium secure units: Prospective national cohort study. *BMJ*, 328(7455), 1534. doi:10.1136/bmj.38075.467569.EE

Mancini, A. D. (2008). Self-determination theory: A framework for the recovery paradigm. *Advances in Psychiatric Treatment*, 14(5), 358–365. doi:10.1192/apt.bp.107.004036

Mann, R. E., Ginsberg, J. I. D., & Weekes, J. R. (2002). Motivational interviewing with offenders. In M. McMurran (Ed.), *Motivating offenders to change: A guide to enhancing engagement in therapy* (pp. 87–102). West Sussex: John Wiley & Sons.

McCarthy, L., & Duggan, C. (2010). Engagement in a medium secure personality disorder service: A comparative study of psychological functioning and offending outcomes. *Criminal Behaviour and Mental Health*, 20(2), 112–128. doi:10.1002/cbm.758

McGlashan, T., Levy, S., & Carpenter, W. (1975). Integration and sealing over: Clinically distinct recovery styles from schizophrenia. *Archives of General Psychiatry*, 32(10), 1269–1272. doi:10.1001/archpsyc.1975.01760280067006

Mclnnis, E., Sellwood, W., & Jones, C. (2006). A cognitive behavioural group based educational programme for psychotic symptoms in a low secure setting: A pilot evaluation. *The British Journal of Forensic Practice*, 8(3), 36–46. doi:10.1108/14636646200600018

McMurran, M. (2002). Motivation to change: selection criterion or treatment need? In M. McMurran (Ed.), *Motivating offenders to change: A guide to enhancing engagement in therapy* (pp. 3–14). West Sussex: John Wiley & Sons.

McMurran, M., & Ward, T. (2010). Treatment readiness, treatment engagement and behaviour change. *Criminal Behaviour and Mental Health*, 20(2), 75–85. doi:10.1002/cbm.762

Moore, E., Lumbard, D., Carthy, J., & Ayres, J. (2012). Giving voice to recovery: Perspectives from within a high secure hospital. In G. Drennan & D. Alred (Eds.), *Secure recovery: Approaches to recovery in forensic mental health settings* (pp. 73–87). Oxon: Routledge.

National Public Health Service for Wales. (2006). *Needs assessment on medium secure units for mentally disordered offenders.* Wales: National Public Health Service for Wales.

National Survivor User Network, & WISH. (2011). *Unlocking service user involvement practice in forensic settings*. London: National survivor user network and WISH.

NHS England. (2013). *NHS Standard contract for medium and low secure mental health services (adults).* London: NHS England.

O'Brien, A., Fahmy, R., & Singh, S. P. (2009). Disengagement from mental health services. *Social Psychiatry and Psychiatric Epidemiology*, 44(7), 558–568. doi:10.1007/s00127-008-0476-0

Osbaldiston, R., & Sheldon, K. M. (2003). Promoting internalized motivation for environmentally responsible behavior: A prospective study of environmental goals. *Journal of Environmental Psychology*, 23(4), 349–357. doi:10.1016/S0272-4944(03)00035-5

Perkins, R. E., & Goddard, K. L. (2005). Involving service users and their relatives. In A. J. B. James, A. Worrall, & T. Kendall (Eds.), *Clinical governance in mental health and learning disability services: A practical guide* (pp. 131–148). London: Royal College of Psychiatrists.

Polaschek, D. L. L., & Ross, E. C. (2010). Do early therapeutic alliance, motivation, and stages of change predict therapy change for high-risk, psychopathic violent prisoners? *Criminal Behaviour and Mental Health*, 20(2), 100–111. doi:10.1002/cbm.759

Prochaska, J. O., & Levesque, D. A. (2002). Enhancing motivation of offenders at each stage of change and phase of therapy. In M. McMurran (Ed.), *Motivating Offenders to Change: A Guide to Enhancing Engagement in Therapy*. West Sussex: John Wiley & Sons.

Professional Practice Board. (2008). *Socially inclusive practice*. Leicester: The British Psychological Society.

Quality Network for Medium Secure Units. (2007). *Standards for medium secure units.* London: College centre for quality improvement and Royal College of Psychiatrists.

Roberts, G., & Wolfson, P. (2006). New directions in rehabilitation: Learning from the recovery movement. In G. Roberts (Ed.), *Enabling recovery: the principles and practice of rehabilitation psychiatry* (pp. 18–38). London: Royal College of Psychiatrists.

Rosen, P. J., Hiller, M. L., Webster, J. M., Staton, M., & Leukefeld, C. (2004). Treatment motivation and therapeutic engagement in prison-based substance use treatment. *Journal of Psychoactive Drugs*, 36(3), 387–396. doi:10.1080/02791072.2004.10400038

Ross, E. C. (2008). Investigating the relationship between the therapeutic alliance and treatment outcome in violent offender treatment. (PhD thesis, Victoria University). Retrieved from http://researcharchive.vuw.ac.nz/handle/10063/1085

Rutherford, M., & Duggan, S. (2007). *Forensic mental health services*. London: Sainsbury Centre for Mental Health.

Ryan, R. M., & Deci, E. L. (2000). Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist*, 55(1), 68. doi:10.1037110003-066X.55.1.68

Ryan, R. M., & Deci, E. L. (2008). A self-determination theory approach to psychotherapy: The motivational basis for effective change. *Canadian Psychology*, 49(3), 186–193. doi:10.1037/a0012753

Ryan, R. M., Plant, R. W., & O'Malley, S. (1995). Initial motivations for alcohol treatment: Relations with patient characteristics, treatment involvement, and dropout. *Addictive Behaviors*, 20(3), 279–297. doi:10.1016/0306-4603(94)00072-7

Ryder, D. (1999). Deciding to change: Enhancing client motivation to change behaviour. *Behaviour change*, 16(03), 165–174. doi:10.1375/bech.16.3.165

Sainsbury, L., Krishnan, G., & Evans, C. (2004). Motivating factors for male forensic patients with personality disorder. *Criminal Behaviour and Mental Health*, 14(1), 29–38. doi:10.1002/cbm.558

Schott, S., & Conyers, L. (2003). A solution-focused approach to psychiatric rehabilitation. *Psychiatric Rehabilitation Journal*, 27(1), 43–50. doi:10.2975/27.2003.43.50

Sheldon, K., & Harding, E. (2010). *Good practice guidelines to support the involvement of service users and carers in clinical psychology services.* Leicester: The British Psychological Society.

Shepherd, G., Boardman, J., & Slade, M. (2008). *Making recovery a reality.* London: Sainsbury Centre for Mental Health London.

Simpson, D. D., Joe, G. W., Rowan-Szal, G., & Greener, J. (1995). Client engagement and change during drug abuse treatment. *Journal of Substance Abuse*, 7(1), 117–134. doi:10.1016/0899-3289(95)90309-7

Slade, M. (2009). *100 ways to support recovery: A guide for mental health professionals.* London: Rethink

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: SAGE.

Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53–80). London: SAGE.

Staring, A. B., Mulder, C. L., van der Gaag, M., Selten, J.-P., Loonen, A. J., & Hengeveld, M. W. (2006). Understanding and improving treatment adherence in patients with psychotic disorders: A review and a proposed intervention. *Current Psychiatry Reviews*, 2(4), 487–494. doi:10.2174/157340006778699738

Startup, M., Wilding, N., & Startup, S. (2006). Patient treatment adherence in cognitive behaviour therapy for acute psychosis: The role of recovery style and working alliance. *Behavioural and Cognitive Psychotherapy*, 34(02), 191–199. doi:10.1017/S1352465805002535

Staton-Tindall, M., Garner, B. R., Morey, J. T., Leukefeld, C., Krietemeyer, J., Saum, C. A., & Oser, C. B. (2007). Gender differences in treatment engagement among a sample of incarcerated substance abusers. *Criminal Justice and Behavior*, 34(9), 1143–1156. doi:10.1177/0093854807304347

Tait, L., Birchwood, M., & Trower, P. (2003). Predicting engagement with services for psychosis: Insight, symptoms and recovery style. *The British Journal of Psychiatry*, 182(2), 123–128. doi:10.1192/bjp.02.252

Tait, L., Birchwood, M., & Trower, P. (2004). Adapting to the challenge of psychosis: Personal resilience and the use of sealing-over (avoidant) coping strategies. *The British Journal of Psychiatry*, 185(5), 410–415. doi:10.1192/bjp.185.5.410

Tetley, A., Jinks, M., Huband, N., & Howells, K. (2011). A systematic review of measures of therapeutic engagement in psychosocial and psychological treatment. *Journal of Clinical Psychology*, 67(9), 927–941. doi:10.1002/jclp.20811

Tetley, A., Jinks, M., Huband, N., Howells, K., & McMurran, M. (2012). Barriers to and facilitators of treatment engagement for clients with personality disorder: A Delphi survey. *Personality and Mental Health*, 6(2), 97–110. doi:10.1002/pmh.1176

Thompson, K. N., McGorry, P. D., & Harrigan, S. M. (2003). Recovery style and outcome in first-episode psychosis. *Schizophrenia Research*, 62(1–2), 31–36. doi:10.1016/S0920-9964(02)00428-0

Thompson, L., & McCabe, R. (2012). The effect of clinician-patient alliance and communication on treatment adherence in mental health care: A systematic review. *BMC Psychiatry*, 12(1), 87. doi:10.1186/1471-244X-12-87.

Tilsen, J., & Nylund, D. (2008). Psychotherapy research, the recovery movement and practice-based evidence in psychiatric rehabilitation. *Journal of Social Work in Disability & Rehabilitation*, 7(3-4), 340–354. doi:10.1080/15367100802487663

Velpry, L. (2008). The patient's view: Issues of theory and practice. *Culture, Medicine and Psychiatry*, 32(2), 238–258. doi:10.1007/s11013-008-9086-2

Wensing, M., & Elwyn, G. (2003). Methods for incorporating patients' views in health care. *BMJ*, 326(7394), 877–879. doi:10.1136/bmj.326.7394.877

Wild, T. C., Cunningham, J. A., & Ryan, R. M. (2006). Social pressure, coercion, and client engagement at treatment entry: A self-determination theory perspective. *Addictive Behaviors*, 31(10), 1858–1872. doi:10.1016/j.addbeh.2006.01.002

Wilkinson, C. E. (2008). An exploration of service users' experiences of a low secure forensic mental health service. . (PhD thesis, University of Leeds). Retrieved from http://etheses.whiterose.ac.uk/428/

Working Group on Psychological Health and Well-Being. (2009). *Psychological health and well-being: A new ethos for mental health.* Leicester: The British Psychological Society.

Yakeley, J., & Wood, H. (2011). Patients' experiences of forensic psychotherapy. *Psychoanalytic Psychotherapy*, 25(1), 105–114. doi:10.1080/02668734.2010.519160

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health*, 15(2), 215–228. doi:10.1080/08870440008400302

Zeldman, A., Ryan, R. M., & Fiscella, K. (2004). Motivation, autonomy support, and entity beliefs: Their role in methadone maintenance treatment. *Journal of Social and Clinical Psychology*, 23(5), 675–696. doi:10.1521/jscp.23.5.675.50744

PUBLIC DOMAIN BRIEFING PAPER

PSYCHOTHERAPY IN FORENSIC SERVICES

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1 SYSTEMATIC REVIEW

Dialectical Behaviour Therapy as applied in forensic services

Background

Dialectical Behaviour Therapy (DBT) was developed as a treatment approach for individuals with a history of self-harming/suicidal behaviours, and with a diagnosis of Borderline Personality Disorder (BPD; Linehan, 1993). There has been interest in the application of DBT in forensic services given the prevalence of BPD and suicidal behaviours within these settings, and the possible links between emotional dysregulation and offending behaviour (Berzins & Trestman, 2004).

Aims

This review aimed to explore the nature and quality of research into the uses and effectiveness of comprehensive DBT, and DBT skills training, for forensic populations. Specifically, to explore the presenting issues that DBT has been used to treat and its effectiveness at producing meaningful behavioural change particularly in offending behaviour.

Methodology

A systematic electronic search for studies utilising DBT or DBT skills training with a forensic sample was carried out using *PsycInfo, Scopus,* and *Web of Knowledge* databases. Reference lists of relevant retrieved papers were also examined.

Results

After application of exclusion criteria, a total of thirteen papers were reviewed. The interventions targeted a range of psychosocial variables related to; emotions; personality; self-evaluation; psychopathology; coping strategies; self-harm/suicide; risk; and offending behaviour, including institutional rule-breaking. They were broadly categorised into studies that specifically targeted individuals with Borderline Personality Disorder (BPD) in the criminal justice system, and studies that targeted the general offender population. Quality was assessed using the Effective Public Health Practice Project (EPHPP) assessment tool (Thomas, 1998).

Conclusions

There was a lack of consistency with regard to outcomes assessed, measures used, and programme protocols. When similar outcomes were assessed there were no consistent positive findings (i.e. studies assessing the same outcome finding the same result), for any emotional, psychological, cognitive, interpersonal, or behavioural variables for individuals with or without BPD in the criminal justice system. In addition, all studies had sufficient methodological limitations to warrant a weak quality rating. As a result it is not possible to determine whether DBT is effective at treating difficulties experienced by individuals in the criminal justice system and/or producing meaningful change in relation to offending behaviour.

Future research would benefit from larger sample sizes, randomisation to matched control groups, control of confounding variables, and adequate follow-up periods. Future research would also benefit from consensus and consistency in terms of outcomes assessed and

measures used, meaningful direction of change, and programme protocols, so that treatments and treatment effects could be compared and a more robust set of findings established.

References

Berzins, L. G., & Trestman, R. L. (2004). The Development and Implementation of Dialectical Behavior Therapy in Forensic Settings. *International Journal of Forensic Mental Health,* 3(1), 93–103. doi:10.1080/14999013.2004.10471199

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York: Guilford Press.

Thomas, H. (1998). *Quality assessment tool for quantitative studies*. Toronto, Canada: Effective Public Health Practice Project, McMaster University.

II EMPIRICAL PAPER

Engagement in psychological interventions within medium security - A service user perspective

Background

There is growing research exploring service user views of psychological interventions (Elliott, 2008; Hodgetts & Wright, 2007), yet there are still many underrepresented individuals, such as those residing in forensic settings (Sheldon & Harding, 2010). Gaining such service user feedback may help psychological practitioners to understand and improve one of the fundamental difficulties encountered in a forensic mental health setting, namely poor treatment engagement (Day, Casey, Ward, Howells, & Vess, 2013; Hodge & Renwick, 2003). Whilst existing literature indicates that motivation, readiness, and therapeutic alliance are important for engagement in forensic settings (Hiller, Knight, Leukefeld, & Simpson, 2002; Kozar & Day, 2012; McMurran & Ward, 2010; Polaschek & Ross, 2010), there are no studies that explore in-depth engagement in psychological interventions with service users.

Aim

The aim of the research was to explore service user experiences and understandings of their engagement in psychological interventions within medium secure settings.

Methodology

National and local ethical approval was gained from the NHS. Eligible service users were identified by their care teams, following provision of information about the study. After service users were given information about the study by a member of their team, they were

offered a further information session with the researcher. Thirteen service users were approached and six participated: two experienced a relapse and therefore were not eligible to take part, and five declined to participate. All participants were males diagnosed with a psychotic illness and all provided informed consent. Interviews were conducted with participants on their residential ward and were transcribed onsite. Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) was used to develop the interview schedule, and to analyse and interpret interview content.

Results

Two themes were selected from the data, which represent how the researcher understood service users sense-making in relation to their engagement in psychological interventions within medium security.

A game of two halves

This theme represents a narrative and seemingly experiential difference between participants in terms of their motivations and level of engagement in psychological interventions. It could be considered that participants are involved in the same game on the same pitch, in that they are all detained in a forensic service and participating in psychological interventions. In one half of this game, participants are shooting for a goal of physical freedom through hospital discharge and these individuals appear to have a passive state of play in psychological interventions, whereby psychological work is not retained or applied to self. In the other half of the game, participants are shooting for a goal of recovery and these individuals appear to have an active state of play in psychological interventions, whereby psychological work is engaged with, applied to self and retained. Some participants' stories suggested that

participating in a psychological intervention resulted in a shift in mind-set that enabled them to change sides; they went from purely shooting for the goal of freedom to one of recovery, which in turn appeared to result in a more active state of play within the intervention.

If you build it they will come

This theme reflects how participants can receive multiple gains that are created by the psychological environment, which they understand as the reason for their continued engagement. These gains include being treated as a person before a patient, gaining hope through the development of understanding about self, and gaining control of the intervention and of their recovery through collaboration. This theme also represents an apparent mechanism of change, whereby motivations and levels of engagement are enhanced when the psychological practitioner builds this environment of gains.

Conclusions

Results may support existing literature highlighting links between type of motivation and level of engagement, with internal motivations, such as desire to change, appearing to result in better engagement than external motivation, such as coercion (Hiller et al., 2002; Rosen, Hiller, Webster, Staton, & Leukefeld, 2004). It therefore seems pertinent for psychological practitioners to understand motivation, so that methods and approaches can be tailored to the individual's current stance and level of readiness, with the view to enhance their internal motivation and engagement with the process (Prochaska & Levesque, 2002).

Results may also support existing literature highlighting links between recovery style in psychosis and engagement. Individuals adopting an 'integrative' style appear to better engage

with psychological interventions than individuals adopting a 'sealing over' recovery style (Jackson et al., 2001; Startup, Jackson, & Startup, 2006), as appeared to be the case for participants in this study whose comments may suggest that they could be classified according to these styles. However, sealing-over can at times be a protective factor (Tait, Birchwood, & Trower, 2003), therefore it is important for psychological practitioners to assess the function of the recovery style, to ascertain in what ways the possible helpful aspects of it, e.g. avoiding being overwhelmed, may be gained in other ways (Gaudiano & Busch, 2013).

Results support the use of recovery-orientated principles in forensic settings. When psychological practitioners treated participants as people before patients or clients, facilitated understanding of self, health, and identity, and collaborated with them, in line with recovery practices (Deegan, 1996), they felt like human beings and, gained hope and control. In turn this appeared to facilitate internal motivation and greater engagement. As well as ensuring to integrate this into own practice, psychological practitioners could work towards instilling core recovery values within teams and services.

A number of important perspectives within forensic mental health are missing from this study which future qualitative research could explore, including, female service users, individuals with personality disorder, those residing in low and high secure care, individuals for whom engagement in psychological interventions has been more difficult and who repeatedly disengage, and individuals who have never attempted to engage in psychological interventions, so as to better understand potential barriers.

Given the lack of published outcome data in forensic services (Davies & Oldfield, 2009), one cannot make the assumption that any one type of motivation or form of engagement in psychological intervention is better than any other in forensic services, or that factors which appear to aid engagement with these individuals have any bearing on outcome. Quantitative research could examine the relationship between types of motivation and level of engagement in psychological interventions within forensic settings; and the relationship between level/type of engagement and any range of psychosocial outcomes.

References

Davies, J., & Oldfield, K. (2009). Treatment need and provision in medium secure care. *The British Journal of Forensic Practice,* 11(2), 24–31. doi:10.1108/14636646200900013

Day, A., Casey, S., Ward, T., Howells, K., & Vess, J. (2013). *Transitions to better lives: Offender readiness and rehabilitation.* Devon: Willian Publishing.

Deegan, P. E. (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal*, 19(3), 73. Retrieved from: http://www.apa.org/pubs/journals/prj/

Elliott, R. (2008). Research on client experiences of therapy: Introduction to the special section. *Psychotherapy Research,* 18(3), 239–242. doi:10.1080/10503300802074513

Gaudiano, B. A., & Busch, A. M. (2013). Engaging people with psychosis in acceptance and commitment therapy and mindfulness. In E. M. J. Morris, L. C. Johns, & J. E. Oliver (Eds.), *Acceptance and commitment therapy and mindfulness for psychosis* (pp. 76–94). West Sussex: Wiley-Blackwell.

Hiller, M. L., Knight, K., Leukefeld, C., & Simpson, D. D. (2002). Motivation as a predictor of therapeutic engagement in mandated residential substance abuse treatment. *Criminal Justice and Behavior*, 29(1), 56–75. doi:10.1177/0093854802029001004

Hodge, J. E., & Renwick, S. J. (2003). Motivating mentally disordered offenders. In M. McMurran (Ed.), *Motivating offenders to change: A guide to enhancing engagement in therapy* (pp. 221–234). West Sussex: John Wiley & Sons.

Hodgetts, A., & Wright, J. (2007). Researching clients' experiences: A review of qualitative studies. *Clinical Psychology & Psychotherapy*, 14(3), 157–163. doi:10.1002/cpp.527

Jackson, H., McGorry, P., Henry, L., Edwards, J., Hulbert, C., Harrigan, S., Dudgeon, P., Shona, F., Maude, D., Cocks, J., & Power, P. (2001). Cognitively oriented psychotherapy for early psychosis (COPE): A 1-year follow-up. *British Journal of Clinical Psychology*, 40(1), 57–70. doi:10.1348/014466501163481

Kozar, C. J., & Day, A. (2012). The therapeutic alliance in offending behavior programs: A necessary and sufficient condition for change? *Aggression and Violent Behavior*, 17(5), 482–487. doi:10.1016/j.avb.2012.07.004

McMurran, M., & Ward, T. (2010). Treatment readiness, treatment engagement and behaviour change. *Criminal Behaviour and Mental Health*, 20(2), 75–85. doi:10.1002/cbm.762

Polaschek, D. L. L., & Ross, E. C. (2010). Do early therapeutic alliance, motivation, and stages of change predict therapy change for high-risk, psychopathic violent prisoners? *Criminal Behaviour and Mental Health*, 20(2), 100–111. doi:10.1002/cbm.759

Prochaska, J. O., & Levesque, D. A. (2002). Enhancing motivation of offenders at each stage of change and phase of therapy. In M. McMurran (Ed.), *Motivating Offenders to Change: A Guide to Enhancing Engagement in Therapy.* West Sussex: John Wiley & Sons.

Rosen, P. J., Hiller, M. L., Webster, J. M., Staton, M., & Leukefeld, C. (2004). Treatment motivation and therapeutic engagement in prison-based substance use treatment.

Journal of Psychoactive Drugs, 36(3), 387–396. doi:10.1080/02791072.2004.10400038

Sheldon, K., & Harding, E. (2010). *Good practice guidelines to support the involvement of service users and carers in clinical psychology services*. Leicester: The British Psychological Society.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* London: SAGE.

Startup, M., Wilding, N., & Startup, S. (2006). Patient treatment adherence in cognitive behaviour therapy for acute psychosis: The role of recovery style and working alliance. *Behavioural and Cognitive Psychotherapy*, 34(02), 191–199. doi:10.1017/S1352465805002535

Tait, L., Birchwood, M., & Trower, P. (2003). Predicting engagement with services for psychosis: Insight, symptoms and recovery style. *The British Journal of Psychiatry*, 182(2), 123–128. doi:10.1192/bjp.02.252

APPENDICES

SYSTEMATIC REVIEW

A systematic review of Dialectical Behaviour Therapy as applied in forensic services

Appendix 1: Database search process

Search engine	Search fields	Search terms and strategy	Results
PsycInfo 1806 to January Week 1 2014	Relevant subject headings (exp). All other terms were searched using the following available fields: abstract, heading word, key concepts, subject heading and title.	1. exp Dialectical Behavior Therapy OR DBT 2. exp Correctional Institutions OR exp Prisons OR exp Maximum Security Facilities OR exp Incarceration OR exp Reformatories OR secur* adj2 (unit or service* or facilit* or hospital* or institut*) OR "young offender* institut*" OR penitentiar* OR YOI OR HMPS OR detention adj2 (cent* or camp* or institut* or facilit*) OR correction* adj2 (cent* or camp* or institut* or facilit* or establishment or service*) 3. exp Mentally Ill Offenders OR exp Juvenile Delinquency OR exp Female Delinquency OR exp Male Delinquency OR exp Female Criminals OR exp Criminals OR exp Male Criminals OR exp Perpetrators OR offender* OR exp Prisoners OR inmate* 4. exp Crime OR exp Criminal Behavior OR exp Criminal Rehabilitation OR offend* adj2 behav* 5. forensic* 6. 2 OR 3 OR 4 OR 5 7. 1 AND 6	Total: 55 Exclusions from abstracts: • Repeated in search: 1 • Non empirical paper: 27 • Non forensic sample: 7 Full-text review: 20 Further exclusions: • Missing DBT module: 2 • No outcome data: 2 • Combined therapies: 3 Eligible: 13 Excluded as duplication: 3 Total for inclusion: 10
SCOPUS All years to present	All terms were searched using the following available fields: article, abstract, title and keyword.	1. "dialectic* behavi*r therap*" OR DBT 2. prison* OR incarcerat* OR reformator* OR "young offender* institut*" OR penitentiar* OR YOI OR HMPS OR detention W/2 (cent* OR camp* OR institut* OR facilit*) OR correction* W/2 (cent* OR camp* OR institut* OR facilit* OR establishment OR service*) OR secur* W/2 (unit OR service* OR facilit* OR hospital* OR institut*) 3. offender* OR delinquen* OR criminal* OR perpetrator* OR inmate*	Total: 53 Exclusions from abstracts: • Repeated within search or in another search engine: 23 • Non empirical paper: 18 • Non forensic sample: 2

		4. crime* OR offend* W/2 behav* 5. forensic* 6. 2 OR 3 OR 4 OR 5 7. 1 AND 6	• Non DBT: 3 • Unrelated to topic: 5 Full-text review: 2 Further exclusions: • Missing DBT module: 1 • Combined therapies: 1 Eligible: 0
Web of Knowledge All years	All terms were searched using the following available fields: title and topic.	1. "dialectic* behavi*r therap*" OR DBT 2. prison* OR incarcerat* OR reformator* OR "young offender* institut*" OR penitentiar* OR YOI OR HMPS OR detention NEAR/2 (cent* OR camp* OR institut* OR facilit*) OR correction* NEAR/2 (cent* OR camp* OR institut* OR facilit* OR establishment OR service*) OR secur* NEAR/2 (unit OR service* OR facilit* OR hospital* OR institut*) 3. offender* OR delinquen* OR criminal* OR perpetrator* OR inmate* 4. crime* OR offend* NEAR/2 behav* 5. forensic* 6. 2 OR 3 OR 4 OR 5 7. 1 AND 6	Total: 40 Exclusions from abstracts: • Repeated within search or in another search engine: 23 • Non empirical paper: 8 • Non DBT: 8 • Unrelated to topic: 1 Full-text review: 0
N.B. Other articles were obtained through searching of references.			

Appendix 2: EPHPP quality assessment tool

Quality component	How the component is rated	Overall section rating
Selection bias	Are the individuals selected to participate in the study likely to be representative of the target population? 1. Very likely 2. Somewhat likely 3. Not likely 4. Can't tell What percentage of selected individuals agreed to participate? 1. 80 - 100% agreement 2. 60 – 79% agreement 3. less than 60% agreement 4. Not applicable 5. Can't tell	1 Strong: The selected individuals are very likely to be representative of the target population (Q1 is 1) and there is greater than 80% participation (Q2 is 1). 2 Moderate: The selected individuals are at least somewhat likely to be representative of the target population (Q1 is 1 or 2); and there is 60 - 79% participation (Q2 is 2). Moderate may also be assigned if Q1 is 1 or 2 and Q2 is 5 (can't tell). 3 Weak: The selected individuals are not likely to be representative of the target population (Q1 is 3); or there is less than 60% participation (Q2 is 3) or selection is not described (Q1 is 4); and the level of participation is not described (Q2 is 5).
Study design	Indicate the study design: 1. Randomized controlled trial 2. Controlled clinical trial 3. Cohort analytic (two group pre + post) 4. Case-control 5. Cohort (one group pre + post (before and after)) 6. Interrupted time series 7. Other specify _____ 8. Can't tell	1 Strong: will be assigned to those articles that described RCTs and CCTs. 2 Moderate: will be assigned to those that described a cohort analytic study, a case control study, a cohort design, or an interrupted time series. 3 Weak: will be assigned to those that used any other method or did not state the method used.

	Was the study described as randomized? 1. Yes 2. No If Yes, was the method of randomization described? 1. Yes 2. No If Yes, was the method appropriate? 1. Yes 2. No	
Confounders	Were there important differences between groups prior to the intervention? OR were participants exposed to anything else that could have affected the dependent variable? 1. Yes 2. No 3. Can't tell The following are examples of confounders: 1. Race 2. Sex 3. Marital status/family 4. Age 5. SES (income or class) 6. Education 7. Health status 8. Pre-intervention score on outcome measure 9. Concurrent interventions 10. Significant events occurring after baseline measures	1 Strong: will be assigned to those articles that controlled for at least 80% of relevant confounders (Q1 is 2); or (Q2 is 1). 2 Moderate: will be given to those studies that controlled for 60 – 79% of relevant confounders (Q1 is 1) and (Q2 is 2). 3 Weak: will be assigned when less than 60% of relevant confounders were controlled (Q1 is 1) and (Q2 is 3) or control of confounders was not described (Q1 is 3) and (Q2 is 4).

	If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g. stratification, matching) or analysis)? 1. 80 – 100% 2. 60 – 79% 3. Less than 60% 4. Can't Tell	
Blinding	Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants? 1. Yes 2. No 3. Can't tell Were the study participants aware of the research question? 1. Yes 2. No 3. Can't tell	1 Strong: The outcome assessor is not aware of the intervention status of participants (Q1 is 2); and the study participants are not aware of the research question (Q2 is 2). 2 Moderate: The outcome assessor is not aware of the intervention status of participants (Q1 is 2); or the study participants are not aware of the research question (Q2 is 2); or blinding is not described (Q1 is 3 and Q2 is 3). 3 Weak: The outcome assessor is aware of the intervention status of participants (Q1 is 1); and the study participants are aware of the research question (Q2 is 1).
Data collection methods	Were data collection tools shown to be valid? 1. Yes 2. No 3. Can't tell Were data collection tools shown to be reliable? 1. Yes 2. No 3. Can't tell	1 Strong: The data collection tools have been shown to be valid (Q1 is 1); and the data collection tools have been shown to be reliable (Q2 is 1). 2 Moderate: The data collection tools have been shown to be valid (Q1 is 1); and the data collection tools have not been shown to be reliable (Q2 is 2) or reliability is not described (Q2 is 3). 3 Weak: The data collection tools have not been shown to

		be valid (Q1 is 2) or both reliability and validity are not described (Q1 is 3 and Q2 is 3).
Withdrawals and drop-outs	Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group? 1. Yes 2. No 3. Can't tell Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest). 1. 80 -100% 2. 60 - 79% 3. less than 60% 4. Can't tell	1 Strong: will be assigned when the follow-up rate is 80% or greater (Q2 is 1). 2 Moderate: will be assigned when the follow-up rate is 60 – 79% (Q2 is 2) OR Q2 is 5 (N/A). 3 Weak: will be assigned when a follow-up rate is less than 60% (Q2 is 3) or if the withdrawals and drop-outs were not described (Q2 is 4).

Overall rating	**Overall rating definition**
1 Strong	Four strong ratings with no weak ratings
2 Moderate	Less than four strong ratings and one weak rating
3 Weak	Two or more weak ratings

Appendix 3: Assessment of study quality using EPHPP tool

Journal Article	Selection bias	Study design	Confounders	Blinding	Data collection methods	Withdrawals and drop-outs	Overall rating
Low, et al., (2001)							
Rating	3	2	3	2	1	2	3: Weak
Justification for score	Generalisability is limited by the use of only one facility, a small number of total referrals, and no analysis of difference between participants and non-participants.	Before and after study.	Concurrent treatments were not controlled for.	Blinding is not described.	Collection methods are valid and reliable.	60-79% completion.	Two weak ratings.

Nee & Farman, (2008)							
Rating	2	2	3	2	3	3	3: Weak
Justification for score	Recruited from three prisons. However, generalisability is somewhat limited by lack of information about percentage of individuals who agreed to participate and no analysis of difference between participants and non-participants.	Non-randomised controlled study. Before and after study.	No assessment of differences between groups, and concurrent interventions were not controlled for.	Blinding is not described.	Authors and/or references were not provided for some questionnaires, which were less well-known or have multiple versions; therefore validity and reliability could not be ascertained.	Less than 60% completion.	More than two weak ratings.

Evershed et al., (2003)							
Rating	3	2	3	3	3	3	3: Weak
Justification for score	Generalisability is limited by the use of only one facility, lack of information about percentage of individuals who agreed to participate in the control group, and no analysis of difference between participants and non-participants.	Non-randomised controlled study.	Important differences between groups, e.g. initial violence severity scores and personality variables, and concurrent interventions, were not controlled for.	Assessor only blinded for one outcome.	BDHI-D only validated in the Dutch population.	Not described for the control group.	More than two weak ratings.

Gee & Reed, (2013)							
Rating	3	2	3	2	3	3	3: Weak
Justification for score	Generalisability is limited by the use of only one facility, lack of information about percentage of individuals who agreed to participate, and no analysis of difference between participants and non-participants.	Before and after study.	Concurrent treatments were not controlled for.	Blinding is not described.	Validity and reliability of the Matrix Evidence Evaluation Questionnaire could not be ascertained. Authors reported difficulties gathering information from NOMS records, indicating lack of reliability with this data collection method.	Less than 60% completion.	More than two weak ratings.

Eccleston & Sorbello (2002)							
Rating	3	2	3	2	1	3	3: Weak
Justification for score	Generalisability is limited by the use of only one facility, lack of information about percentage of individuals who agreed to participate, and no analysis of difference between participants and non-participants.	Before and after study.	No consideration of confounding variables is presented, therefore it is assumed that none were assessed or controlled for, e.g. concurrent treatments.	Blinding is not described.	Collection methods are valid and reliable.	No information about withdrawals/ drop-outs is provided.	More than two weak ratings.

McCann & Ball, (1996)							
Rating	3	2	3	2	3	1	3: Weak
Justification for score	Generalisability is limited by the use of only one facility, lack of information about percentage of individuals who agreed to participate, and no analysis of difference between participants and non-participants.	Control group is utilised but this remains a before and after study as statistical difference between groups was not assessed.	Important differences between groups, e.g. pre-intervention scores on some outcome measures, were not controlled for.	Blinding is not described.	Authors and/or references were not provided for some questionnaires, which were less well-known or have multiple versions; therefore validity and reliability could not be ascertained. The CCS is an eating disorders questionnaire and is validated for this use only.	80-100% completion.	More than two weak ratings.

Barnoski, (2002)							
Rating	3	2	2	2	3	3	3: Weak
Justification for score	Generalisability is limited by the use of only one facility, lack of information about percentage of individuals who agreed to participate, and no analysis of difference between participants and non-participants.	Non-randomised controlled study.	Differences between groups in terms of important variables, such as gender, ethnicity and risk, were controlled for. However, some important factors that were identified and controlled for in the follow-up (below) were missed in this study highlighting its limitation.	Blinding is not described.	There was insufficient information about how recidivism data was obtained and participants were only followed-up for one year.	No information about withdrawals/ drop-outs from treatment is provided.	More than two weak ratings.

Drake & Barnoski, (2006)							
Rating	3	2	1	2	2	3	3: Weak
Justification for score	Generalisability limited by; use of only one facility; lack of information about percentage of individuals who agreed to participate; and no analysis of difference between participants and non-participants.	Non-randomised controlled study.	Differences between groups in terms of gender, ethnicity, risk, age, length of stay and criminal history were controlled for.	Blinding is not described.	Insufficient information about how recidivism data was obtained, but participants were followed-up for three years.	No information about withdrawals/ drop-outs from treatment is provided.	Two weak ratings.

Rosenfeld et al., (2007)							
Rating	2	2	3	2	3	3	3: Weak
Justification for score	Recruited from probation services across two New York boroughs. However, generalisability is somewhat limited less than 80% agreement and no analysis of difference between participants and non-participants.	Non-randomised controlled trial. Before and after study.	Differences between groups were not analysed, yet the authors highlighted that differences were likely.	Blinding is not described.	Insufficient information about how recidivism data was obtained and participants were followed up for anywhere between 2-21 months.	Less than 60% completion.	More than two weak ratings.

Blanchette et al., (2011) **Rating** **Justification for score**	2 Recruited from four facilities. However, generalisability is somewhat limited by lack of information about percentage of individuals who agreed to participate and no analysis of difference between participants and non-participants.	2 Before and after study.	3 No consideration of confounding variables is presented, therefore it is assumed that none were assessed or controlled for. In addition, the duplication study indicates that another intervention (psychosocial rehabilitation) was also concurrent on the wards in the service.	2 Blinding is not described.	3 Validity and reliability of the IFS could not be ascertained. The authors found weak internal consistency for WAYS. They also questioned the reliability of their revocation data.	3 No information about withdrawals/ drop-outs from treatment is provided.	3: Weak More than two weak ratings.

Pein et al., (2012)							
Rating	3	2	3	2	1	3	3: Weak
Justification for score	Generalisability limited by; use of only one facility; lack of information about percentage of individuals who agreed to participate; and no analysis of difference between participants and non-participants.	Control group is utilised but this remains a before and after study as statistical difference between groups was not assessed.	Important difference between groups (personality disorder) was not controlled for.	Blinding is not described.	Collection methods are valid and reliable.	No information about withdrawals/ drop-outs is provided.	More than two weak ratings.

Trupin et al., (2002)							
Rating	3	2	3	2	3	3	3: Weak
Justification for score	Generalisability limited by; use of only one facility; lack of information about percentage of individuals who agreed to participate; and no analysis of difference between participants and non-participants.	Control group is utilised but only for risk therefore this is primarily a before and after study and becomes a non-randomised controlled study in relation to risk.	Concurrent treatments were not controlled for.	Blinding is not described.	Validity and reliability of the CRA could not be ascertained. Authors suggest that ward based reports of behaviour were not reliable.	No information about withdrawals/ drop-outs is provided.	More than two weak ratings.

Shelton et al., (2009)							
Rating	3	2/1	3	2	1	3	3:Weak
Justification for score	Recruited from three facilities, however, generalisability is limited as only one facility for each age range and gender was utilised. Also, lack of information about percentage of individuals who agreed to participate and no analysis of difference between participants and non-participants.	Before and after study for the first part of the investigation. Controlled clinical trial.	Differences between groups in terms of important variables, such as pre-intervention scores, were controlled for. However, less than 60% of other demographic information collected was analysed or controlled for, such as offence classification and ethnicity.	Blinding is not described.	Collection methods are valid and reliable.	Less than 60% completion.	More than two weak ratings.

Shelton et al., (2011)							
Rating	3	2	3	2	1	2	3: Weak
Justification for score	Generalisability limited by; use of only one facility; lack of information about percentage of individuals who agreed to participate; and no analysis of difference between participants and non-participants.	Before and after study.	No consideration of confounding variables is presented, therefore it is assumed that none were assessed or controlled for.	Blinding is not described.	Collection methods are valid and reliable.	60-79% completion.	Two weak ratings.

Appendix 4: Instructions for authors

REMOVED.

EMPIRICAL PAPER

Engagement in psychological interventions within medium security:

A service user perspective

Appendix 1: NHS REC ethical approval letter

REMOVED

REMOVED

REMOVED

REMOVED

Appendix 2: R&D ethical approval letter

REMOVED

REMOVED

Appendix 3: Email correspondence confirming site specific ethical approvals

REMOVED

Appendix 4: Study information sheet for clinical teams

STUDY INFORMATION SHEET FOR CLINICAL TEAMS (MDT)

Title of the study:
Engagement with psychological therapy in medium security: A service user perspective.

Researchers:
Charlotte Etchells (Principal) and Richard Bennett (Secondary)

What is the purpose of the study?
Good engagement is crucial for success in psychological therapy, however, service users who are detained in secure services often have difficulties fully engaging with therapy and other aspects of their treatment. Little is known about service user perceptions of the engagement process, particularly detained service users. We are interested in knowing what therapists and clients do that aids and hinders engagement in therapy. Feedback will be given to psychologists and other interested service providers to aid clinical practice.

What will happen in the study?
Eligible service users will be approached by a nurse/assistant psychologist who works on the ward and provided with further information about the study. If a service user agrees to participate, the principal researcher will meet with them at a convenient time on the ward to conduct an interview that will last up to an hour. They will first be asked to sign a consent form. Participants will be asked questions about engaging in psychological therapy in the MSU. A second interview may be arranged if necessary. Please read the 'participant information sheet' provided for more specific details.

Who can take part?
Service users who meet the following criteria are eligible to take part:

- Currently residing on a rehabilitation ward on a permanent basis
- Have attended an individual or group programme of psychological therapy with an assistant, trainee or qualified psychologist in the MSU in the last year
- Are not awaiting trial
- Are not transferred prisoners
- Are able to work on a one to one basis with a female interviewer
- Can speak English

Service users with active acute relapse who are not settled in mood and mental state cannot participate in this study. However, service users with minor residual symptoms who are in the recovery process and are settled in mood can participate, as long as the team do not feel that their mental health would be adversely affected or the safety of either participant or researcher would be jeopardised.

What does the team have to do?
It would be helpful if as a team you could identify those service users who meet the above criteria and the team psychologist will inform the principal researcher who has been selected. The Responsible Clinician (RC) for each service user will be required to

sign a consent form stating that the service user can be approached about participation. Some consent forms have been provided if the RC is present during these discussions and can provide consent immediately.

If you require any further information please contact the principal researcher, Charlotte Etchells, via (*personal details removed*).

Your help will enable us to give a voice to service users and gain valuable information about how psychologists can work effectively to engage service users and improve outcomes. Your help is therefore greatly appreciated. Thank you for taking time to read this sheet.

Appendix 5: Participant study information leaflet

PARTICIPANT INFORMATION SHEET

Title of the study:
Engagement with psychological therapy in medium security: A service user perspective.

Researchers:
Charlotte Etchells (Principal) and Richard Bennett (Secondary)

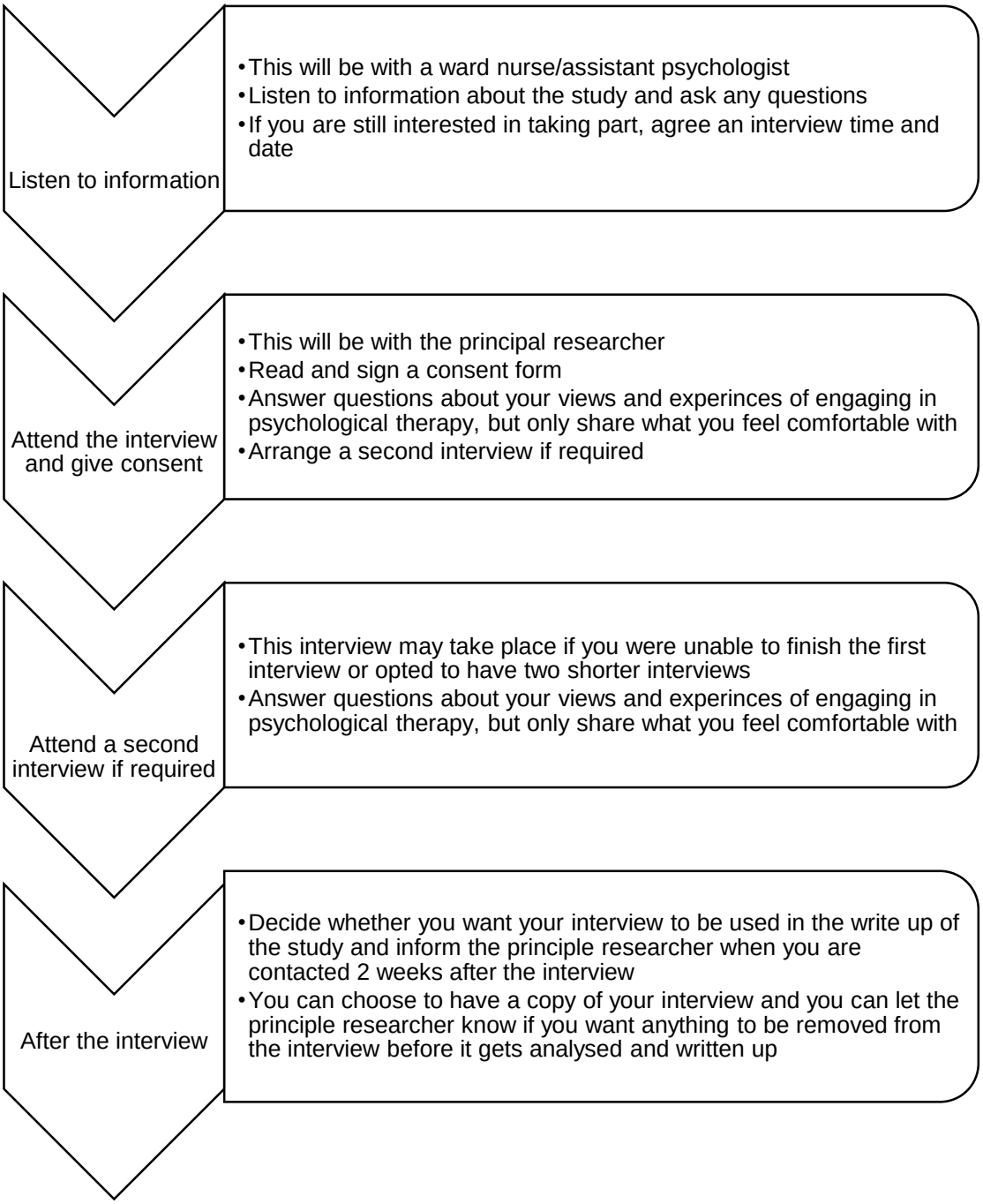
Invitation to participate:
You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

What is the purpose of the study?
We are interested in knowing what helps or stops people engaging in psychological therapy whilst living in secure services. This information is valuable to psychologists because it can help them to make changes to the way they work so that people can feel more able to engage and get the most out of therapy. This study is a student research project.

Why have I been chosen?
You have been invited to take part in this study because you have worked with a psychologist in the last year; therefore you have valuable opinions about engaging in psychological therapy. Your opinions can help psychologists to improve the service they offer so it is of more benefit to others.

Do I have to take part?
No. It is up to you to decide whether or not to take part. You are also free to withdraw during an interview and up to two weeks after you have participated. You can also choose for all or part of your interview not to be used after it has been written up. If you choose to withdraw, information that you have provided will be destroyed. A decision not to take part, or to withdraw, will not affect your care.

What exactly will I have to do?



Will it be confidential?
Yes. When handling, processing, storing and destroying any information that you provide, the researchers will follow procedures set out by the Data Protection Act 1998. Interviews will be audio-recorded on a password protected recording device to make sure that none of your comments are missed. The recordings will be stored on the principle researcher's password-protected computer under a substitute name, not your real name. No one other than the principal researcher will hear the audio recording of your interview. The principal researcher will transcribe (type out) your interview on the computer using the substitute name and will remove other information which may identify you, such as the name of your location and any names of people you talk about in the interview. The secondary researcher (Richard Bennett) may see the typed interview with your substitute name. The principal researcher may also take a copy of your typed interview, with the substitute name, to a checking group held at the University of Birmingham. This is a small group of research students who will help the principal researcher make sure that they have interpreted your interview correctly. No one else will see a copy of your written interview. No members of staff will be told what you have said in the interview.

Extracts from your interview which include direct quotes that you have made may be used in the write up of the study and members of the public may be able to access the write up of the study. However, only your substitute name and not your real name will be used, all other identifiable information such as the hospital you reside in will also be changed and any quotes that appear to identify you will not be used. If you are concerned that some of the things that you have said may identify you, you are able to withdraw this part of the data or ask that it not be used in the final write up. You can request a written copy of your interview to help you decide if you want all or part of the interview to be removed from the analysis.

The principal researcher has a duty of care to report back to the nurses in charge after any interview to give them an opinion about your mood during the interview. However, no member of staff will be told what you have said in the interview, your comments are confidential.

There are exceptions to the rule of confidentiality:

- If you give the interviewer any information about crimes which you have committed or are planning to commit, this will be discussed with nurses in charge and your clinical team. The interview may need to be terminated for this discussion to take place. The police may become involved and the audio-recording may need to be used as evidence in a court of law.
- If you tell the interviewer anything that suggests that you or any other individual is going to come to harm in any way, this will be discussed with nurses in charge and your clinical team. The interview may need to be terminated for this discussion to take place.

Expenses and payments:
You will not receive any expenses, payments or rewards for participating in this study. Your comments will not be shared with staff or members of your clinical team therefore the nature and quality of care you receive will not be affected in any way by your participation.

Are there things that might stop me from taking part?
At the current time your clinical team has decided that you are eligible to take part in this study, however, you may find that your situation changes and you are no longer eligible. Things that will stop you from participating are:

- If you are not able to understand information about this study even after you have discussed it with the principal researcher and asked questions
- If you move hospitals or are discharged from the hospital
- If you are moved to an acute or ICU ward
- If your mood or mental health changes to the point where it is deemed unsafe or not in your best interests to participate by your clinical team or the nurses in charge on the day of the interview

It may be that these changes are temporary and you can still participate at a later date, but if these changes are more permanent you will no longer be able to participate. This will be discussed with you by the principal researcher and/or a member of your clinical team.

What are the possible disadvantages/risks of taking part?
There are no likely risks to taking part in this study; however, it is possible that you have had some difficulties when engaging in psychological therapy which are hard for you to talk about. You should therefore only share what you feel comfortable with and are encouraged not to discuss things which you think might affect your mood or mental health. If the interviewer feels that your mood or mental health have been affected by the interview, this will be feedback to the nurses in charge.

What are the possible benefits of taking part?
We cannot promise that this study will help you directly, but some people find it a positive experience that they have been given an opportunity to share their opinions about a service, which can then help to make a difference to that service. This study hopes to highlight common concerns and/or appreciations about engagement in psychological therapy so that we might help psychologists to change the way they work and improve the services they offer so they are of more benefit to people like you.

What happens when the research study stops?
The researchers will analyse all the interviews looking for common things that participants have said. Those common patterns will be used in the write up of the study and quotes from your interview may be used with a substitute name as examples of those common patterns. However, if you choose to read a copy of your interview and you do not want something you have said to be included in the final write up of the study, it will be removed and not used. A separate group of service users who have not been involved in the study will meet to discuss how the general findings might be used to help make changes in psychology practice. You will receive a written feedback sheet containing information about the general findings. The psychologists working in your service, and other staff members who are interested, will be invited to a presentation of the general findings. The write up of this study may be published in a journal which can be accessed by members of the public. The audio-recording of your interviews will be kept for no longer than 5 years on a password protected computer. The write up of your interviews will be kept for no longer than 10 years on the secondary researcher's password protected computer. Any paper documents will be securely locked in

the principal researcher's office for up to 1 year after completion of the research. After these time points all electronic and paper data will be destroyed.

What if there is a problem?
If you have a concern about any aspect of this study, you should ask to speak with the principle researcher, Charlotte Etchells, who will do her best to answer your questions. Nursing staff or a member of your clinical team can contact Charlotte who will arrange a meeting to discuss the concern with you. You can also contact PALS (the customer relations team) to gain advice and support. They are available Mondays to Fridays 8am to 8pm on Freephone 0800 953 0045, via email at pals@bsmhft.nhs.uk and by text on 07985 883 509. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure, details of which can be obtained from the hospital. PALS can help you with a formal complaints procedure.

In the unlikely event that you are harmed during the study there are no special compensation arrangements. If you are harmed and this is due to someone's negligence then you may have grounds for a legal action for compensation against The University of Birmingham, but you may have to pay your own legal costs. The normal NHS complaints mechanisms and PALS will still be available to you.

Who is organising and funding the research?
The University of Birmingham is sponsoring this study.

Who has reviewed the study?
This study was given a favourable ethical opinion for conduct in the NHS by Essex Research Ethics Committee.

Thank you for considering taking part and taking time to read this sheet. This information sheet is yours to keep.

Appendix 6: RC consent form

RESPONSIBLE CLINICIAN CONSENT FORM

Research site (circle): Omitted for anonymity

Study Title: Engagement with psychological therapy in medium security: A service user perspective.

Researcher: Charlotte Etchells

Service User:

Please initial boxes:

- I confirm that I have understood the information sheet dated 29.04.13 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I confirm that the above named service user meets the inclusion criteria provided in the team information leaflet at the time of signing this form. ☐
- I confirm that there is no reason at the time of signing this form that this service user should not be interviewed for the purpose of this study. ☐
- I agree that the above named service user's participation is voluntary and that they are free to withdraw at any time during the research interview, without giving any reason, without their care being affected. ☐
- I agree that the above named service users participation (or lack of) in the above study will not affect the care that they receive. ☐
- I understand that with the exception of risk, no part of the interview data will be made available to me or any other member of the NHS team responsible for the above named service user. ☐
- As the above named service user's Responsible Clinical, I agree for this service user to be approached for participation in the above study. ☐

.....	.....	.....
Name of Responsible Clinician	**Date**	**Signature**
.....	.....	.....
Name of researcher	**Date**	**Signature**

Appendix 7: Full interview schedule with prompts

Can you tell me about the reason you were asked to see a psychologist in the MSU?

- What can you tell me about your involvement in the decision to see a psychologist?
- What can you tell me about your role in selecting a psychologist?
- How did you feel about going to see a psychologist?
- What were your expectations?
- How did you find the process of being referred to a psychologist?

Can you tell me about the first meeting you had with the psychologist?

- What were your first thoughts?
- What was good about it?
- What was not so good?
- Can you tell me about any issues that it brought up for you?
- Can you tell me about anything anyone did which made this meeting easier for you? (psychologist/team/peers)
- Can you tell me about anything anyone did which made this meeting more difficult for you? (psychologist/team/peers)

What do you think helped your decision to see your psychologist regularly?

- Can you tell me about any personal reasons for making this decision? (Motivation/gain/benefit)
- Can you tell me about any external reasons for making this decision? (team/peers/status/compulsion/advice)
- Can you tell me about any aspects of the psychologist or the meetings you had with them that helped you make this decision? (personality/ interactional style/structure of sessions)

What can you say about the relationship between you and the psychologist?

- What was good about it?
- What was not so good about it?
- What was helpful?
- What was unhelpful?
- Can you tell me about any aspects of the relationship that you found particularly difficult/challenging?

Can you tell me about any times when it became too difficult or you felt like giving up?

- Can you tell me about the reasons for this? (internal/external/therapist)
- What helped you to overcome this? (internal/external/therapist)
- Was there anything that wasn't helpful?

Appendix 8: Participant consent form

PARTICIPANT CONSENT FORM

Research site (circle): Omitted for anonymity

Study Title: Engagement with psychological therapy in medium security: A service user perspective.

Researcher: Charlotte Etchells

Please initial boxes:

- I confirm that I have understood the information sheet dated 29.04.13 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand that my participation is voluntary and that I am free to withdraw at any time during the research interview, without giving any reason, without my care being affected. ☐
- I understand that my participation in the above study will not affect the care that I receive. ☐
- I understand that the research interview will be audio-recorded. ☐
- I understand that following the research interview the principal researcher has a duty of care to provide an opinion about my mood during the interview to the nurses in charge, but my comments during the interview will not be shared. See exception in point 8. ☐
- I understand that following the research interview I will have a two-week period for reflection. The researcher will then contact me at which point I may withdraw my interview entirely or in part, without giving any reason, without my care being affected. ☐
- I understand that I can request a written copy of my interview and that any information I do not wish to be analysed or used in the final write up of this study will be removed. ☐
- I understand that the data collected during this study, but not the interview itself, will be looked at by the secondary researcher and may be looked at by members of the University of Birmingham checking group, to ensure that the analysis is a fair and reasonable representation of the data. ☐

- I understand that parts of the data may also be made available to the NHS team responsible for me, but only if I disclose that I or someone else is at risk or disclose any information about my past, current or future involvement in a crime. Parts of the data may also be made available to the police if I disclose information about crimes. ☐

- I understand that direct quotes from my interview may be published in any write-up of the data, but that my name will not be attributed to any quotes and that I will not be identifiable by my comments. ☐

- I agree to take part in the above study. ☐

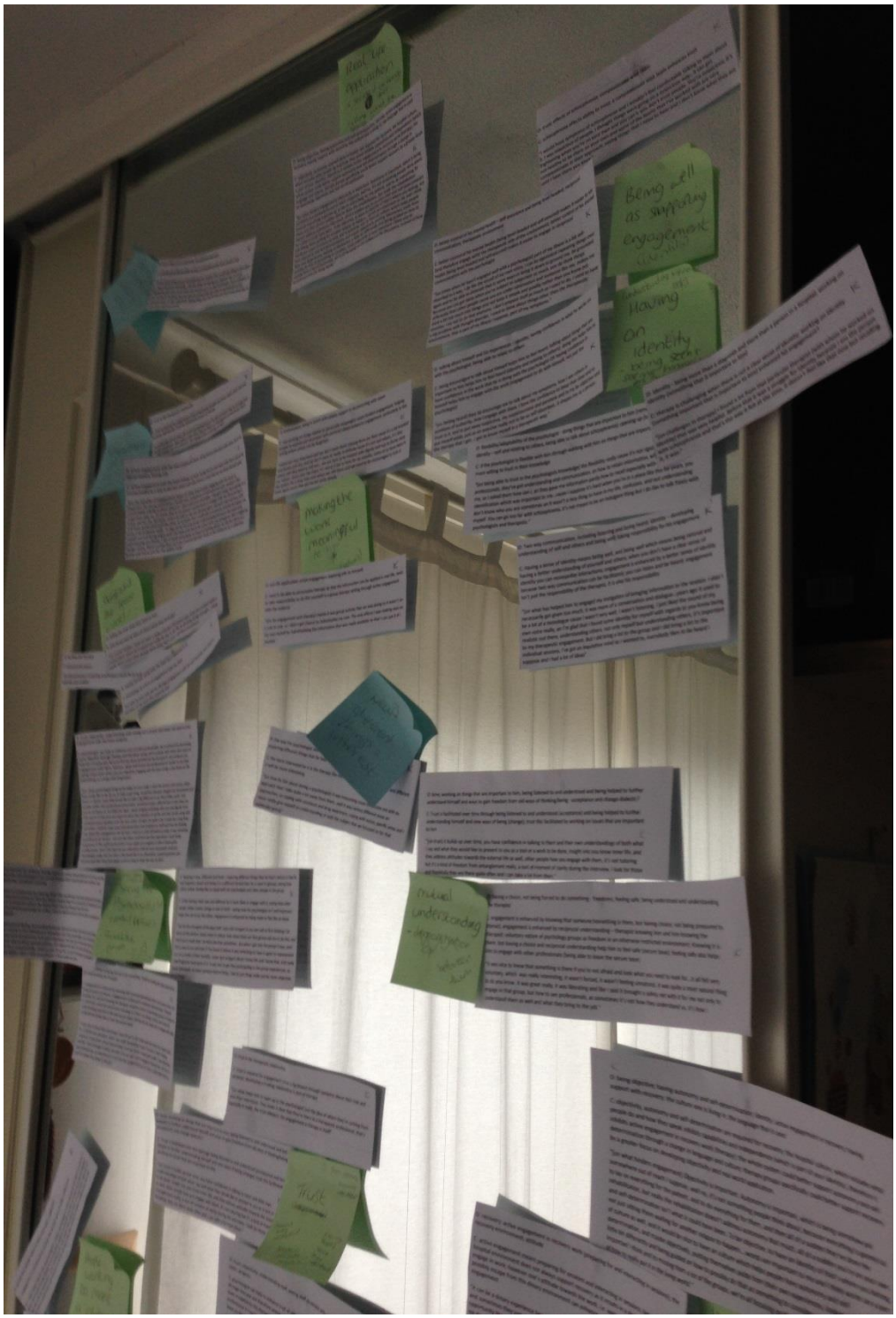
.....	.....	.....
Name of participant	**Date**	**Signature**
.....	.....	.....
Name of researcher	**Date**	**Signature**

Appendix 9: Initial noting stage

Descriptive comments (what they are talking about) ***Linguistic comments (how are they talking about it)*** **<u>Conceptual comments</u>**	**Kyle's interview**	**Objects of concern (what matters to them)** **Experiential claims (what does it mean)**
Talking about relapse prevention work and wrap – *speaks about this as a needing to be strong and long lasting – uses very twice, tough, durable* – <u>without the strong folder, what would happen?</u> - It contains lots of information (*relapse signature, prompts, unhelpful thinking, notes)* - <u>this is important to his recovery, engagement is for recovery?</u> - Views this work as a way to evidence to self and others that he is committed to his recovery – <u>is recovery possible without it Kyle? Why do others need to see this – believing/support?</u> - He speaks about active engagement with the work/materials. *His passion and use of words suggests this is of great importance to*	I: what did she say? P: she said I don't think you're the only one, and that's why they do things like the wrap group, they give you your own c-c-very very tough folder you know durable [mm], so you can write down all your issues [loud external bang], relapse signatures, an what work you've done and what you find helpful, prompt list, notes, eh [loud external bang] [inaudible], unhelpful thinking an an how to er. You can you can build up a a portfolio so that you and ev-other people have got confidence that you're serious about recovery [ok], not just owning it and putting it on the side and leaving it, but that's like this is your life type moment you know, you	O: recovery; active engagement in the work; retaining information for real life long-term application; having an extensive durable tangible representation of the work he has done; having control and support C: active engagement in therapy supports recovery; active engagement is doing and owning the work and relating it to your life in the long-term; recovery is made tangible by doing recovery focused therapeutic work and having physical materials related to this; doing this work and having the materials helps him to feel like he has personal control over his recovery and provides a safety net

him – he refers to this folder/work as his life – <u>recovery is a strong focus to the work, he engages for this?</u> He is acknowledging the long term commitment to working on his recovery and the evolving nature of self and recovery – *positive connotations of growth and development* - Needs to be tangible – <u>is the folder a tangible representation of recovery?</u> <u>The folder gives control and a safety net?</u>	know what I mean [yeah], you can you can I-I have it for years and I'm planning to do so just just for my own my own it's like for my own eh … well what can I, what would I call it, I don't know, my own erm ... my own a-attempts to find something material in the … [inaudible] that's just about think, you don't want something material, something that I can change and grow on and work on [mm] …	

Appendix 10: Photographic example of the process of establishing theme connections



Appendix 11: Super-ordinate and sub-ordinate themes for one participant

Super-ordinate themes **Sub-ordinate themes**	**Kyle's supporting quotes**
Engagement as process of recovery	
Acceptance of a difficulty	I had the habit of emotionally self-harming, not physically, just in my thought patterns and unhealthy thought patterns, and seeing people passing judgments and all them helpful patterns styles that I've learnt about recently. Emotions were emotive stuff, it's not really as important as it as it tricked me into thinking.
Desire to explore the difficulty	You can go too far with schizophrenia, it's not meant to be an indulgent thing but I do like to talk freely with psychologists and therapists and doctors in general about schizophrenia and identity.
Motivation to change	I felt strongly about what I wanted to see of it and what I wanted to give to my recovery.
Therapy seen as a mechanism of change	It's like load-shedding sometimes [by talking about problems during his psychological intervention]… it is to be grounded… I know I can find peace another day but just having that rest is important to gather, get your wits about you, and not be so much under pressure in your thinking. And therapy, that's what I think they bring, an opportunity to find some rest, and when you find some rest and slow down a bit, you got the opportunity to find real peace in your life and in some ways freedom. I know freedom doesn't start the day you walk through the door, it's much more than that, and so it's very valuable to listen as a group and as a hospital wide you know population to try and find freedom from whatever afflictions you've got…your outlook as well, what you're gonna do with your time when you are loose, so things that you learn day to day that make a difference for the future.
Active participation in therapy	They do things like the WRAP [Wellness Recovery Action Planning] group, they give you your own very very tough folder, you know durable, so you can write down all your issues, relapse signatures, an what work you've done and what you find helpful, prompt list, notes, unhelpful thinking. You can build up a portfolio so that you and other people have got confidence that you're serious about recovery, not just owning it and putting it on the side and leaving it, but this is your life type moment. You can have it for years and I'm planning to do so just for my own attempts to find something material, something that I can change and grow on and

	work on.
Looking towards maintenance for the future	I slip into unhealthy ways of doing things, not so much now, now that I've got that kind of information [about his unhelpful thinking patterns] I like to keep it [in his wrap folder] so that continues, that recovery, and it's a gift basically, not from the psychologist but when someone helps you find groundedness… it gives me hope for the future, for the community
Collaboration	
Gaining control in an otherwise repressive environment	Autonomy, self-determination, things like that that are important to me because I've had to struggle to keep hold of them in this sort of setting that's subjected to subjection and it's been difficult cause nothings really geared up to keep that close, everything's laid on for you, everything's given for you, but thankfully the psychology groups are quite flexible, they sort of pick up and go with the ideation and they try an give me some sort of clarity When this hasn't happened: I haven't always seen eye to eye with, because psychologists know everything about everything except to surrender…they've always got something to say, bit like me really, and I don't mean that now, I'm looking at it from the past…I'm always the subject
Working on things that matter	Before I did that specific work on identity [therapy was challenging]…I found a lot from that particular therapist [with whom he worked on identity] that was very helpful, but before that it was a struggle for identity because I am the person with schizophrenia and that's the way it felt at the time, it doesn't feel like that now but recalling it…[on overcoming those challenges in therapy] it wasn't the psychotherapist, it was obviously, but that doesn't change, but it was the focus on identity… I'm glad I found some identity for myself, it's important to my therapeutic engagement
Given a voice	I didn't necessarily get given too much, it was more of a conversation and dialogue… I did bring a lot to the group and I did bring a lot to the individual sessions. I've got an inquisitive mind so I wanted too, everybody likes to be heard I suppose and I had a lot of ideas
Nature of therapist	
Desire to make a difference	It's just the quality of the presentations that they give, it makes light of a hard job, takes a load off, makes you feel a bit light in the group, a bit lighter having attended…you can't measure it, it's

	something that a lot of people in that field bring to the job, it's their yearning to make difference in people's lives
Having a special ability	They don't have charisma they have substance, and something else comes in that I don't quite know what it is to replace charisma, its professional you know what I mean…no, it's not charisma no, it's something that I, its intuition, the feel of intuitively knowing how the groups going, and they use that implicitly and explicitly
Engagement as security	
Containment of thoughts	They brought the wellness to me, I didn't just stumble on it, they gave me the confidence that I lacked in looking to be well and wanting to be well and doing the work necessary to stay boundaried with my own particular delusion thought patterns and unhelpful thinking styles that I developed over the years. It did bring clarity, they brought some kind of shared ground, that safety was important to me. I had that place of safety, which I didn't always have in hospital, I was paranoid about everybody…but you have to leave it alone in those times, and it goes off and it curtails getting well and getting back into the community and getting on with your life. It it's well worth engaging in for that reason alone to feel safe."
Not being alone	To know that if I'm unwell I would chose to engage with the team brings a safety net for me, because I won't be left to my own devices again, because it got serious with self-harm issues and stuff like that, so to know that I could talk to someone around that gave me quite a bit of peace really.
Tangible coping strategy	They do things like the WRAP [Wellness Recovery Action Planning] group, they give you your own very very tough folder, you know durable, so you can write down all your issues, relapse signatures, an what work you've done and what you find helpful, prompt list, notes, unhelpful thinking. You can build up a portfolio so that you and other people have got confidence that you're serious about recovery, not just owning it and putting it on the side and leaving it, but this is your life type moment. You can have it for years and I'm planning to do so just for my own attempts to find something material, something that I can change and grow on and work on.

Appendix 12: Examples of supporting quotes for Theme 1

Theme 1: A game of two halves	
Cameron	
Shooting for freedom and passive state of play	"I didn't think that I really needed to [attend psychology sessions]… I suppose it was to get out and for my family…I kind of thought that it might help in that process…I suppose agreeing and accepting that fact that they [doctor] suggest it doesn't do me any harm" "At the start when there was, when you're not sure why or what you're going to be doing and you're not comfortable or that comfortable around that person, I suppose that's when you kind of feel as if you're not wanting to do it… it's hard to open up to somebody you don't really know and they're asking you you know questions that are not really too comfortable talking about really, so I mean obviously that was an issue at the start you know, it was a bit of frustration with the fact that I had to be there, why? really"
Changing sides and more active state of play	"…as the sessions went on I was more at ease and stuff I didn't really think about that as much…. it was still in my mind why was I there, but as the sessions was going on, I wasn't as frustrated being as they was explaining what I was gonna be doing in the sessions, they kind of painted the picture of what was gonna be happening, so that kind of made it a bit easier" "You kind of see what they [psychologist] are trying to do, you feel more open to answering the questions even though they might be difficult, but you can see that there's a point to it…if you can see why they're asking the questions and what they are trying to get out of you, you are more willing to answer the questions... they're just trying to help really, they're just trying to figure out what is happening and what I'm feeling and what and how can be done to help"

Shooting for recovery and active state of play	"I suppose the over the overall thing is getting better, it goes hand in hand I suppose, getting out and getting better…seeing the psychologist would help in that, getting out is a big thing but getting better is a big thing" "You're helping yourself to get better by sticking to the course and making a full effort I suppose, a proper effort to get through it and help yourself in that way" "[engagement is] being positive and being there, giving it your all really…being open I suppose to it and willing to just talk…being truthful about things and what's happening and what happens and being truthful about things, not deviating from the truth…it helps them understanding what is actually happening, if you're honest they can, there's more chance of them helping you figure out what is happening and what can be done"
Donald Shooting for freedom and passive state of play Changing sides and more active state of play	"I guess I need to see a psychologist here in the hospital in order to progress, in order to get some leaves, to have some progression…it's the doctor say, do this to get some leaves "I didn't see it as vital to see a psychologist, so it was a little bit weird, I wasn't talking too much at the beginning" "As time progressed, I became more open… [he became more open because] we talk about lots of things, discussed about the crime, being here and the past since I was a little child…she made me understand the serious of my crimes, in the beginning it [seriousness of crime] didn't matter to me too much, I thought it was something minor....I found this interesting, having a conversation about these things… I think in the future it will be different, I will think different about these things"

Appendix 13: Examples of supporting quotes for Theme 2

Theme 2: If you build it they will come	
Person before patient	Cameron "[psychologist was] quite kind…made you feel welcome, put you at ease, obviously because I was feeling a bit nervous, but they, they made me feel quite comfortable, so it helped….quite kind and smiled and kind of friendly…just put you at ease, with the way they spoke to you and just how they were towards you…they greeted me nicely, you know asked how I was, how my day was going, which you know automatically kind of helps the situation."
Impact of this on trust	"She was very like open with me in what we were doing so that put me at ease and I suppose if they're gonna be open with you, you know like you're opinions are important, it puts more trust, you trust them more if you think they're being honest with you and want to know what you think….not just springing anything on me really, there was no secrets really"
Treated as a friend	Warwick "She seemed chirpy, well jolly [that helps because] you can talk to her, it makes you feel like you're talking to a friend… [that helps because] you seem to pick things up a lot easier" Brian "We would have a little laugh [laugh] you know, so it's not just you know all so serious" "I can kind of like see her as a friend, she's just kind of like from where I'm from, it helps me relax a little…easier to talk"

Not being seen as a person before patient	<u>Roger</u> "She was bubbly, nice, as far as that counts… you get along a lot better personally" <u>Kyle</u> "I haven't always seen eye to eye with, because psychologists know everything about everything except to surrender…they've always got something to say, bit like me really, and I don't mean that now, I'm looking at it from the past…I'm always the subject"
Hope through understanding *Impact of the environment (other people) on hope*	<u>Donald</u> "…we talk about lots of things, discussed about the crime, being here and the past since I was a little child…she made me understand the serious of my crimes, in the beginning it [seriousness of crime] didn't matter to me too much, I thought it was something minor....I found this interesting, having a conversation about these things… I think in the future it will be different, I will think different about these things" <u>Kyle</u> "I'm not like everybody else, I slip into unhealthy ways of doing things, not so much now, now that I've got that kind of information [about his unhelpful thinking patterns] I like to keep it [in his wrap folder] so that continues, that recovery, and it's a gift basically, not from the psychologist but when someone helps you find groundedness… it gives me hope for the future, for the community" <u>Cameron</u> "The whole experience hasn't been as bad as I thought it would be, [he thought it would be bad at the start because] you get people [other patients] saying that it's not, that it doesn't work or it doesn't help you, from people who've done it as well, there's people that are sceptical about it if that's the right word, but yeah there's always gonna be that thought [that it might be bad] at the start of it."

	Brian "You hear about these things all the time, psychologist can help you, you hear it from everybody, you even see it on TV, the newspapers…[interrupts interviewer to say] and the doctor as well."
Control through collaboration	Cameron "Over time I became more involved in what we were doing, what we were gonna do…the fact that there was more involvement as time went by that was that as a good thing…because you're not being like told what's gonna happen, you've got like a bit of input to it, so you don't feel as though you're being told what to do and your contributing to what you're actually going to be doing, which is, which obviously makes you feel more involved…I suppose it motivates you more with it… more willing I suppose…if they're showing you that they want you to have more involvement, it makes you feel more important I suppose and you're not just there and they're talking at you, but they're actually talking with you and so it makes you more positive about the whole thing really." "The things that helped me is that they're not just talking at me, they're giving, asking me like my input and stuff which helps and they're showing that they can trust, they're kind of trusting me to see where were going, and so that helps a lot." Kyle "It all felt very voluntary which was really interesting, it wasn't forced, it wasn't feeling unnatural, it was quite a most natural thing to do you know, it was great really, it was liberating and like I said it brought a safety net with it for me not only engage in that group but how to see professionals and engage with them" "Before I did that specific work on identity [therapy was challenging]…I found a lot from that particular therapist [with whom he worked on identity] that was very helpful, but before that it was a struggle for identity because I am the person with schizophrenia and that's the way it felt at the time, it doesn't feel like that now but recalling it…[on overcoming those challenges in therapy] it wasn't the psychotherapist, it was obviously, but that doesn't change, but it was the focus on identity… I'm glad I found some identity for myself, it's important to my therapeutic engagement"

	"Autonomy, self-determination, things like that that are important to me because I've had to struggle to keep hold of them in this sort of setting that's subjected to subjection and it's been difficult cause nothings really geared up to keep that close, everything's laid on for you, everything's given for you, but thankfully the psychology groups are quite flexible, they sort of pick up and go with the ideation and they try an give me some sort of clarity" "I do let some things come as a given from them [psychologists] you know [because] of their flexibility really, cause it's not rigid, they're professionals, they've got understanding and communication, an how to retain information, which was important to me, so I asked them how can I, an they gave me information partly how to recall especially with ideas of identification which was important to me." <u>Roger</u> "I don't like it when they ask the same questions all the time…going on and on asking questions, the same but in different ways, like the way you are asking questions now…it's boring…it's a bit annoying…we're just going over the same things again and again, no point… I tell her, can we stop going over the same things…she doesn't mind, she listens, we do a different topic"
Lack of collaboration	<u>Roger</u> "They kept on changing psychologist, they kept on moving to different places and stuff like that, different hospitals… I've had three or four different ones… it was a bit hard, always someone different, someone new asking the same questions… felt like a bit of a wind up… I had to keep on starting again… I had to keep going through it all again, they was asking the same questions…I get a bit stressed… it's boring… what's the point, we just do the same things…[current psychologist is different because] this one has helped me a lot…about getting a better understanding." <u>Kyle</u> "I haven't always seen eye to eye with, because psychologists know everything about everything except to surrender…they've always got something to say, bit like me really, and I don't mean that now, I'm looking at it from the past…I'm always the subject."

	<u>Warwick</u> "When I was in [first MSU], I didn't like it so much, I found it personal, they were talking a lot about family and cause I'd fallen out with the family it used to get on my nerves… I didn't have the same respect for them because I'm pulled out the family, as far as I'm concerned I don't have a family."

Appendix 14: Instructions for authors

REMOVED