PROFESSIONAL DOCTORATES

Women sent away: The needs and experiences of women in prison and forensic inpatient services.

Galway, Roisin

Award date:
2021

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Bangor University

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The needs and experiences of women in prison and forensic inpatient services.

Róisín Galway

North Wales Clinical Psychology Programme

Submitted in partial fulfilment of the requirements for the degree of

Doctor of Clinical Psychology

June 2021

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Declaration

I hereby declare that this thesis is the results of my own investigations, except where otherwise stated. All other sources are acknowledged by bibliographic references. This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree unless, as agreed by the University, for approved dual awards.

Yr wyf drwy hyn yn datgan mai canlyniad fy ymchwil fy hun yw'r thesis hwn, ac eithrio lle nodir yn wahanol. Caiff ffynonellau eraill eu cydnabod gan droednodiadau yn rhoi cyfeiriadau eglur. Nid yw sylwedd y gwaith hwn wedi cael ei dderbyn o'r blaen ar gyfer unrhyw radd, ac nid yw'n cael ei gyflwyno ar yr un pryd mewn ymgeisiaeth am unrhyw radd oni bai ei fod, fel y cytunwyd gan y Brifysgol, am gymwysterau deuol cymeradwy.

Signed:

Date: 01/06/2021

Acknowledgements

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I cannot begin to express my thanks to my parents and grandparents, whose unconditional love and support has enabled me to pursue my vocation and overcome various obstacles along the way. To my partner and my closest friends, I am indebted

to you for your belief in me and emotional support throughout this journey. Without all of you, this would not have been possible.

And finally, I would like to extend my thanks to the women who chose to participate in my qualitative research. I hope that I did justice to you and your stories. This thesis would not have been possible without your courage, openness, and enthusiasm.

The decision to focus this thesis on the needs and experiences of women in prison and secure inpatient services was driven by my commitment to social justice, and my experiences of working with women in these services. I hope that this research can contribute to improving the lives of women in prison and forensic inpatient services, and I dedicate this research to each of them.

“If we can welcome these women back into our communities, their voices and their wisdom can help us realise a more compassionate system of justice. This will require a social acceptance of responsibility for the conditions of injustice that brought these women into conflict with the law. Mutual assumption of responsibility - by the women when they break the law and by society when it fails to care and protect – would represent a more just effort to repair the social contract.” (p. 141, O’Brien, 2001)

Women sent away: The needs and experiences of women in prison and forensic inpatient services.

Thesis Summary

This thesis focuses on the needs and experiences of women in prison and forensic inpatient services. The reasons why women enter and remain within these services are complex and varied however, one commonality is that they are deemed to pose risks to themselves and/or others. Whilst there are some similarities between women in prison and women in forensic inpatient services, they are two distinct populations.

Chapter one reviews the available literature evaluating the efficacy of offence-specific interventions in reducing recidivism in women who offend. Several existing reviews detail the available evidence for a broad range of interventions facilitated with women who offend, including psychological therapies and substance misuse programmes, focusing on health and risk outcomes. However, the current review is thought to be the first to focus exclusively on the efficacy of offence-specific interventions in reducing recidivism.

Chapter two explores the experience of women from North Wales residing in out-of-area secure inpatient services. Seven participants were interviewed about their experiences of being in services away from their area of origin and their journeys through the secure pathway. Using Interpretative Phenomenological Analysis methodology, the identified themes highlighted the challenges of being far from home for both participants and their families. Women shared the impact of difficult and distressing experiences in services on their wellbeing and beliefs about themselves. The final theme was one of hope and a desire to help other women in secure care. The research discusses the impact of distance on maintaining connections with

community teams, as important sources of support during women's admissions to secure services.

The third and final chapter explores how the findings of both the literature review and empirical paper can contribute to current theory and clinical practice, promoting women's recovery and rehabilitation.

Chapter one

Literature Review

The Efficacy of Offence-specific Interventions in reducing Risk and Recidivism in Women: A Systematic Review.

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Abstract

Almost a quarter of women released from prisons in England and Wales reoffend; this figure is three times higher for women serving less than 12-month sentences (Prison Reform Trust, 2019). Offender programmes used within prison, probation and forensic inpatient services aim to reduce an individual's risk of reoffending. Whilst offence-specific interventions are widely offered to men who offend, comparatively few are offered to women. The current systematic review aimed to evaluate the efficacy of offence-specific interventions in reducing women's recidivism. Overall, recidivism in programme completers was low (*m*=14.05%). However, the quality of studies included (*n*=7) was low, limiting the conclusions drawn. Several studies yielded met the inclusion criteria, with the exception of reporting recidivism outcomes. A second review was conducted incorporating these studies, broadening the outcomes of interest to include incidents of violence in hospital or prison, and self-report outcomes related to offending (*n*=10). Incidents reduced following programme completion however, self-report outcomes were mixed. The review highlighted a lack of evidence for the efficacy of offence-specific interventions facilitated with women and limited use of recidivism as an outcome measure within the literature, despite often being a key aim of the interventions.

Keywords: Female, prison, forensic, violence, gender-responsive, offender behaviour.

Introduction

Between 2000 and 2016, the global female prison population increased by 50%, compared with a 20% increase in the male prison population (Walmsley, 2017). In 2021, the UK Government announced plans to expand the female prison estate in England and Wales, against the recommendations of commissioned expert advice (Corston, 2007). Whilst the literature surrounding women who offend is growing, it is dwarfed by the literature discussing men.

A key determinant of incarceration rates is the level of recidivism, with first time offenders accounting for less than 8% of the prison population in England and Wales (Cuthbertson, 2017). While some risk factors for recidivism apply to both genders *e.g.,* substance use, others are gender-specific *e.g.,* men, but not women, with histories of juvenile offending are more likely to reoffend (Collins, 2010). Gendered pathways research focuses on factors unique to, or more prevalent in, women who offend. Research consistently highlights the disproportionate effect of victimisation, poverty, and employment issues on women's offending and recidivism (Heubner, DeJong & Cobbina, 2010). The relationships between these factors are complex and expose the impact of societal inequalities on women's journeys to, and through, the criminal justice system. Mental health and trauma are frequently identified as specific criminogenic factors in women (Hollin & Palmer, 2006). The UK Social Exclusion Unit report (2002) found that 70% of women in prison experience two or more mental health problems, 35 times higher than the general population. In Scotland, a survey of adverse childhood experiences (ACEs) within the prison population found that women were more likely to have experienced all categories of ACEs than men, particularly childhood sexual abuse (Scottish Prison Service, 2018).

Although post-prison reoffending rates are lower for women than men in England and Wales, those who do reoffend commit more crimes on average (House of Lords, 2019). Recidivism rates have fluctuated between 21-25% for women released from prison from 2006 to 2018 (Ministry of Justice, 2020). In analyses of US outcome data, almost half of women released from prison were reconvicted, the majority within two years (Heubner et al., 2010). The same review found no relationship between substance misuse treatment, or other programme completion, and recidivism. Women categorised as drug-dependent were three times more likely to reoffend, whereas women living with a partner were less likely (Huebner et al., 2010).

Recidivism research findings, primarily focusing on men, have been synthesised into the risk, need, responsivity principles of effective intervention (Latessa & Lowenkamp, 2006). Described and evaluated in detail elsewhere (e.g., Ward, Mesler & Yates, 2006), the principles emphasise that for interventions to be effective, they need to be appropriate to the level of risk, targeted towards criminogenic factors, and accessible. Research about women emphasises the need and responsivity principles, with the most widely evaluated interventions focusing on substance misuse, mental health, trauma, and coping skills. It appears that the risk principle is overlooked for women who offend, possibly because they generally present lower risk than men.

Many interventions offered to women who offend are adapted versions of widely used psychological therapies, including Dialectical Behaviour Therapy (DBT, e.g., Gee & Reed, 2013), mindfulness (e.g., Ferszt, Miller, Hickey, Maull & Crisp, 2015) and Cognitive Behaviour Therapy (CBT, e.g., Wolff, Frueh, Shi & Schumann, 2012). Tripodi, Bledsoe, Kim and Bender (2011) conducted a systematic review of interventions for women in US prisons, including studies targeting recidivism, psychological wellbeing, substance misuse, and parenting. Prison-based therapeutic

community programmes for substance misuse had the greatest impact on recidivism (Tripodi et al., 2011). CBT, group-based trauma therapy, and psychoeducation groups had positive impacts on depression (Sacks et al., 2008; Spiropoulos et al., 2005; Pomeroy et al., 1999), anxiety (Cole, Sarlund-Heinrich & Brown, 2007; Valentine & Smith, 2001; Pomeroy et al., 1999), and dissociative episodes (Bradley & Follingstad, 2003). Notably, none of the studies included in the review evaluated offence-specific programmes.

A rapid evidence assessment conducted by the UK National Offender Management Service concluded that numerous interventions have been found to reduce women's offending, including substance abuse treatment, gender-responsive CBT programmes, community opioid maintenance, and booster programmes intended to maintain treatment effects following release from prison (Stewart & Gobeil, 2015). However, the review highlights a paucity of research examining the efficacy of programmes in reducing violence in women who have offended.

Despite the emphasis on addressing wider criminogenic needs, women are also offered, or in some areas mandated to complete, programmes specifically addressing risk and offending behaviours. For the purpose of this review, the term offence-specific intervention is used to differentiate between interventions with an offence-focus (e.g., violence, arson) and other interventions offered to people who offend (e.g., DBT). The use of offence-specific interventions is dominant within men's services, while mental health and trauma interventions dominate in women's services. Many offence-specific interventions were designed to address male offending and critics argue that they are not appropriate for women (Joiner, 2011).

The current review synthesises evidence of the efficacy of offence-specific interventions in reducing recidivism in women, including gender-responsive treatments, as well as those designed for men.

Method

Pre-registration

The protocol was developed and registered with PROSPERO before commencing database searches, to provide transparency of methodological processes and prevent duplication of the review.

Inclusion criteria

The review focused on evaluations of interventions utilised with adult females in the criminal justice system, including community, prison and forensic hospital settings. The interventions of interest targeted offending behaviours, focused on reducing reoffending, facilitated with either individuals or groups. The primary outcome of interest was recidivism, including reconviction and cautions through breach of probation related to further offending. The review considered all research designs, and only included papers published between January 2000 and October 2020, written in English.

Exclusion criteria

Studies involving adult males only, or adolescents, were excluded. For studies involving male and female participants, the findings relating to recidivism had to be reported separately, allowing extraction of data relating to women. The review also excluded studies evaluating non-offence interventions, such as DBT or substance misuse programmes.

Search strategy

The search strategy was developed to include both published data and grey literature, including government publications. The search terms were: (‘female*’ OR 'women') AND ('adult*') AND (‘offen*’, OR ‘crim*’, OR ‘inmate*’, OR ‘convict*’, OR 'custod*', OR ‘incarcerate*’, OR 'detain*', OR ‘prison*’, OR ‘jail’, OR 'probat*') AND ('violen*', OR ‘fire set*’, OR ‘arson*’, OR 'aggress*') AND (‘intervention*’, OR ‘program*’, OR 'treatment', OR 'prevent*', OR 'pilot', OR 'study') AND (‘recidiv*’, OR 'reoffend*', OR 'evaluat*', OR 'efficac*). Wildcard operators were used to cover different word forms (e.g., ‘offend*’ for offender, offending and offenders) and different spellings of words (e.g., ‘program*’ for US and UK spelling). Databases were selected based on their subject areas and relevance to the review question: ASSIA, Cinahl Plus, Cochrane Library, Criminal Justice Database, National Criminal Justice Reference Service, PsycINFO and Social Science Premium Collection.

Study selection

Titles and abstracts of identified articles were screened against the inclusion criteria. Duplicates were noted and removed. Full texts of potentially relevant articles were screened in a second stage. Articles citing or cited by articles meeting criteria in the second stage were also considered, based on their title and abstract. A bespoke screening and selection tool (Appendix 1) was utilised to screen the full-text articles against the inclusion criteria. Ten percent of full-text papers, including articles included and excluded by the first author, were independently screened by the second author. Agreement was 100%.

Data extraction

The data was extracted by the first author, using a bespoke data extraction table, including:

Descriptive:

- Study design.
- Where and when the study was conducted.
- Inclusion and exclusion criteria.
- Sample size, demographics.
- Intervention(s).
- Outcome measures.

Analytical:

- Recidivism outcomes.
- Attrition data.

The data extraction table was piloted on three articles by the first and third author. Any amendments to the data extraction table were made at this stage, before extracting data from all papers identified for inclusion in the review.

Missing data

In articles where data were missing or unclear *e.g.,* data relating to female participants not reported separately, the corresponding author was contacted. If no response was received, a further email was sent two weeks after the first email and a final email was sent one week later. If there was no response, the study was excluded from the review.

Assessment of methodological quality

Articles were assessed for methodological quality utilising the Joanna Briggs Institute critical appraisal checklists for quasi-experimental studies (Joanna Briggs Institute, 2016a; Appendix 2) and Randomised Control Trials (RCTs, Joanna Briggs Institute, 2016b; Appendix 3). The checklists consist of statements about research design and procedures, which are marked as ‘yes’, ‘no’, ‘unclear’ or ‘not applicable’. Quality assessment was undertaken by the first author, with 20% independently reviewed by the third author. Any disagreements were resolved by consensus.

Results

Search results

Electronic database and hand searches of reference lists identified 10,683 citations (Figure 1). Following the removal of duplicates, the titles, and abstracts of 8,174 citations were screened for inclusion, and 100 full-text articles were screened for eligibility. On initial review, seven papers met all inclusion criteria.

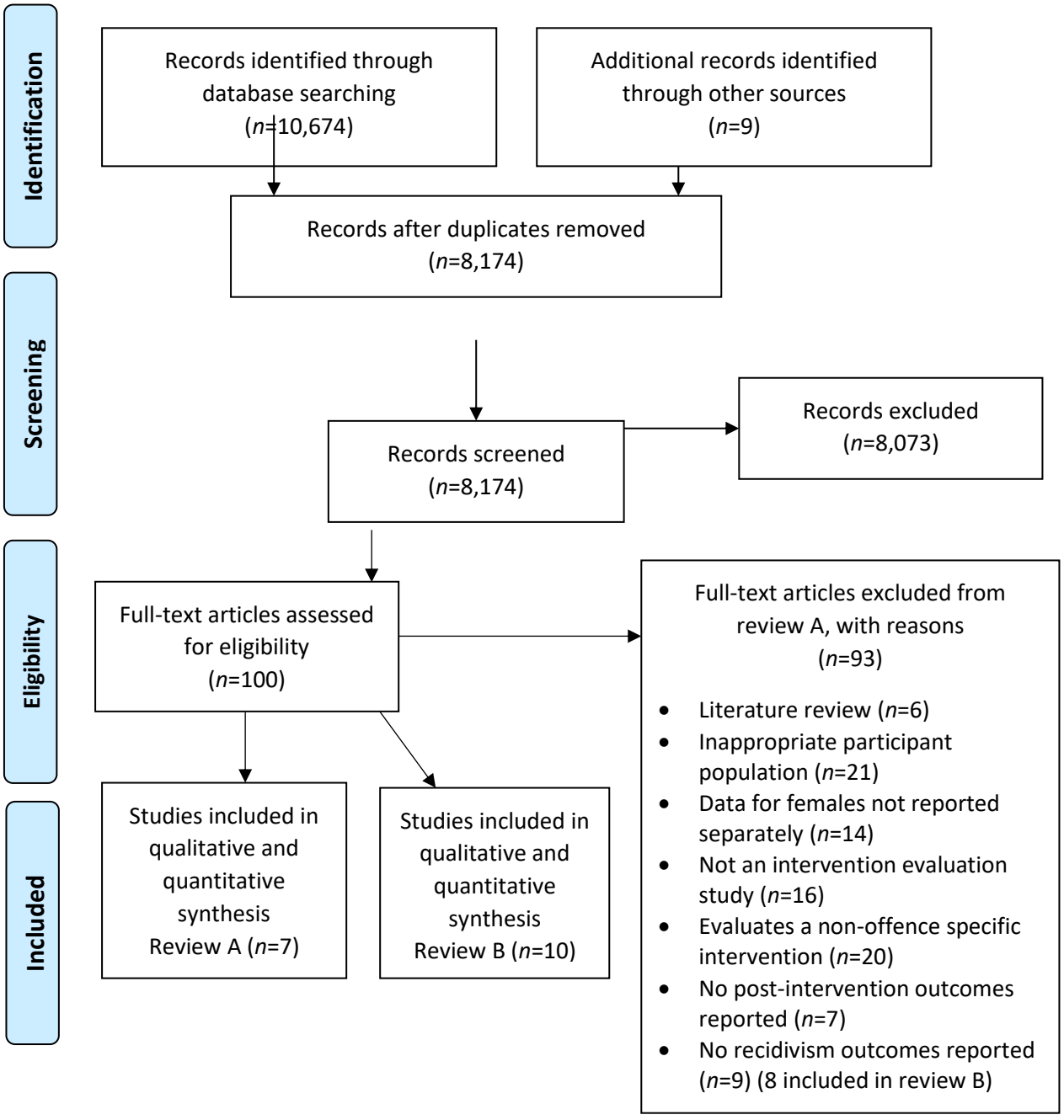
Several studies met most of the criteria, except for reporting recidivism outcome data. These papers reported other risk outcome measures of relevance to the review question, including incidents of violence and self-report measure outcomes specifically relating to offences, for example interest in fire (firesetting treatment). As participants in these evaluations remained within hospital or prison at the time of follow-up, these measures were deemed by the first author to be proxies for recidivism. The decision was made to separately report the results of the planned review (review A), focusing exclusively on recidivism outcomes; *and* the outcomes of a second screening, focusing on these additional risk outcomes (review B).

Departures from pre-registered protocol

Figure 1 details the included and excluded papers, and reasons for exclusion. The search yielded six literature reviews of relevance to the research question and their reference sections were also checked for eligible papers. Seven papers met inclusion criteria for review A and ten met criteria for review B, including two studies meeting criteria for both. As well as the changed detailed above, court-diversion programmes from the US were also deemed to be eligible, despite not being specifically mentioned in the protocol.

Figure 1.

PRISMA flow diagram for reviews A and B



Review A

Study characteristics (Table 1)

The included studies were published between 2002 and 2020, conducted in the UK (*n*=1) and US (*n*=6). Interventions focused on domestic violence, referred to as

interpersonal violence (IPV, *n*=5), general violence (*n*=1), and firesetting (*n*=1). Female participant samples varied from six to 102 (*m*=51). The average participant age was 31 years, excluding two studies which did not report demographic data for female participants separately (Cotti et al., 2020; Tollefson et al., 2009). Participants were predominantly white (57%), with one study not reporting participant ethnicities (Taylor et al., 2006). Most studies (*n*=5) recruited women in the community, arrested for IPV offences and court-ordered into treatment. Other samples included women in a forensic inpatient hospital (*n*=1), and prison (*n*=1). The follow-up periods ranged from nine months to 36 months. It was not possible to calculate programme attrition rates for all studies, as this data was not consistently reported, and some studies only reported data for programme completers.

Study designs were categorised as either RCT (*n*=1), or quasi-experimental (*n*=6) and corresponding quality assessment tools were used (Joanna Briggs, 2016a, 2016b). Overall, the quality of the included studies was poor (Table 3), with some articles lacking clarity in certain areas. The most prevalent issue was that most studies did not include control groups (*n*=5), precluding inference of causation. Half of the studies (*n*=3) only examined recidivism, rather than multiple outcome measures. The reliability of crime data is widely debated within the literature (e.g., Ariel & Bland, 2019), though for the purpose of these evaluations, it is the most appropriate available measure of reoffending. The RCT (Kubiak et al., 2016) was also of low quality, with evidence of detection bias and possible performance bias, as it was unclear whether participants were aware of their group allocation. The quality of the study would have been strengthened by blinding of allocation, delivery, and analysis.

Table 1.

Characteristics and recidivism results of review A studies

Study	Country	Number of female participants (*n*=total male and female)	Number of female participants at follow-up %	Population	Intervention (and control group)	Recidivism outcome	Length of follow-up	Female participants reoffended during follow-up %
Buttell (2002)	USA	102 (102)	56 (55)	Community – arrested and court-ordered into treatment	Batterer Intervention Programme (normative scores on DIT)	Recidivism data	24 months	28 (52.0)
Carney & Buttell (2004)	USA	26 (26)	26 (100)	Community – arrested and court-ordered into treatment	Batterer Intervention Programme	Recidivism data, assertiveness in marital relationships (SSAS), controlling behaviours (CPS), abusiveness (PAS)	12 months	1 (3.85)
Cotti et al. (2020)	USA	61 (154)	61 (100)	Community – arrested and court-ordered into treatment	Duluth IPV and CBT Programmes	Recidivism data	Up to 36 months	2 (3.25) both Duluth
Kubiak et al. (2016)	USA	42 (42)	35 (83)	In prison and released	Beyond Violence (TAU)	Recidivism data	12 months	11 (31.43)
Taylor et al. (2006)	England	6 (6)	6 (100)	Forensic LD inpatient hospital	Fire-setters treatment programme	Case description, recidivism data, attitudes towards fire (FAS), interest in fire (FIRS), anger (NAS)	24 months	0 (0%)

Tollefson et al. (2009)	USA	31 (88)	28 (90)	Community – arrested and court-ordered into treatment	Mind-Body Bridging Group	Recidivism data	9 – 27 months (*m*=18 months)	1 (3.57)
Wray et al. (2013)	USA	92 (184)	70 (76)	Community – arrested and court-ordered into treatment	Mutual Violence Intervention (Assessment only control)	Recidivism data	12 months	3 (4.29)

Note. DIT (Defining Issues Test); SSAS (Spouse-specific Assertiveness Scale); CPS (Control of Partner Scale); PAS (Propensity for Abusiveness Scale); FAS (Fire Attitude Scale); FIRS (Fire Interest Rating Scale); NAS (Novaco Anger Scale).

Table 2.

Summary of interventions evaluated in review A

Study	Intervention	Model	Length of programme	Developed for women	Primary focus
Buttell (2002)	Batterer Intervention Programme	CBT	12 weeks 2hrs once a week	No	Anger management, skills development
Carney & Buttell (2004)	Batterer Intervention Programme	CBT	16 weeks 2hrs once a week	No	Anger management, skills development
Cotti et al. (2020)	Duluth Programme	Feminist cognitive psychoeducation	20 weeks	No	Belief systems shaping relationships, cycle of violence, effects of abuse, anger-management.
Kubiak et al. (2016)	Beyond Violence	Trauma theory	20 sessions	Yes	Prevent recidivism, improve mental health and anger expression.
Taylor et al. (2006)	Fire-setters treatment programme	CBT	40 sessions 2hrs twice a week	No	Psychoeducation about fire, coping, interpersonal skills, relapse prevention.
Tollefson et al. (2009)	Mind-Body Bridging Group	Mind-body medicine	10 group sessions 1.5-2hrs once a week (Additional individual sessions)	No	Identifying triggers and anger-management techniques.
Wray et al. (2013)	Mutual Violence Intervention	CBT	12 sessions 1.5hrs once a week	Yes (Women-only group)	Reduce harmful relationship behaviours, promote healthy and safe relationships, increase emotional awareness.

Table 3.

Summary of quality assessment of review A studies

Study	Checklist used	1	2	3	4	5	6	7	8	9	10	11	12	13
Buttell (2002)	Quasi-experimental	Y	U	N	N	Y	U	N/A	U	Y	-	-	-	-
Carney & Buttell (2004)	Quasi-experimental	Y	N/A	N/A	N	Y	Y	N/A	Y	Y	-	-	-	-
Cotti et al. (2020)	Quasi-experimental	Y	Y	U	N	N	Y	Y	U	Y	-	-	-	-
Kubiak et al. (2016)	RCT	Y	N	Y	U	N	U	U	Y	N	Y	Y	Y	U
Taylor et al. (2006)	Quasi-experimental	Y	N/A	N/A	N/A	Y	Y	N/A	Y	Y	-	-	-	-
Tollefson et al. (2009)	Quasi-experimental	Y	N/A	N/A	N/A	N	Y	Y	Y	N/A	-	-	-	-
Wray et al. (2013)	Quasi-experimental	Y	Y	U	Y	Y	N	Y	Y	Y	-	-	-	-

Note. Quasi-experimental checklist has nine statements and RCT checklist has 13 statements. Y = yes; N = no; U = unclear; N/A = not applicable.

Interventions

Interventions (Table 2) ranged from ten to 40 sessions (*m*=19) and had various theoretical underpinnings, the majority based on CBT (*n*=4). Two studies evaluated Batterer Intervention Programmes (BIP) which participants were court-ordered to complete following arrests for IPV offences. Buttell (2002) evaluated a BIP delivered by a third-sector charity in Alabama, USA, as an alternative to prison sentences. The programme was based on CBT and developed for men, with no content adaptations made for women. Carney and Buttell (2004) evaluated a programme delivered by a third-sector charity in South Carolina, USA. The primary focus of BIPs is anger-management and skills development through psychoeducation classes, focusing on identifying values, overcoming defences, and developing interpersonal skills (Buttell, 2002; Carney & Buttell, 2004).

The Duluth programme was developed for men, based on feminist cognitive theory conceptualising male violence as attempts to gain power and control within heterosexual relationships (Cotti et al., 2020). The programme has been criticised for not addressing women's IPV offending, nor violence within same-gender relationships. The 'Choice and Consequences' Duluth programme was facilitated with female participants, and outcomes were compared with participants receiving a CBT anxiety and anger-management intervention in a mixed-gender group.

In the Mutual Violence Intervention evaluation, participants were allocated to groups based on their individual needs: assessment only, male-only, female-only, or both-partner treatment (Wray et al., 2013); the current review reports outcomes for the latter two groups. Tollefson et al. (2009) evaluated a Mind-Body Bridging programme,

drawing on third-wave therapeutic models, underpinned by the central assumption that the cause of IPV is the perpetrator's mind-body state before the violent act.

Central to Beyond Violence (Covington, 2011), is the understanding of the relationship between trauma, violence and substance misuse, based on research evidence with women who offend. Kubiak et al.'s (2016) evaluation compared Beyond Violence outcomes to a mandated Assaultive Offender Programming, developed for men convicted of violent offences.

The bespoke Fire-setters Treatment Group Programme was developed for use with men and women with Learning Disabilities residing in a forensic inpatient service (Taylor et al., 2006), based on the principles of functional analysis and arson offence cycles. In firesetting literature, distinctions are made between the term firesetting, which is the behaviour, and arson, which is the crime (Burton, McNeil & Binder, 2012).

Outcome: Recidivism

Participant recidivism during follow-up ranged from 0% to 52%, with variations in the way this was measured. None of the participants who completed the firesetters treatment programme (Taylor et al., 2006) reoffended within the 24-month follow-up period. Five participants had been discharged from the forensic hospital and resided in supported accommodation in the community, and one participant remained in hospital at follow-up. The findings were based on feedback from staff working with the participant, rather than police or criminal justice records, as used in the remaining studies.

In Carney and Buttell (2004) and Tollefson et al.'s (2009) evaluations of IPV interventions, one female participant reoffended during follow-up. Cotti et al. (2020) found that two women (5.41%) who completed the Duluth programme committed

further IPV offences during the follow-up period, whereas none of the 25 women who completed CBT committed further IPV offences during follow-up. None of the women from the both-partner Mutual Violence group reoffended during the follow-up and one woman from the female-only group was convicted of three further IPV offences, representing a 4% recidivism rate for both groups. Tollefson et al. (2009) found that one woman who completed the Mind-Body Bridging Programme and two women who did not complete the programme reoffended during the follow-up period.

Kubiak et al. (2016) reported that no women in either condition returned to prison during the follow-up period. Eight women from the TAU group (50%) and three women who completed Beyond Violence (15.8%) spent time in jail during the follow-up period. Six women (37%) from the TAU group and two women (11%) who completed Beyond Violence were rearrested during follow-up, without conviction. The authors conducted a bivariate logistic regression, which found that women who attended Beyond Violence were less likely to reoffend than the women in the TAU group (*OR* = 0.19; *CI* = .04, .91, *p* = .04). Over half of the BIP participants were arrested for further IPV offences during the 24-month follow-up (Buttell, 2002). The focus of the evaluation was on the impact of the intervention on moral reasoning, which they found to have a low positive correlation (r_{pb} = .32) with rearrest.

Review B

Two studies from review A reported outcomes additional to recidivism (Carney & Buttell, 2004; Taylor et al., 2006) and were included in review B.

Study characteristics (Table 4)

Review B studies (*n*=10) were published between 2001 and 2019 and conducted in Canada (*n*=1), UK (*n*=4), and USA (*n*=5). Studies evaluated programmes focused on

violence (n=4), anger-management (*n*=2), IPV (*n*=2), and firesetting (*n*=2). Samples of female participants varied from six to 63 (*m*=28); average age of 35 years, excluding participants from Taylor et al. (2016) which did not report women's ages separately. Participants were predominantly white (57%), with participants in two UK studies almost exclusively white (95-100%; Annesley et al., 2017; Taylor et al., 2016). Two studies did not report ethnicities (Jotangia et al., 2015; Taylor et al., 2006). Samples included women in prison (*n*=4), forensic inpatient services (*n*=4), and in the community (*n*=2). Half of the studies only reported pre- and post- intervention data (*n*=5), with no follow-up. In the remaining studies, follow-up periods ranged from three and 24-months. As with review A, it was difficult to calculate mean attrition due to the different study designs and sampling techniques used.

The additional studies included in review B were categorised as RCT (*n*=1) or quasi-experimental design (*n*=7) and the same assessment tools were used. The quality of the additional review B studies was poor (Table 6). As with review A, most of the studies did not involve control groups (*n*=5), making it difficult to identify treatment effects. The majority (*n*=6) used multiple self-report outcome measures and commented on the validity and reliability of measures within the articles. The RCT (Kubiak et al., 2015) was low quality, as there was no allocation blinding. Intention to treat was not reported however, non-completers more likely to be white and younger at the age of their offence than those who completed the intervention (Kubiak et al., 2015).

Table 4.

Characteristics of additional review B studies

Study	Country	Number of female participants (total male and female)	Number of female participants at follow-up	Population	Intervention (and control group)	Recidivism-related outcome	Length of follow-up
Annesley et al. (2017)	England	22 (22)	15	Forensic inpatients	Arson Treatment Group Programme and Arson Treatment Individual Programme	Interest in fire (FIRS) and functional assessment of firesetting (FAFS)	Pre/post
Carney & Buttell (2006)	USA	63 (63)	59	Community – arrested and court-ordered into treatment	Batterer Intervention Program	Assertiveness in marital relationships (SSAS), controlling behaviour (CPS), propensity for abuse (PAS)	Pre/post
Eamon et al. (2001)	Canada	33 (33)	33	Prison	Anger management program (Control)	Anger (NAS), aggression (AQ), institutional charges.	Pre/post
Fedock et al. (2019)	USA	26 (26)	26	Prison	Beyond Violence	Anger (STAXI-2)	Pre/post, 3month follow-up
Jotangia et al. (2015)	England	38 (38)	38 (38)	Forensic inpatients	Reasoning and Rehabilitation Mental Health Programme, R&R2MHP (TAU waitlist)	Violent attitudes (MVQ), Anger (NAS-PI), behaviour on the ward (DBSP)	Pre/post, 3month follow-up

Kubiak et al. (2012)	USA	35 (35)	29	Prison	Beyond Violence	Aggression and hostility (BW-AQ), anger (Expagg), conduct problems (SAQ)	Pre/post
Kubiak et al. (2015)	USA	22 (22)	19	Prison	Beyond Violence	Anger (STAXI-2), instrumental and expressive anger (Expagg)	Pre/post
Taylor et al. (2016)	England	6 (50)	6	Forensic LD inpatient	Anger treatment	Incidents of violence and aggression in hospital notes	12months pre/post intervention

Note. Fire Interest Rating Scale (FIRS), Functional Assessment of Fire Starting (FAFS), SSAS (Spouse-specific Assertiveness Scale), Control of Partner Scale (CPS), Propensity for Abusiveness Scale (PAS), Novaco Anger Scale (NAS), Aggression Questionnaire (AQ), State-Trait Anger Inventory (STAXI-2), Maudsley Violence Questionnaire (MVQ), Novaco Anger Scale and Provocation Inventory (NAS-PI), Disruptive Behaviour and Social Problem Scale (DBSP), Buss-Warren Aggression Questionnaire (BW-AQ), Revised Expressions of Aggression Scale (Expagg), Self-Appraisal Scale (SAQ). Other outcome measures not related to the research question have not been included in this review.

Table 5.

Summary of interventions evaluated in additional review B studies

Study	Intervention	Model	Length of programme	Developed for women	Primary focus
Annesley et al. (2017)	Arson Treatment Group Programme	CBT and CAT	61-66 sessions 2.5hrs once a week	Yes	(Group and Individual) Dangerousness of firesetting, coping, social skills, trauma, self-esteem, relapse prevention.
	Arson Treatment Individual Programme	CBT and CAT	32 sessions (not stated)	Yes	
Carney & Buttell (2006)	Batterer Intervention Program	CBT	16 sessions 2hrs once a week	No	Anger-management, skills development
Eamon et al. (2001)	Anger Management Program	CBT	12 sessions (not stated)	(not stated)	Increase awareness of personal anger process, anger-management, skills development
Fedock et al. (2019)	Beyond Violence	Trauma theory	20 sessions 2 hrs once a week	Yes	Prevent recidivism, improve mental health, anger expression.
Jotangia et al. (2015)	Reasoning and Rehabilitation Mental Health Programme (R&R2MHP)	CBT	16 session 1.5hrs once a week Weekly individual mentor session	No	Reduce antisocial attitudes and behaviours, improve social problem-solving skills
Kubiak et al. (2012)	Beyond Violence	Trauma theory	20 sessions 2hrs once a week	Yes	Prevent recidivism, improve mental health, anger expression.
Kubiak et al. (2015)	Beyond Violence	Trauma theory	20 sessions 2hrs twice a week	Yes	Prevent recidivism, improve mental health, anger expression.
Taylor et al. (2016)	Anger treatment	Cognitive therapy	18 sessions Twice a week (session length not stated)	No	Cognitive restructuring, arousal reduction, behavioural skills training.

Table 6.

Summary of quality assessment of additional review B studies

Study	Checklist used	1	2	3	4	5	6	7	8	9	10	11	12	13
Annesley et al. (2017)	Quasi-experimental	Y	N/A	N/A	N	Y	Y	N	Y	N/A	-	-	-	-
Carney & Buttell (2006)	Quasi-experimental	Y	N/A	N/A	N	Y	Y	Y	Y	Y	-	-	-	-
Eamon et al. (2001)	Quasi-experimental	Y	U	Y	Y	Y	Y	Y	Y	Y	-	-	-	-
Fedock et al. (2019)	Quasi-experimental	Y	N/A	N/A	N	Y	Y	Y	Y	Y	-	-	-	-
Jotangia et al. (2015)	Quasi-experimental	Y	Y	Y	Y	Y	Y	Y	Y	Y	-	-	-	-
Kubiak et al. (2012)	Quasi-experimental	Y	Y	Y	N	Y	Y	Y	Y	Y	-	-	-	-
Kubiak et al. (2015)	RCT	Y	U	Y	N	N	U	U	Y	Y	Y	Y	Y	Y
Taylor et al. (2016)	Quasi-experimental	Y	N/A	N/A	N	N	N/A	Y	U	Y	-	-	-	-

Note. Y = yes; N = no; U = unclear; N/A = not applicable.

Interventions

Interventions ranged from twelve to 66 sessions (*m*=27), with various theoretical underpinnings including CBT, Cognitive Analytic Therapy (CAT) and trauma theory (Table 5). Three studies evaluated the Beyond Violence programme (Fedock et al., 2019; Kubiak et al., 2012, 2015), described earlier in this paper. Carney and Buttell (2006) evaluated the same BIP evaluated in Carney and Buttell (2004), with a larger sample.

Annesley et al. (2017) evaluated the development of an arson programme, delivered in group and individual formats. Nine women completed Arson Treatment Group Programme (ATGP; 56%) and six women completed Arson Treatment Individual Programme (ATIP; 67%). The programme was specifically developed for women with histories of firesetting behaviours regardless of conviction, based on research around firesetting by women.

Eamon et al. (2001) evaluated a manualised anger-management programme, aiming to develop participants' understanding of their individual anger processes, and skills to aid anger control. Taylor et al. (2016) evaluated a manualised anger intervention (Taylor & Novaco, 2005) facilitated individually with patients in a forensic hospital. Participants were assessed as having borderline to mild LD, with average Wechsler Adult Intelligence Scale full scale IQ scores of 68.8 (*SD*=6.7). The intervention was based upon individualised analyses and formulation of participants' anger problems, delivered over six preparatory and 12 treatment sessions.

Reasoning and Rehabilitation Mental Health Programme (R&R2MHP; Young & Ross, 2007) is a manualised programme, aiming to reduce antisocial attitudes and behaviour, whilst improving problem-solving skills in young people and adults with

mental health problems. The programme is a shortened and adapted version of the Reasoning and Rehabilitation (R&R; Ross, Fabiano & Ewles, 1988) programme, originally developed for use with adolescents, based on the association between antisocial attitudes and recidivism.

Outcome: Incidents of violence

This outcome was considered of closest equivalence to recidivism for participants in prison or hospital at follow-up. Taylor et al. (2016) categorised incidents as damage to property, verbal abuse, threats to assault and physical assault. The authors reported a reduction in female participants' aggressive incidents across all categories, except damage to property, by over a third (34.5%), between the pre- (m=1.62, SD=0.63) and post-treatment (m=1.34, SD=0.56), with medium-large effect sizes.

Eamon et al. (2001) reviewed institutional charges in prison records during the pre- to post-test periods. The number of charges decreased significantly for treatment completers (p <.05), but not for the control group (p <.53). No further detail regarding the nature of the charges incurred were reported, thus it is unclear how many of these related to incidents of violence or aggression, compared with other rule breaches.

Outcome: Firesetting self-report measures

Taylor et al. (2006) reported non-significant changes in pre- and post-intervention scores on both the Fire Attitude Scale (FAS; Muckley, 1997) and Fire Interest Rating Scale (FIRS; Murphy & Clare, 1996). One participant's score increased on the FAS and two participants' scores increased on the FIRS post-intervention.

In the evaluation by Annesley et al. (2017), the measures used with the ATGP and ATIP changed during programme development, with only participants in the first cohorts completing the FIRS (Murphy & Clare, 1996). In the first group (n=4) and

individual (*n*=2) cohorts, mean scores on the FIRS reduced between pre- (group *m*=55.00, *SD*=11.75; individual *m*=28.00, *SD*=1.41) and post-intervention (group *m*=34.50, *SD*=14.53; individual *m*=44.50, *SD*=21.92). The majority of the first group cohort's (*n*=6) mean Functional Assessment of Fire Starting (FAFS; unpublished) subscale scores increased following intervention and individual (*n*=6) cohort results were mixed. The highest rated motivators for firesetting were depression, anger and anxiety, across group and individual completers.

Outcome: Self-reported anger and violence

Seven review B studies used at least one self-report measure of anger. Carney and Buttell (2004) found that participants' scores on the Spouse-Specific Assertiveness Scale (SSAS; O'Leary & Curley, 1981) passive/aggressive subscale significantly reduced from pre- (*m*=36.77, *SD*=13.02) to post-intervention (*m*=30.77, *SD*=10.51), moderate effect size (*t*=2.93, *p*=.007). The authors also found a significant reduction in Propensity for Abusiveness Scale (PAS; Dutton, 1995) scores from pre- (*m*=61.58, *SD*=16.91) to post-intervention (*m*=54.19, *SD*=14.88), moderate effect size (*t*=2.74, *p*=.011). No significant differences were found at post-intervention on either the Control of Partner Scale (CPS; Follingstad et al., 1988) or SSAS assertiveness subscale.

Carney and Buttell (2006) reported significant reductions in pre- and post-intervention scores for BIP completers, on the SSAS passive-aggressive subscale (pre *m*=35.86, *SD*=12.35; post *m*=31.08, *SD*=9.11, *t*=3.64, *p*=.001, *d*=.44), CPS (pre *m*=80.17, *SD*=15.04; post *m*=75.81, *SD*=14.37, *t*=2.30, *p*=.025, *d*=.30) and PAS (pre *m*=58.95, *SD*=19.97; post *m*=54.66, *SD*=16.94, *t*=2.49, *p*=.013, *d*=.23). However, they found no significant difference in SSAS assertiveness subscale scores.

Kubiak et al. (2012) and Kubiak et al. (2015) utilised the Revised Expressions of Aggression Scale (Expagg; Campbell, Muncer, McManus & Woodhouse, 1999) before and after the Beyond Violence programme. Kubiak et al. (2012) reported that participants' scores on both the instrumental (13.8 to 13.0) and expressive (23.3 to 22.7) subscales showed non-significant changes between pre- and post-intervention. Kubiak et al. (2015) reported significant decreases in instrumental anger (17.8 to 12.9), whilst expressive anger showed little change (24.4 to 24.6). Kubiak et al. (2012) found no significant changes in either total or subscale scores on the Buss-Warren Aggression Questionnaire (Buss-Warren, 2000). The authors reported a significant increase in post-intervention scores (1.7 to 2.2) on the Self-Appraisal Questionnaire (Loza, Neo, Shahinfar & Loza-Fanous, 2005). This result was unexpected as it is a measure of historical behaviours in adolescence, considered to be static.

Additionally, Kubiak et al. (2015) reported outcomes on the State-Trait Anger Expression Inventory (STAXI-2; Speilberger, 1999). Participants' state (23.1 to 17.7, *d*=1.00) and trait anger (17.8 to 13.7, *d*=1.05) scores decreased after intervention, with large effect sizes. STAXI Anger Expression Index scores also decreased (40.8 to 30.3, *d*=1.05) and the Anger Control-Out (*d*=-0.96) and Anger Control-In (*d*=-1.22) scores both significantly increased, with large effect sizes, indicating that participants had developed skills in controlling their anger. Fedock et al. (2019) also utilised the STAXI-2 (Speilberger, 1999) and found a significant decrease in trait anger between pre- and post-intervention scores following Beyond Violence. The authors also reported a non-significant increase in state anger scores. Anger Control-In significantly increased, whilst Anger Control-Out increased but was non-significant. Anger Expression-Out decreased and Anger Expression-In increased, though neither were significant.

Eamon et al. (2001) found no significant difference between treatment and control groups on all Aggression Questionnaire subscales (Buss & Perry, 1992) and the majority of the Novaco Anger Scale subscales (NAS; Novaco, 1975). The NAS Anger Regulation Scale scores significantly increased in the treatment group. Scores across the majority of NAS Cognitive, Arousal and Behavioural subscales significantly decreased, except on the Suspicion, Irritability and Verbal Aggression subscales which were non-significant. Differences in pre- and post-intervention NAS Provocation subscale scores were all non-significant for both participant groups, except on Frustration/Interruption which significantly decreased in the treatment group only. Within-group scores significantly decreased on the AQ Physical Aggression subscale for both groups and on the Anger subscale for the treatment group only. Eamon et al. (2001) interpreted these findings as indicative of changes in problem-solving style, with anger-management completers demonstrating improved anger control, moving from physical aggression towards verbal conflict resolution.

Jotangia et al. (2015) conducted intention to treat analyses and found no significant differences between Maudsley Violence Questionnaire (MVQ; Walker, 2005), Novaco Anger Scale and Provocation Inventory (NAS-PI; Novaco, 2003) and Disruptive Behavior and Social Problem Scale (DBSP; Young, Gudjonsson, Ball & Lam, 2003) scores at pre- and post-intervention. No significant differences were found on the MVQ for treatment completers at follow-up. The authors suggest possible explanations for this, including the measures not adequately capturing the relational nature of female aggression (Jotangia et al., 2015). A per protocol analysis showed significant improvements in DBSP staff ratings for the treatment group, with a large effect size, suggesting that the women who completed R&R2MHP engaged in more positive social interactions post-treatment.

Taylor et al. (2006) reported non-significant decreased total Novaco Anger Scale scores (Novaco, 2003) between pre- and post-intervention (91.2 to 81.8). However, two participant's scores increased following the firesetting programme. Subscale scores were not reported.

Discussion

Systematic review methodology was used to investigate the efficacy of offence-specific interventions in reducing recidivism in women. A second review was conducted, prompted by the limited number of papers yielded, broadening the outcomes of interest to include incidents in prison or inpatient services, and self-reported measures related to the offending behaviours targeted by the intervention.

The offence-specific interventions targeted IPV (*n*=7), general violence (*n*=5), firesetting (*n*=3) and anger (*n*=2). Only three programmes were developed specifically for use with women (Beyond Violence, Covington, 2011; ATGP/AITP, Annesley et al., 2017), including the women-only arm of Mutual Violence (Wray et al., 2013). Six of the remaining interventions were developed for use with men, despite evidence highlighting gender differences in the prevalence of types of offending (Prison Reform Trust, 2019) and gender-specific criminogenic needs (Heubner et al., 2010).

Overall, the quality of the studies was low, limiting the conclusions that can be drawn. In review A, overall recidivism in women who completed the offence-specific interventions was low (*m*=14.05%). As there are no known equivalent reviews of offence-specific interventions, it is not possible to compare this with a benchmark or accepted percentage. Most studies reported recidivism rates lower than 21.5% - 24.4% for women released from prison in England and Wales between 2006 and 2018 (Ministry of Justice, 2020). Heubner et al. (2010), found no significant relationship

between programme completion and recidivism for women released from prison in a review of USA criminal justice outcome data. Interestingly, none of the studies included in this review reported whether the recidivism outcomes were significant. The findings of review B were varied. In two studies, incidents of violence decreased following programme completion (Eamon et al., 2001; Taylor et al., 2016). The evaluations of firesetting programmes reported limited changes, with inconclusive results, and outcomes relating to self-reported anger and violence were varied, with overall mixed results for the efficacy of the interventions.

The small number of relevant studies yielded was expected, as there is less emphasis in the literature on the use of offence-specific interventions with women who offend, and greater emphasis on interventions directly addressing the criminogenic needs of women including trauma, mental health and substance misuse. This reiterates the National Offender Management Service rapid evidence assessment findings, highlighting the paucity of programme evaluations focused on reducing women's violence (Stewart & Gobeil, 2015). In addition, most interventions evaluated were not specifically developed for women. This is of particular concern regarding the court mandated IPV interventions used in the US, as women are ordered to complete interventions which were not designed based on theory and evidence relating to women. Despite this, the majority of the IPV programmes evaluated reported recidivism of less than 5% during follow-up. However, the highest recidivism rate across all review A studies was following completion of an IPV programme, with over half of the women reoffending during follow-up (Buttel, 2002). This may highlight issues with the specific programme evaluated, rather than the efficacy of IPV interventions adapted for use with women.

Strengths and limitations of the studies

The methodological quality of the studies was generally low. Most studies included in both reviews did not include control group comparisons (*n*=11). Many of the authors reflected on ethical issues regarding withholding or delaying treatment for individuals who present with high risk, whilst acknowledging the limiting effect this has on the quality and generalisability of their findings. Some studies reported outcomes for participants who did not complete the interventions, providing useful comparison data. It was also difficult to assess the extent to which participants received any other treatments that could have influenced study outcomes. This is particularly problematic with studies conducted in forensic inpatient settings, as participants were likely to be receiving pharmacological treatment, making it difficult to account for the treatment effects of medication, combined with any therapeutic influence of the ward environment. The inclusion of control groups would have strengthened any conclusions made regarding the efficacy of the interventions.

The generalisability of findings from each study are limited by the small sample sizes. Women account for a small proportion of prison and secure inpatient populations however, it would be remiss to conceptualise them as a homogenous group. The overarching finding of this review is the need for more high-quality evaluations of offence-specific interventions for women. Notably, there was limited representation of diverse ethnicities within the UK study samples, with participants being predominantly white (Annesley et al., 2017; Taylor et al., 2006). In a 2010 census of inpatients in mental health and Learning Disability services in England and Wales, 23% of male and female patients belonged to Black, Asian and Minority Ethnic (BAME) groups (Care Quality Commission, 2011). Similarly, BAME women account for 18% of the women's prison population, compared with 11.9% of the general population (Prison

Reform Trust, 2017). However, BAME women were not represented in either of the evaluations conducted in England included in this review, highlighting a gap in the research.

All three UK studies were conducted with patients residing in secure hospitals, in contrast to studies in the USA involving either women in prison or in the community. This highlights a lack of evaluations meeting the criteria for this review conducted in the female prison estate in the UK, despite offering various approved programmes. It is hypothesised that existing reviews may not have been captured by the search terms or included databases.

Strengths and limitations of the review

This is thought to be the first systematic review answering the review question, intending to build on findings from existing reviews reporting on mental health, trauma and substance misuse-related outcomes for women in prison and secure services. The main limitation of the review is the narrow focus on recidivism as an outcome, and this was partially overcome through broadening the outcomes of interest in review B. Additionally, recidivism as the sole outcome of interest ignores any other benefits or gains participants may have experienced and reported through self-report measures and qualitative feedback. An obvious limitation of the review was the exclusion of studies published in languages other than English. It is also anticipated that a larger number of relevant papers may have been yielded if the search was extended to other electronic databases.

Implications and recommendations

The review highlights the dilemma faced by justice, health and social care practitioners regarding whether to offer interventions based on limited evidence, or not offer any

intervention in the absence of robust evidence. Future research should address the methodological limitations of existing programme evaluations. Any offence-specific interventions piloted with women in the future should be evaluated robustly and the results shared, contributing to the evidence-base and informing clinical practice. These evaluations should include waitlist controls, to help identify treatment effects. Delaying rather than denying treatment to the control group would involve consideration of planned release or discharge dates, to ensure fair access. Evaluations should attend to outcomes relating to different ethnic groups and include participants representative of the total prison or secure inpatient female population. It would also be beneficial to compare the efficacy of offence-specific interventions and non-offence-specific interventions (e.g. DBT) in reducing risk and recidivism in women, to further develop an understanding of the impact of both types of programmes.

Conclusion

Initial findings from evaluations of several offence-specific programmes suggest that they have some effect in reducing recidivism in women who offend. However, there is insufficient high-quality research currently available, limiting the conclusions drawn. Future research should focus on continuing the development and robust evaluation of interventions, based on the available evidence regarding the needs of women who enter the criminal justice system. This would contribute to improving the lives of some of the most vulnerable members of society and reduce the risks that they pose to others, within the context of their own suffering.

References

Annesley, P., Davison, L., Colley, C., Gilley, L., & Thomson, L. (2017). Developing and evaluating interventions for women firesetters in high secure mental healthcare. *Journal of Forensic Practice, 19*(1), 59-76. https://doi.org/10.1108/JFP-12-2015-0054

Ariel, B., & Bland, M. (2019). Is crime rising or falling? A comparison of police-recorded crime and victimization surveys. In *Methods of criminology and criminal justice research.* Emerald Publishing Limited.

Bradley, R. G., & Follingstad, D. R. (2003). Group therapy for incarcerated women who experienced interpersonal violence: A pilot study. *Journal of Traumatic Stress, 16,* 337-340. https://doi.org/10.1023/A:1024409817437

Burton, P. R. S., McNeil, D. E., & Binder, R. L. (2012). Firesetting, arson, pyromania and the Forensic Mental Health Expert. *Journal of the American Academy of Psychiatry and the Law Online, 40*(3), 355-365.

Buss, A., & Perry, M. (1992). The aggression questionnaire. *Journal of Personality and Social Psychology, 63,* 452-459.

Buss, A. H., & Warren, W. L. (2000). *Aggression questionnaire [Manual].* Los Angeles, CA: Western Psychological Services.

Buttell, F. P. (2002). Levels of moral reasoning among female domestic violence offenders: Evaluating the impact of treatment. *Research on social work practice*, *12*(3), 349-363. https://doi.org/10.1177/1049731502012003001

Campbell, A., Muncer, S., McManus, I., & Woodhouse, D. (1999). Instrumental and expressive representations of aggression: One scale or two? *Aggressive Behavior,*

25, 435-444. https://doi.org/10.1002/(SICI)1098-2337(1999)25:6<435::AID-AB4>3.0.CO;2-Q

Care Quality Commission. (2011). Count me in 2010: Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales. [Online]. Retrieved from: https://www.cqc.org.uk/sites/default/files/documents/count_me_in_2010_final_tagged.pdf

Carney, M. M., & Buttell, F. P. (2004). A multidimensional evaluation of a treatment program for female batterers: A pilot study. *Research on Social Work Practice*, *14*(4), 249-258. https://doi.org/10.1177/1049731503262223

Carney, M. M., & Buttell, F. P. (2006). An evaluation of a court-mandated Batterer Intervention Program: Investigating differential program effect for African American and White women. *Research on Social Work Practice, 16*(6), 571-581. https://doi.org/10.1177/1049731506289115

Cole, K., L., Sarlund-Heinrich, P., & Brown, L. S. (2007). Developing and assessing effectiveness of a time-limited therapy group for incarcerated women survivors of childhood sexual abuse. *Journal of Trauma & Dissociation, 8,* 97-121. https://doi.org/10.1300/J229v08n02_07

Collins, R. E. (2010). The effect of gender on violent and nonviolent recidivism: A meta-analysis. *Journal of Criminal Justice, 38*, 675-684. https://doi.org/10.1016/j.jcrimjus.2010.04.041

Corston, J. (2007). *The Corston Report: A review of women with particular vulnerabilities in the Criminal Justice System.* The Home Office. https://webarchive.nationalarchives.gov.uk/20180207155341/http://www.justice.gov.uk/publications/docs/corston-report-march-2007.pdf

Cotti, C., Foster, J., Haley, M. R., & Rawski, S. L. (2019). Duluth versus cognitive behavioral therapy: A natural field experiment on intimate partner violence diversion programs. *Journal of experimental psychology: applied*. https://doi.org/10.1037/xap0000249

Covington, S. (2011). *Beyond Violence: A prevention program for women.* La Jolla, CA: Center for Gender and Justice.

Cuthbertson, P. (2017). *Who goes to prison? An overview of the prison population of England and Wales* [online]. Civitas. https://civitas.org.uk/content/files/whogoestoprison.pdf

Dutton, D. (1995). A scale for measuring propensity for abusiveness. *Journal of Family Violence, 10,* 203-221. https://doi.org/10.1007/BF02110600

Eamon, K. C., Munchua, M. M., & Reddon, J. R. (2001). Effectiveness of an Anger Management Program for women inmates. *Journal of Offender Rehabilitation, 34*(1), 45-60. https://doi.org/10.1300/J076v34n01_04

Fedock, G., Kubiak, S., & Bybee, D. (2019). Testing a new intervention with incarcerated women serving life sentences. *Research on Social Work Practice, 29*(3), 256-267. https://doi.org/10.1177/1049731517700272

Ferszt, G. G., Miller, R. J., Hickey, J. E., Maul, F., & Crisp, K. (2015). The impact of a Mindfulness Based Program on perceived stress, anxiety, depression and sleep of

incarcerated women. *International Journal of Environmental Research and Public Health, 12,* 11594-11607. https://doi.org/10.3390/ijerph120911594

Follingstad, D. R., Rutledge, L., McNeill-Harkins, K., & Polek, D. (1988). Factors related to physical violence in dating relationships. *Victimology International Journal, 3*, 169-182.

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 and Counselling, 15*(3), 233-252. https://doi.org/10.1080/13642537.2013.810659

Hollin, C. R., & Palmer, E. J. (2006). Criminogenic need and women offenders: A critique of the literature. *Legal and Criminological Psychology*, *11*(2), 179-195. https://doi.org/10.1348/135532505X57991

House of Lords. (2019). Library briefing: Women in the Criminal Justice System Debate on 25 July 2019. [Online publication]. http://researchbriefings.files.parliament.uk/documents/LLN-2019-0095/LLN-2019-0095.pdf

Huebner, B. M., DeJong, C., & Cobbina, J. (2010). Women coming home: Long-term patterns of recidivism. *Justice Quarterly, 27*(2), 225-254. https://doi.org/10.1080/07418820902870486

Joanna Briggs Institute. (2016a). JBI critical appraisal checklist for quasi-experimental studies. *Joanna Briggs Institute Reviewers' Manual*. Retrieved 04/01/2021 from: https://joannabriggs.org/sites/default/files/2020-08/Checklist_for_Quasi-Experimental_Appraisal_Tool.pdf

Joanna Briggs Institute. (2016b). JBI critical appraisal checklist for randomised controlled trials. *Joanna Briggs Institute Reviewers' Manual*. Retrieved 04/01/2021 from: https://joannabriggs.org/sites/default/files/2020-08/Checklist_for_RCTs.pdf

Joiner, M. N. (2011). What is the impact of gender-responsive treatment on women who offend? *College of Professional Studies Professional Projects.* Paper 31.

Jotangia, A., Rees-Jones, A., Gudjonsson, G. H., & Young, S. (2015). A multi-site controlled trial of the R&R2MHP Cognitive Skills Program for mentally disordered female offenders. *International Journal of Offender Therapy and Comparative Criminology, 59*(5), 539-559. https://doi.org/10.1177/0306624X13512092

Kubiak, S., Kim, W. J., Fedock, G., & Bybee, D. (2012). Assessing short-term outcomes of an intervention for women convicted of violent crimes. *Journal of the Society for Social Work and Research, 3*(3), 197-212. https://doi.org/10.5243/jsswr.2012.13

Kubiak, S., Kim, W. J., Fedock, G., & Bybee, D. (2015). Testing a violence-prevention intervention for incarcerated women using a randomized control trial. *Research on Social Work Practice, 25*(3), 334-348. https://doi.org/10.1177/1049731514534300

Kubiak, S., Fedock, G., Kim, W. J., & Bybee, D. (2016). Long-term outcomes of a RCT intervention study for women with violent crimes. *Journal of the Society for Social Work and Research*, *7*(4), 661-679. https://doi.org/10.1086/689356

Latessa, E. J., & Lowenkamp, C. (2005). What works in reducing recidivism. *University of St. Thomas Law Journal*, *3*(7), 521-535.

Loza, W., Neo, L. H., Shahinfar, A., & Loza-Fanous, A. (2005). Cross-validation of the Self-Appraisal Questionnaire: A tool for assessing violent and non-violent recidivism with female offenders. *International Journal of Offender Therapy and Comparative Criminology, 49,* 547-560. https://doi.org/10.1177/0306624X04273433

Ministry of Justice. (2020). Proven reoffending statistics quarterly bulletin, England and Wales, January 2018 to March 2018. [Online]. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/872390/bulletin_Jan_to_Mar_2018.pdf

Muckley, A. (1997). *Firesetting: Addressing offending behaviour.* Redcar, Cleveland, UK: Redcar and Cleveland Psychological Service.

Murphy, G. H., & Clare, I. C. H. (1996). Analysis of motivation in people with mild learning disabilities (mental handicap) who set fires. *Psychology, Crime and Law, 2,* 153-164. https://doi.org/10.1080/10683169608409774

Novaco, R. W. (1975). *Anger control: The development and evaluation of an experimental treatment.* Irvine, CA: Lexington Books.

Novaco, R. W. (2003). *The Novaco Anger Scale and Provocation Inventory (NAS-PI).* Los Angeles, CA: Western Psychological Services.

O'Leary, K. D., & Curley, A. D. (1986). Assertion and family violence: Correlates of spouse abuse. *Journal of Marital and Family Therapy, 12,* 281-289. https://doi.org/10.1111/j.1752-0606.1986.tb00654.x

Pomeroy, E. C., Kiam, R., & Abel, E. M. (1999). The effectiveness of a psychoeducational group for HIV-infected/affected incarcerated women. *Research on Social Work Practice, 9,* 171-187. https://doi.org/10.1177/104973159900900203

Prison Reform Trust. (2017). Counted out: Black, Asian and minority ethnic women in the criminal justice system. [Online]. Retrieved from: http://www.prisonreformtrust.org.uk/Portals/0/Documents/Counted%20Out.pdf

Prison Reform Trust. (2019). Why focus on reducing women's imprisonment? England and Wales Fact Sheet. [online] Retrieved from: http://www.prisonreformtrust.org.uk/Portals/0/Documents/Women/Why%20Women%20England%20and%20Wales%202018%20data.pdf

Ross, R. R., Fabiano, E. A., & Ewles, C. D. (1988). Reasoning and rehabilitation. *International Journal of Offender Therapy and Comparative Criminology, 32*, 29-35. https://doi.org/10.1177/0306624X8803200104

Sacks, J. Y., Sacks, S., McKendrick, K., Banks, S., Schoenberger, M., Hamilton Z., Stommel, J, & Shoemaker, J. (2008). Prison therapeutic community treatment for female offenders: Profiles and preliminary findings for mental health and other variables (crime, substance use, and HIV risk). *Journal of Offender Rehabilitation, 46,* 233-261. https://doi.org/10.1080/10509670802143680

Scottish Prison Service. (2018). *Women in Custody 2017.* file:///C:/Users/rogal/Downloads/16th%20PRISONER%20SURVEY%202017%20-%20Women%20in%20Custody6070_2848.pdf

Speilberger, C. D. (1991). *State-Trait Anger Expression Inventory: STAXI Professional Manual.* Lutz, FL: Psychological Assessment Resources.

Spiropoulos, G. V., Spruance, L., van Voorhis, P., & Schmitt, M. M. (2005). Pathfinders and problem solving: Comparing effects of two cognitive-behavioral

programs among men and women offenders in community and prison. *Journal of Offender Rehabilitation, 42*, 69-94. https://doi.org/10.1300/J076v42n02_05

Social Exclusion Unit. (2002). *Reducing reoffending by ex-prisoners.* London: SEU.

Stewart, L. & Gobeil, R. (2015). Effective interventions for women offenders: A rapid evidence assessment. National Offender Management Service, Analytical Summary 2015. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/448859/effective-interventions-for-women-offenders.pdf

Taylor, J. L., & Novaco, R. W. (2005). *Anger treatment for people with developmental disabilities.* Chicester, England: John Wiley & Sons.

Taylor, J. L., Robertson, A., Thorne, I., Belshaw, T., & Watson, A. (2006). Responses of female fire-setters with mild and borderline intellectual disabilities to a group intervention. *Journal of Applied Research in Intellectual Disabilities*, *19*(2), 179-190. https://doi.org/10.1111/j.1468-3148.2005.00260.x

Taylor, J. L., Novaco, R. W., & Brown, T. (2016). Reductions in aggression and violence following cognitive behavioural anger treatment for detained patients with intellectual disabilities. *Journal of Intellectual Disability Research, 60*(2), 126-133. https://doi.org/10.1111/jir.12220

Tollefson, D. R., Webb, K., Shumway, D., Block, S. H., & Nakamura, Y. (2009). A mind-body approach to domestic violence perpetrator treatment: Program overview and preliminary outcomes. *Journal of Aggression, Maltreatment & Trauma*, *18*(1), 17-45. https://doi.org/10.1080/10926770802610657

Tripodi, S. J., Bledsoe, S. E., Kim, J. S., & Bender, K. (2011). Effects of correctional-based programs for female inmates: A systematic review. *Research on Social Work Practice, 21*(1), 15-31. https://doi.org/10.1177/1049731509352337

Valentine, P. V., & Smith, T. E. (2001). Evaluating traumatic incident reduction therapy with female inmates: A randomized controlled clinical trial. *Research on Social Work Practice, 11,* 40-52. https://doi.org/10.1177/104973150101100103

Walker, J. S. (2005). The Maudsley Violence Questionnaire: Initial validation and reliability. *Personality and Individual Differences, 38,* 187-201. https://doi.org/10.1016/j.paid.2004.04.001

Walmsley, R. (2017). World Female Imprisonment List (4th Ed.). https://www.prisonstudies.org/sites/default/files/resources/downloads/world_female_prison_4th_edn_v4_web.pdf

Ward, T., Melser, J., & Yates, P. M. (2007). Reconstructing the Risk–Need–Responsivity model: A theoretical elaboration and evaluation. *Aggression and violent behavior*, *12*(2), 208-228. https://doi.org/10.1016/j.avb.2006.07.001

Wolff, N., Frueh, B. C., Shi, J., & Schumann, B. E. (2012). Effectiveness of cognitive-behavioral trauma treatment for incarcerated women with mental illness and substance abuse disorders. *Journal of Anxiety Disorders, 26,* 703-710. http://dx.doi.org/10.1016/j.janxdis.2012.06.001

Wray, A. M., Hoyt, T., & Gerstle, M. (2013). Preliminary examination of a mutual intimate partner violence intervention among treatment-mandated couples. *Journal of Family Psychology*, *27*(4), 664. DOI: 10.1037/a0032912

Young, S., Gudjonsson, G., Ball, S., & Lam, J. (2003). Attention deficit hyperactivity disorder in personality disordered offenders and the association with disruptive behavioural problems. *Journal of Forensic Psychiatry & Psychology, 14,* 491-505. https://doi.org/10.1080/14789940310001615461

Young, S. J., & Ross, R. R. (2007). *R&R2 for youths and adults with mental health problems: A prosocial competence training program.* Ottawa, Ontario: Cognitive Centre of Canada.

Appendices

Contents

Appendix 1.

Screening and selection tool

Article information	
Database	
Author	
Year	
Title	
Journal	
Full-text in English	(Y/N)
Participant information	
Female only	(Y/N)
Adults 18+	(Y/N)
Offenders	(Y/N)
Prison, Forensic Hospitals or Community	
Country	
Intervention	
Group or individual	(Group/Individual)
Name of intervention	
Offence focused	(Y/N)
Focus/offence type	
Comparators	(Y/N)
Outcomes	
Recidivism	(Y/N)
Other	
Design	
My review	(Y/N)
Include in review	

Tool completed for each full-text article obtained.

Appendix 2.

Joanna Briggs critical appraisal checklist for non-randomized experimental studies

JBI CRITICAL APPRAISAL CHECKLIST FOR QUASI-EXPERIMENTAL STUDIES

Reviewer _____Date_____

Author_____Year_____ Record Number_____

	Yes	No	Unclear	Not applicable
1. Is it clear in the study what is the 'cause' and what is the 'effect' (i.e. there is no confusion about which variable comes first)?	☐	☐	☐	☐
2. Were the participants included in any comparisons similar?	☐	☐	☐	☐
3. Were the participants included in any comparisons receiving similar treatment/care, other than the exposure or intervention of interest?	☐	☐	☐	☐
4. Was there a control group?	☐	☐	☐	☐
5. Were there multiple measurements of the outcome both pre and post the intervention/exposure?	☐	☐	☐	☐
6. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	☐	☐	☐	☐
7. Were the outcomes of participants included in any comparisons measured in the same way?	☐	☐	☐	☐
8. Were outcomes measured in a reliable way?	☐	☐	☐	☐
9. Was appropriate statistical analysis used?	☐	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

Appendix 3.

Joanna Briggs critical appraisal checklist for randomized controlled trials

JBI CRITICAL APPRAISAL CHECKLIST FOR RANDOMIZED CONTROLLED TRIALS

Reviewer _____Date_____

Author_____Year_____ Record Number_____

	Yes	No	Unclear	NA
1. Was true randomization used for assignment of participants to treatment groups?	☐	☐	☐	☐
2. Was allocation to treatment groups concealed?	☐	☐	☐	☐
3. Were treatment groups similar at the baseline?	☐	☐	☐	☐
4. Were participants blind to treatment assignment?	☐	☐	☐	☐
5. Were those delivering treatment blind to treatment assignment?	☐	☐	☐	☐
6. Were outcomes assessors blind to treatment assignment?	☐	☐	☐	☐
7. Were treatment groups treated identically other than the intervention of interest?	☐	☐	☐	☐
8. Was follow up complete and if not, were differences between groups in terms of their follow up adequately described and analyzed?	☐	☐	☐	☐
9. Were participants analyzed in the groups to which they were randomized?	☐	☐	☐	☐
10. Were outcomes measured in the same way for treatment groups?	☐	☐	☐	☐
11. Were outcomes measured in a reliable way?	☐	☐	☐	☐
12. Was appropriate statistical analysis used?	☐	☐	☐	☐
13. Was the trial design appropriate, and any deviations from the standard RCT design (individual randomization, parallel groups) accounted for in the conduct and analysis of the trial?	☐	☐	☐	☐

Overall appraisal: Include ☐ Exclude ☐ Seek further info ☐

Comments (Including reason for exclusion)

Chapter two

Empirical study

Far from home: Women's experiences of being in secure forensic inpatient services.

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Abstract

Specialist secure mental health inpatient service provision for women in England and Wales is limited, and beds are often commissioned in out-of-area services to meet their mental health and risk management needs. In North Wales, there are no NHS beds for women at low, medium or high secure level, and the majority of women are placed out-of-area in South Wales, or across the border in England. The current study aimed to explore the experiences of women from North Wales who had resided in out-of-area secure inpatient services, using Interpretative Phenomenological Analysis (IPA) methodology. The three key themes discussed highlight the challenges of being in services at a great distance from home and families; the impact of difficult and distressing experiences in services; and factors which facilitated progress and remaining hopeful. This is thought to be the first study involving women from across the secure pathway, from high secure through to the community. The findings are explored in relation to existing literature and the limitations of the research are discussed.

Keywords: Women, mental health, forensic, secure hospital, inpatient, qualitative.

Introduction

Most people detained under the Mental Health Act (1983; 2007) access local acute inpatient services (National Assembly for Wales, 2005). However, some individuals require periods of higher level relational, environmental, and procedural security (Kennedy, 2002) to manage their risks to themselves and others. Also known as forensic inpatient services, these establishments offer assessment, treatment and support for people with mental health problems (Durcan, Hoare & Cumming, 2011). Reasons for detention in secure services include court diversion for treatment of mental health difficulties following conviction; transfer from prison to hospital for assessment and treatment; or following an escalation in frequency and severity of risk behaviours, with or without an offending history. Duke, Furtado, Guo and Vollm (2018) highlighted concerns that adults remain in forensic hospitals for unnecessarily long periods, and the human, resource and financial costs are high.

Low, medium and high secure inpatient services in England and Wales provide incrementally enhanced levels of care and treatment based on individual need (National Assembly for Wales, 2005). Inpatient community rehabilitation services occupy the level below secure hospitals, before clients potentially step-up to secure care, or step-down towards community reintegration. Women account for 22% of the low and medium secure service population in England (Denison, Pashley & Daddow, 2019). Women have longer lengths of stay and are more likely to reside in independent provider hospitals than men (Denison et al., 2019), raising questions as to why there are observable gender differences.

Due to small numbers, there are comparatively fewer services for women than men. Bartlett, Somers, Fiander and Harty (2014) undertook an ambitious project to map

NHS and independent sector low and medium secure provision for women in England and Wales. In 2014, there were 1,625 low and medium secure beds for women across England and Wales, and over 400 women in low and medium secure services (*n*=36%) were in out-of-area placements (Bartlett et al., 2014). Almost all women in NHS medium secure beds were located within their home region; whereas twice as many women in independent sector medium secure services were placed out-of-area than were in their home area. Though the exact distances were not reported, the authors acknowledged the potential impact on women, affecting family contact, links with community services and discharge planning (Bartlett et al., 2014). Response to Freedom of Information (FOI) requests revealed more recent figures (Appendix 1). In December 2019, NHS England commissioned a total of 1,215 secure beds for women. The average cost of a bed was £490 per day for low secure, and £555 per day for medium secure. Medium secure services alone are estimated to cost 10% of the NHS mental health budget and 1% of the entire NHS budget (Duke et al., 2018).

Service provision for women in Wales is significantly smaller, with most women needing secure provision residing either in out-of-area NHS services in England, or independent hospitals in England and Wales. A higher proportion of Welsh patients were in secure services in Wales in 2019-2020 than the previous seven years (NHS Wales, 2020), highlighting a national commitment to helping patients remain in Wales during inpatient admissions.

There has been increasing emphasis on the importance of involving service users and carers in developing and improving mental health services (Together for Mental Wellbeing, 2014), providing a unique and valuable insight into care and treatment. Van Daalen-Smith, Adam, Hasim and Santerre (2020) interviewed twelve Canadian women previously admitted to acute psychiatric hospitals about their lived

experiences. Using thematic analysis, the authors identified patterns across the data, drawing out themes of relevance. One of the overarching messages in the women's stories was that their hospitalisation was unhelpful and traumatic, with these experiences outweighing the helpful experiences described. The women felt disempowered by services' focus on medical treatment of their distress, to "chemically subdue them into submission" without offering opportunities to talk (p. 320, van Daalen-Smith et al., 2020). The authors highlighted that the women wanted to feel heard, valued and connected with others, and contribute to decisions made about their care.

Few studies have explored the specific needs of women in forensic inpatient services (Coffey, 2006). Scholes, Price and Berry (2021) conducted a systematic review of women and staff's experiences of inpatient mental health hospitals. Eighteen eligible studies involved 187 women and 168 staff from around the world. Most studies involving service users were conducted in acute inpatient services and the authors noted a lack of studies involving women from forensic settings, with only three eligible studies yielded (Scholes et al., 2021). The review identified three key themes described as 'therapeutic milieu', 'safe haven' and a 'broken system'. A consistent, available and caring staff group contributed to participants' feelings of safety. Women also shared experiences contributing to further suffering and distress, including low staffing levels, feeling coerced by the medical model and side-effects of medication (Scholes et al., 2021). Women highlighted the role of meaningful activity in facilitating their recovery. This review affirmed the paucity of research exploring the lived experiences of women in forensic services, and factors of importance in supporting their progress.

The great distance between women's area of origin and the hospitals they reside in creates additional barriers to maintaining relationships with families and carers. A survey in 2017-2019 asked 190 women about their experiences of being detained in secure services across England. Pashley, Denison and Moore (p. 8, 2019) found that more than 70% of respondents were in hospitals over an hour away from home, noting "the distance from family and friends was reported as a significant barrier to women's recovery". Over 60% of women surveyed had been in three or more services, and some women had difficulty recalling every service they had been in (Pashely et al., 2019). This highlights challenges in understanding women's experiences of secure services, and the significant impact that being at a great distance from loved ones has on their wellbeing and progress.

Canning, O'Reilly, Wressell, Cannon and Walker (2009) highlighted a lack of consistency in carers' support from secure services. Approximately half of all medium and high secure inpatient services in England and Wales (*n*=38) participated in a survey about carers' support services (Canning et al., 2009). Whilst services acknowledged the benefits of providing carers' support, the great distances between services and carers' place of residence were identified as significant barriers to engagement (Canning et al., 2009). This research highlights the hindrance of distance in supporting meaningful contact between service users, their families and carers.

The aim of the current study was to explore the experiences of women from North Wales who have resided in out-of-area secure mental health inpatient services. The majority, if not all, women from North Wales requiring forensic inpatient care have resided in out-of-area services. Beds are commissioned in either out-of-area NHS or independent sector services, in England or South Wales, except for one independent low secure service within North Wales.

Method

Interpretative Phenomenological Analysis (IPA) methodology was chosen to answer the research question, as the focus is on people's sense-making of their life experiences (Smith et al., 2009). The inclusion criteria were i) adult (>18 years) female with a Care Co-ordinator in the North Wales Health Board; ii) currently or previously residing in out-of-area secure mental health inpatient services; deemed to iii) have capacity to consent to participate; and iv) be physically and mentally well enough to participate, by their Responsible Clinician. There was no specified cut-off for time lapsed for women no longer residing in inpatient settings however, women needed to be Care Co-ordinated in order to meet the inclusion criteria. Eligible participants were identified by their named Care Co-ordinator.

Participants

Seven women, aged 20-33 years, were interviewed about their experiences. Participants had been in secure inpatient services for an average of eight years (range 5-11 years), and the average age of admission was 18 (range 13-23 years). Six women resided within rehabilitation services, low, medium and high secure hospitals, and one woman lived in the community. Table 1 summarises participant demographic information. Participants were given pseudonyms to maintain anonymity.

Table 1.

Summary of participant demographics

	Number of participants (%)
Ethnicity – White (British, English and Welsh)	7 (100)
Preferred language - English	7 (100)
Welsh speaker	4 (57)
Non-parent	7 (100)
Detained under civil section (3)	3 (43)
Detained under criminal section	3 (43)
No section (discharged)	1 (14)

Ethics

Ethical approval was granted by Bangor University and NHS Health Research Authority/Health and Care Research Wales. Local approval was granted by all participating services in NHS and independent sector organisations. Participants provided written consent (Appendix 2) and were informed that their participation or withdrawal from the study was voluntary and would not impact their care (Appendix 3).

Interviews

An interview schedule was developed (Appendix 4), in accordance with IPA guidelines (Smith, Flowers & Larkin, 2009). Interview questions focused on eliciting participants' experiences of being in out-of-area secure services and the sense that they had made of these experiences. The questions focused on women's experiences of their journey

through inpatient services, being a Welsh patient in hospitals outside of Wales, and maintaining contact with their family and professionals involved in their care. The research was undertaken during the COVID-19 pandemic, and in adherence of national and service guidelines, all interviews were conducted remotely via phone or video-conferencing platform. In accordance with individual care plans and local procedures, staff were present with five participants to facilitate their involvement. Interviews were conducted by the first author and lasted an average of 32 minutes (range 20 – 65 minutes). Interviews were audio-recorded and transcribed verbatim, with identifiable information removed, including names of services and providers.

Analysis

Drawing on phenomenological philosophy, IPA is concerned with the unique connection of the individual with the world and their lived experience (Smith et al., 2009). Central to the theoretical underpinnings of IPA, is the concept of the hermeneutic circle. Through analysis, the researcher is attempting to make sense of the participant making sense of their experiences. IPA is committed to the particular (Smith et al., 2009), therefore the current research is explicitly focused on the experiences and the sense that this purposely selected group of participants have made of their experiences, within their particular context.

The literature surrounding IPA does not prescribe a single analysis procedure however, several common processes are involved, starting with sequentially analysing individual transcripts (Smith et al., 2009). The analysis process used is detailed in Appendix 5. First entering the participant's world through repeated reading (Smith et al., 2009), initial notes were made based on content, language and conceptual phenomena in each transcript. Emergent themes were developed, representing a

move away from the original data and focusing on the analyst's interpretations. Themes summarised patterns across emergent themes, based on similarities, differences, frequency and contextual relevance (Smith et al., 2009). Patterns were then identified across cases and captured within superordinate themes, ordered to create a coherent narrative.

Author reflective statement

The first author is a white, female Trainee Clinical Psychologist with experience of working with women in secure inpatient services. The research topic was motivated by a desire to share women's stories about their experiences and make recommendations for providers, encouraging collaborative service development. The experiences and values of the author have influenced the undertaking of this research and subsequent analysis, approaching from a position of compassion and empathy. All transcripts were viewed independently by the second author and identified themes were discussed, to explore different interpretations and enhance the quality of the research.

The data analysis was conducted from an interpretivist stance, focusing on "the uniqueness of human inquiry" (p. 223, Schwandt, 1998). Drawing on phenomenological, hermeneutic and ideographic theory in IPA, the interview and analysis processes were applied to the exploration of the women's sense-making of their individual experiences in out-of-area services.

Results

The women described their journeys through secure services, with most being admitted during adolescence. They shared their experiences in services across the UK and expressed a yearning to return home. The narratives were dominated by

difficult and distressing experiences, with minimal emotional expression. Participants also described the impact of positive experiences and their hopes for the future. The richness and depth of data varied across the interviews. Some participants provided limited responses to open-ended questions, giving greater detail when asked questions about specific events and experiences. This section contains a discussion of three superordinate themes and themes of relevance to the research aim (table 2).

Box 1.

Transcript notation used

(*p*1) – page of transcript

… – significant pause

[ ] – material omitted

[*text*] – explanatory information added by authors

Table 2.

Master table of superordinate themes and themes

With and without Wales	Never asked, never told	Focus on progress
Home, family and distance	***Trauma, care and abuse***	***Factors which promote and facilitate progress***
Distance from home	Traumatic experiences	Structure and meaningful activities
Impact of distance on communication and visits with family	Invalidation and denial of experiences	Medication and therapies
Wanting to return to North Wales	Desire to feel cared for	Therapeutic relationships with staff
	Disempowerment	
Welsh language and identity	Moved object	***A desire to help others***
Welsh language	Powerless to make changes	Finding their voice and helping others
Contact with community teams and North Wales services	***Risk and risk management***	***Focusing on the future***
Contact with community teams	Normalisation of self-harm and suicide	Looking forward and messages of hope
Need for services in North Wales	Seclusion and restraint	
	Emotional disconnect from experiences	
Admissions, transitions and the service journey	Absence of emotional content	
Admissions in adolescence		
Unexpected moves		

With and without Wales

Women described their individual journeys through services, from admission to transitions between hospitals. The narratives contained a strong message that North Wales was home, with all participants expressing a desire to return.

Home, family and distance

Home was a consistent feature in the data. Though not overtly asked what the concept of home meant to them, women's responses to other questions indicated that home was a place where their families were. Participants spoke about the challenges of being at a great distance from home, and the impact this had on themselves and their families. Most had been in services in North West England, of closest proximity to North Wales across the border; however, many had also been in hospitals in South Wales, South East England and Scotland, up to approximately 300 miles away. There was a sense of actual and felt distance, with some women not knowing where services were in proximity to home. Catrin (*p*2) described one transition "it was all the way in [*East Midlands*], erm so I was hundreds – well, not hundreds but I was miles and miles away from home." Lowri's (*p*18) sentiment was captured in the title of this superordinate theme, as a powerful message of *hiraeth*[1] "I feel happy in Wales but [ ] without Wales I wasn't very happy".

Participants talked about how the distance impacted on maintaining contact with their family, facing unique challenges in secure services where access to internet-enabled devices is restricted or entirely prohibited. Gwenan (*p*5) described the impact on her relationships "I lost touch with friends and [ ] family members and, cause they put me

[1] Hiraeth is a Welsh word which does not directly translate into English, meaning a deep longing for home.

in all sort of places, like down in [*South East England*]". Lowri (*p*9) shared how accessing personal devices enabled her to stay connected when she was in Scotland "it wasn't too bad, we was allowed our phones and ipads and all that [ ] cause I can keep in contact with my family then". Catrin (*p*47) described the financial barrier to maintaining regular contact with loved ones "you have to buy a phone card that has a certain amount of time on it [ ] which is daft really considering people in hospital didn't tend to have a lot of money".

The most consistent message related to challenges faced by families in visiting participants. Some challenges were universal, with the greater distance resulting in longer journeys for families to travel, and some families had specific challenges in accessing personal transport, illustrated in box 2.

Box 2.

Catrin (*p*2) – "My mum can't drive erm, so I couldn't see her very often."

Rhian (*p*22) – "I've not seen my mum and dad for two years…which is quite heart breaking."

Lowri (*p*10) – "I didn't like it cause everyone else had visits cause they lived closer."

Gwenan (*p*17) – "it's not erm…convenient cause it's all the way down south you know, my mum did visit once or twice with my brother [ ] on the train straight from [*North Wales*] to [*South Wales*] took like [ ] maximum 3 half hours just to go from North Wales right down to [*South Wales*] to see my mum for three hours".

Rhian spoke about the difficulties of having closed visits, communicating with her mum in a separate room through an intercom system "I used to have to see my mum through a glass window…It was horrible. I couldn't even give her a hug or anything." (*p*27). Sioned (*p*15) talked about missing out on the progression of family life while she was

in hospital “I just miss my family, missing my niece and nephew growing up, it’s quite hard, it was nearly two years, I don’t even know what they look like”.

The women overtly described the geographical distance separating them from their loved ones; underlying this was a deeper sense of detachment from home. Whilst interpersonal difficulties with caregivers may have contributed to, or indeed have been the direct trigger for the women’s distress prior to inpatient admissions, they undoubtedly experienced a sense of loss when forcibly removed from their family homes. The women’s forced extraction from their secure base and primary caregivers likely played out in their subsequent attempts to form bonds with staff in inpatient services, discussed in subsequent themes. Thus, home was not only a building or a place of familiarity, but an epicentre of emotional connectedness. In being sectioned, the women’s proximity to and freedom to return to this secure base was taken out of their control, leaving them feeling truly isolated and disconnected from loved ones.

The narratives told a story of women being sent away when they were distressed and presenting with high levels of risk, then being permitted to return to their area of origin when they had made progress, with the ultimate reward of going home. Catrin (*p*6) spoke about moving from an adolescent inpatient service after self-harming “when I got back [*from general hospital*] they said that I would be moving hospitals and it took a while for them to find a place” before she was moved to South Wales. Each move further away represented greater barriers to accessing their secure base and reduced the possibility of being reunited with their attachment figures. Women portrayed their unpredictable and seemingly directionless journeys through services, as Rhian (*p*28) described “I’ve been lost in the system for years”. This was interpreted as an illustration of the complete severance of attachment with her secure base, no longer anchored to a safe place to return to.

Participants talked about missing home and saw returning to North Wales as an indication of progress. This desire to be reunited with loved ones is likely driven by the yearning for reconnection with their safe base and attachment figures. Catrin (*p*17) described wanting her progress to be rewarded “I really wanted to prove, that, I was well enough to move because this new hospital was 20minutes away from my mum and I hadn’t been that close to her in years.” Similarly, Ffion (*p*10) saw moving to a service in North Wales as reflective of her progress “yeah because I was doing so well and they brought me back in Wales”.

Welsh language and identity

Although none of the women identified Welsh as their preferred spoken language, four were bilingual Welsh-speakers. Participants highlighted limited opportunities to speak Welsh in hospital, as Seren (*p*27) shared “I am first language English but [ ] I am fluent in Welsh. And there’s nobody who ever ever speaks Welsh, which I do miss at times”. Ffion (*p*18) described barriers to communicating with staff at times of distress, which she was able to overcome in a Welsh service:

> “If I was struggling or something, and if I had someone English talking to me, I wouldn’t talk to that person so they’d go off and get the Welsh-speaker and then they’d come to talk to me and then I can work on it”.

This demonstrated the impact of emotional distress on a person’s ability to utilise complex linguistic processes associated with bilingualism, highlighting the importance of providing opportunities for individuals to speak in their preferred language, particularly within the context of secure care. Sioned (*p*8) described barriers to communicating with staff in English “they struggle to understand me [*laughs*] [ ] apparently my accent’s strong”, emphasising that she was different and far from home.

However, one service had made efforts to incorporate Welsh language signage on the ward, which Ffion (*p*16) was involved in creating "I had to put posters up in Welsh. Like, basic stuff, what people can like, say corridor and stuff". Seren (*p*8) spoke about crossing paths with other Welsh women "it's always nice when you go somewhere in England and then there's like other Welshies with you". This appeared to represent a connection with the home that she was longing to return to.

Contact with community teams and North Wales services

Participants were asked about their contact with their Care Co-ordinators and community teams in North Wales. Responses varied, with some women having minimal contact and others having more frequent contact and visits from their Care Co-ordinators. The key message was that meaningful contact with community services reduced their sense of isolation. Sioned (*p*6) felt supported by her Care Co-ordinator, saying "he's really passionate about helping me" and Catrin (*p*46) described feeling supported by a team who had consistently been involved in her care since she transitioned to adult services, "it helped me feel a little less alone". Catrin's experience may represent a formation of a new secure base, which was perhaps more available and accessible than her home and primary caregivers during her inpatient journey. She describes this contact as a positive constant, engendering a sense of safety and connection, at times when she otherwise felt disconnected from home.

Community teams were most consistently involved at points of transition, with Care Co-ordinators attending planning meetings with inpatient teams. Rhian (*p*25) did not know how to initiate contact with her team "I don't know how to contact them. That's what I'm saying, I – the only time I see [*Clinical Case Manager*] or [*Care Co-ordinator*] is [ ] if I'm leaving or erm, 117s and CPAs [ ] I don't think that's good". This emphasised

the sense that she had felt “lost” in the system, in contrast with other women who had some connection with others from home. It may also be indicative of her own barriers to eliciting support from others, resulting from previous failed or punished attempts to elicit care in her life. Some women spoke about the role of the community team in supporting them with complaints. Catrin (*p*45) described the support she received “I could just ring them and they would ring and [ ] try and sort things out, they’d listen to the complaints that I had that”. This was interpreted as an attempt to seek out a strong and protective other, to ensure that her needs were met when her own efforts were unsuccessful; mirroring a child seeking out an adult to intervene in the environment on their behalf. Seren (*p*27) felt that the level of contact that she had suited her needs “it’s not like we talk every week or anything but, like we talk about when things like, when they matter so, yeah it’s alright I feel like it’s fine”. Catrin (*p*44) felt that she had a better experience with her community team than some English patients, despite the distance:

“I’ve seen the English patients who are – have been transferred to another place in England, their mental health teams are, awful. They aren’t really involved in their care very much from what I’ve seen erm but compared to the Welsh mental health team when you’re transferred out-of-area, they’ve just been brilliant.”

Some women felt that community team involvement improved with proximity, removing the barriers created by the distance. Rhian (*p*1) was particularly passionate about the need for women’s inpatient services in North Wales:

“I think they should have somewhere like [male medium secure service] for patients – for female patients to go to because, it – I think it might help them, make them feel more at ease to go somewhere that they know [ ] not just patients, but for their for their families and friends as well.”

Admissions, transitions and the service journey

Many of the women first entered inpatient services in adolescence. Gwenan (*p*2) described the fear that many participants shared when they were first admitted "I was scared cause it was my first time, I didn't even know adolescent hospitals existed". Participants gave little detail about life events as factors contributing to their admissions, focusing on their self-harm and suicidal behaviours. This may have been an intended, or unintended, avoidance of recalling and disclosing painful periods in their lives. Lowri (*p*2) described the start of her journey in services "I started self-harming [ ] and I tried to kill myself so that's what made me go into hospital, they sectioned me". This disconnect from distress is discussed further in a subsequent theme.

Following their forced displacement from their homes, the women found themselves in unfamiliar places, without their caregivers and without any autonomy to return. Subsequent moves represented further displacement and disconnection, as Lowri (*p*7) explained "I didn't know anyone, didn't know the staff, I had to start from scratch again". A source of significant distress was unexpected and unplanned moves between services. Seren described several distressing moves:

Box 3.

Seren (*p*2) – "It was a shock, especially because I hadn't anticipated the move. They all did it very suddenly they only gave me half an hour notice, you know, I'd gone from being in North Wales, about an hour away from where I live, to [*East England*] which is about 8 hours away, so it wasn't great. I didn't have a choice in the matter either."

Seren (*p*7) - "I was woken up at 6:00 in the morning and literally carried to the back of a van because I refused to go. They'd packed all my things while I was asleep and they just told me that I was moving to South Wales and I literally have no idea".

In direct opposition to the sense of security elicited by an attachment with a secure base, attachment disturbances contribute to difficulties in tolerating and coping with distress and despair for future relationships. Each severance of connection with the original or subsequent tentatively formed bases further eroded the women's psychological wellbeing and ability to form meaningful relationships with others. This likely contributed to their engagement in harmful behaviours, as attempts to cope with the pain and distress of these accumulative losses.

Never asked, never told

Participants shared stories of difficult and distressing experiences within inpatient services. Some women were more open about these experiences and others shared limited detail. In the interview debrief, women were encouraged to seek support from their care team if they experienced any distress after sharing their stories.

Trauma, care and abuse

There were two significant distressing experiences that the women consistently reported: the impact of being restrained, and being in seclusion. Catrin (*p*11) spoke about being assaulted by staff when being restrained "I told her 'you're hurting me, you're digging your nails into me' and she was like 'no I'm not' and I had the cuts on after to prove it". Women talked about frequently being in seclusion, as Ffion (*p*3) described "you only had to do one thing wrong, they'd put you in seclusion straight away". Through being secluded, the women's sense of isolation through their disconnection from home was physically manifested by being totally segregated from all human contact, without access to opportunities to use their usual coping strategies. The women described how this further exacerbated their distress, rather than

alleviating it. Attempts to manage risks through the removal of materials which could be used to self-harm with, consequently eroded women's privacy and dignity. Ffion (*p*2) shared her experience "every time when they put me in seclusion, they'd put [*me*] naked in seclusion, even if there's a male on the obs". Seren (*p*17) shared a distressing experience of being in seclusion when she moved to a new service:

"it's [ ] traumatising when people are changing you out of your clothes and putting you in secure clothes, it's horrible. So horrible. And then I think I just, I just lay on the floor for like, four hours just crying because, I was like, shit I'm stuck here."

These experiences, exacerbated by the detachment from their secure base, were incredibly painful for the women, and their reliance on a limited repertoire of coping skills resulted in further physical and psychological harm. These experiences of being restrained and moved to seclusion may also have been both traumatising and retraumatising for the women, representing re-enactments of past traumatic experiences of maltreatment and abuse.

Women talked about the messages that they internalised as a consequence of these experiences, changing the way that they thought about themselves. Catrin (*p*12) internalised the belief that there was something inherently wrong with her "I…was being treated like this and so I thought it must be me [ ] I must deserve it". These experiences did not appear to change the women's beliefs about others, but instead perpetuated their incredibly low self-worth. These experiences may have served to further affirm their pre-existing beliefs about their value and self-worth, developed through their early life experiences.

Participants voiced a need to feel cared for and their experiences validated. Rhian expressed a desire for opportunities to talk about her distress "I used to take a lot of

overdoses [ ] no one ever sat down with me and asked me why I was doing the stuff I was doing". This represents an incongruence or block between the perceived caregiver (staff) and the care recipient (the woman), which may have mirrored her experiences of care in her formative years. Catrin (*p*37) recognised one of the functions of her self-harming behaviours was to initiate opportunities for care, unfulfilled in secure services, "I know I used to self-harm because, going to general hospital would feel like care for me".

Disempowerment

Power dynamics in the lives of women in secure services was a prominent theme throughout the data. Women experienced disempowerment through their detention, as Catrin (*p*2) described "I was 16, I wanted to leave at that point because I was old enough to discharge myself [ ] it was then that they decided to section me". The language used by the women to describe their journeys through services was indicative of things being done to them, rather than collaborative decision-making. Women described being 'moved' and 'put' in services by a collective 'they' who were rarely defined. This was evocative of a child, shielded from the rationale of parental decision-making and being told what to do and where to go, without being gifted with a reason or explanation ('because we said so'), facing subsequent consequences for noncompliance. This was illustrated in Catrin's (*p*32) narrative about an incident of self-harm "I refused to get treatment erm and, erm they gave me some PRN, some sedative medication and in the end they just kind of came in and picked me up, put me in a wheelchair and took me". A sense of passive acceptance was present throughout the data, as Lowri (*p*2) shared "they moved me to…[Scotland]. Then they moved me back down here", with no emotional expression.

Participants also discussed the impact of not being believed when attempting to highlight concerns with their care. Seren (*p*12) shared her anguish “it was just so frustrating, you know, [ ] when you feel like you’re not being listened to. Especially over something so serious about, you know, patient safety”. Catrin (*p*9) described needing to find proof to evidence failings in her care “I was so fed up of people not believing me when this stuff happened [ ] I wanted to prove to them that it was”.

Risk and risk management

A consistent theme within the narrative was the normalisation of self-harm and suicidal behaviours, which appeared to be a significant trigger for admissions during adolescence. Women viewed their self-harm behaviours as a failure to cope, rather than as coping strategies; a belief reinforced by how services shaped their responses to distress, demonstrated by Lowri (*p*8):

Box 4.

Interviewer: How did you cope with [*moving to a service in Scotland*]?
Lowri: I didn’t, I self-harmed every day.

Participants found being nursed on constant observations, as a form of risk management, invasive and unhelpful. Women described risk-averse risk management approaches, as Catrin (*p*17) reflected “they were quite scared to take me off 1:1”. Some women described having to wear strong clothing, designed to be untearable and safer than regular clothing for people presenting as highly suicidal, as Seren (*p*17) shared “the entire time I was on that ward, which was 11 months, erm, I was in secure clothing [ ] I never wore my own clothes once”. This removal of identity and individuality further contributed to the sense of depersonalisation experienced by participants.

Emotional disconnect from experiences

There was an overwhelming absence of emotional expression within women's narratives surrounding distressing and traumatic experiences. It is difficult to demonstrate the absence of content however, some participants demonstrated a limited emotional vocabulary to describe their internal experiences. For example, Lowri expressed feeling "happy" about positive experiences but struggled to articulate her thoughts and emotions in further detail. This limited emotional awareness and difficulties in expressing emotions can be a consequence of an individual growing up in an invalidating environment, perpetuated by their own subsequent invalidation of their internal experiences and limited opportunities to improve their understanding. There was limited expression of anger, interpreted as a passive acceptance of distressing and invalidating experiences:

Box 5.

Seren (*p*8) – "I mean I've had worse [*laughs*]."

Seren (*p*17) – "But obviously, you know, after a while you get used to it…and it just became the new normal."

Cartin (*p*35) – "But obviously looking back now, it just…it's not very good care [*laughs*]."

This emotional disconnect was interpreted as the women's attempts to defend themselves from the pain of the loss of home. Facing the reality of their situation would likely have been overwhelming, compounding their existing high levels of distress, which they were battling to manage each moment of each day.

Focus on progress

All seven women voiced hopes for the future and a desire to progress through services. For some, their focus was on stepping-down to services closer to home and for others, the reality of being discharged into the community was tangible.

Factors which promote and facilitate progress

Women spoke about positive experiences in hospitals, which they attributed to facilitating their progress. A structured day provided predictability and containment for Rhian, in contrast to the unpredictability and inconsistency of frequent unexpected moves between services:

Box 6.

> Interviewer: [ ] What kind of things have been particularly helpful for you at [*high secure hospital*]?
>
> Rhian: The structure, a lot of structure, not giving up on patients.

This is particularly pertinent within the context of the women's potentially unpredictable and apparently incongruent internal experiences, and their own sense of feeling uncontained at times. A structured and predictable routine may have provided boundaries and parameters which engendered some sense of safety for the women, within lives which may otherwise have felt intolerably uncertain.

Access to meaningful occupation and community leave were of central importance, providing structure and a sense of normality in the women's lives. Lowri (*p*11) emphasised the value of meaningful activities "keep me busy, keep my mind occupied". Seren (*p*9) said that the best hospital that she had been in had the most facilities "they had really good facilities, like they had a pottery room with like an actual

kiln, we had two pet goats [ ] it was nice". Engaging in on- and off-ward activities may have not only served as a distraction from internal distress, but also as an escape from the interpersonal and power dynamics on the ward. In addition to recreational activities, participants valued accessing education, with many missing out on school and college during their admissions, as Catrin (*p*21) shared "I got myself back into education, which is good cause I hadn't been in education all that time". This desire to access education may have also been indicative of an investment in her future self after her inpatient journey.

Women also described the benefits of medication and therapy in hospital. Sioned (*p*17) spoke about being prescribed new medication when she moved hospitals "they put me on clozapine here and it's been the best medication that I've tried in my life [ ] it helped me hell of a lot". She also described learning different coping skills in therapy "with the help of Psychology [ ] I can cope better, I try to use my skills when I can and I've got a sensory box so I use that too" (*p*8).

Women talked about the benefits of therapeutic relationships with staff. Seren (*p*18) said that these relationships were of central importance "having the good relationship with the staff was the most important thing for me. You know, that's what I valued most". Rhian (*p*21) emphasised the importance of a consistent and containing approach to her care "staff persevered with me and got me to where I am". In forming these positive therapeutic relationships with staff, the women felt safe and supported, despite being at such distances from home. Although their desire to return to their area of origin remained a primary focus, these positive relationships served to promote the women's wellbeing and contribute to their progression through services.

A desire to help others

Participants were passionate about improving the inpatient experience of other women. Catrin (*p*12) reflected on finding her voice, recognising that she initially found it easier to advocate for others than herself “it makes me feel good to be able to help fight for somebody who doesn’t feel strong enough to be able to fight for themselves”. This progression could be seen through both her inpatient journey and her transition from adolescence to adulthood, where initially she sought out support from the community team to advocate on her behalf, then developing the confidence to advocate for her peers, before developing the confidence to advocate for herself. This represented her gradual recovery from invalidating experiences, as she began to trust her emotional responses and interpretations of problems with the care she received, and started believing that she was deserving of good quality care. Catrin was particularly motivated to influence services’ approaches to working with people diagnosed with Borderline Personality Disorder “I really [ ] want to, definitely change the way BPD patients are treated in general and I wanna go back and right some wrongs” (*p*12). Rhian had ambitions for working in services herself in the future and hoped that her story may contribute to service development “if I could help to build a hospital in North Wales, someone get the best start in life, that’s what I would like” (*p*15).

Focusing on the future

Although they described difficult and painful experiences in hospital, participants also expressed hope for their futures. There was a sense that the women’s lives were on hold in hospital, as Gwenan (*p*7) described “I can’t wait to go to supported accommodation to get on with my life”. Catrin shared her experiences as someone

who had transitioned to living in the community “ah I was so happy [*laughs*]. It was so nice to finally be home”. The women in inpatient services remained optimistic and Rhian (*p*9) shared a message of hope for women in high secure hospital:

“They say when you come to [*high secure hospital*], it’s the end of the road, it’s not the end of the road [ ] I was just saying to a member of staff the other day, staff have planted the seed [ ] and I’ve grown”.

Discussion

This research provided insight into women’s experiences of out-of-area secure inpatient services, emphasising the challenges that women faced in being far from their home, families and community teams. Whilst difficult and distressing experiences were not unique to being in out-of-area services, the distance and disconnect from supportive others magnified their sense of isolation and disempowerment. This echoes the findings from Pashley et al. (2019), identifying the distance from home and families as a significant barrier to women’s recovery in secure services.

The theme of home was ubiquitous in the women’s narratives. Though not overtly explored during the interviews, the concept of home was interpreted as representing both a physical location and an emotional connection to a secure base. The severance of this connection with home through the women’s detention in secure care was considered deeper than the distance and barriers to communication by applying attachment theory (Bowlby, 1988). The challenges that the women faced in forming therapeutic relationships with unfamiliar and changeable staff groups represented barriers to developing an alternative secure base in the absence of home. Highlighted in research surrounding the impact of children’s placement into care, mirroring the women’s detention in secure inpatient services, children try to form new attachments

with temporary foster carers, whilst longing to return to their family of origin and existing attachment figures (Goldsmith, Oppenheim & Wanlass, 2004). Bowlby (1988) describes this as a biologically driven process, which occurs regardless of the level of maltreatment or abuse perpetrated by the caregiver. The women's pre-admission interpersonal relationships with significant others were not explored within the interviews however, these relationships were demonstrated to be fragmented by the women's displacement, as the women described feeling isolated and disconnected from their home.

Van Daalen-Smith et al. (2020) identified similar experiences of harm within services, though few women in the current research discussed medication, or concerns around chemically induced passivity. In the current study, women consistently described distressing experiences associated with being restrained and put into seclusion. Research has demonstrated that women who have been sexually abused in childhood described incidents of restraint in hospital as a re-enactment of their trauma (Gallop, McCay, Guha & Khan, 1999). These experiences may therefore have represented new traumas, whilst also replicating and triggering existing traumas for the women. This highlights the damage and negative consequences that some risk management procedures can have on women when they are experiencing high levels of distress in secure care. In recent decades, the literature surrounding the impact of using restrictive interventions increasingly advocates the use of alternative risk management strategies, moving away from traditional power dynamics focusing on control and restriction, and instead manifesting a culture of empowerment and collaboration (e.g., Ching, Daffern, Martin & Thomas, 2010).

Van Daalen-Smith et al.'s (2020) theme of indifference maps onto the disempowerment and passive acceptance identified in the current research, which the

authors described as more unsettling than narratives of betrayal and harm. In the current research, this was interpreted as a protective avoidance of connecting with the pain of the women's losses and distressing experiences within services. Van Daalen-Smith et al. (2020) highlighted that the act of participating in research is a manifestation of resistance, mirroring the intention of the current study to provide women with an opportunity to share their stories and feel heard.

Although participants shared many stories about distressing and unhelpful experiences, there was a strong message of hope throughout. This contrasts with the findings in van Daalen-Smith et al.'s (2020) study, where women said that they were 'broken' by their experiences in hospital and were more expressive of their distress and emotional experiences than participants in the current research. This may be indicative of the differences in participant populations, or due to the Canadian women no longer being in hospital and having actively reflected on their experiences, attending the interviews with prepared notes; whereas the current participants were still in inpatient settings.

Women identified important experiences that facilitated their progress and transition to services closer to home. The themes reflected the findings of Scholes et al.'s (2021) systematic review, particularly relating to the importance of therapeutic relationships with staff, and the impact of meaningful activity on facilitating progress. Similar important staff qualities were identified in both the review and current study, including being "caring, compassionate and respectful" (p. 7, Scholes et al., 2021). In Scholes et al.'s (2020) review, women described a lack of occupational and recreational activity within services, acknowledging the impact of limited resources and staffing on services' ability to facilitate engagement. In the current study, women recognised the

importance of structure and access to occupation, including education which many had missed out on during their admissions.

Most women found reflecting on their experiences challenging. This is understandable, given that services usually do not routinely encourage service users to reflect on their experiences of previous services, primarily focusing on risk reduction and progression through the pathway. This may also be indicative of participants' passive acceptance of their experiences within services. It may be painful to think about the care they have received, from a position of limited autonomy to independently make impactful changes, and within the context of their previous failed attempts.

There are several obvious limitations; firstly, the first author is non-Welsh speaking and the need to facilitate interviews in English may have unintentionally excluded Welsh-speaking women from participating. Secondly, there were challenges to conducting remote interviews, with poor connections and audio-delays impacting on the flow of dialogue. These issues would have been mitigated by conducting face-to-face interviews however, this was not permitted during the COVID-19 pandemic. Thirdly, it is acknowledged that the length of the interviews were shorter than typically found in IPA research. It is hypothesised that numerous factors contributed to this, including the women's limited experience of talking about the subject in question, and the novelty of remote interviewing for all parties. Future researchers exploring similar phenomena may benefit from conducting multiple interviews with participants over an extended period of time, to overcome some of these challenges.

Fourth, hospital staff were present in five of the seven interviews, undoubtedly impacting the women's responses. This had been considered in the planning stages and approved by the various ethics committees, based on an understanding of

procedures in secure services relating to accessing internet-enabled devices. Staff presence was therefore necessary to ensure that the women could participate, rather than being excluded from the research. However, it would be remiss to ignore the impact of staff presence. The most extensive free dialogue was obtained from the two participants interviewed without staff present. This may be indicative of the absence of staff, or their level of independence, which meant that they did not require support to attend the interview.

Although the data captures the unique experiences of the women interviewed, it is possible to make general recommendations for women's secure inpatient services. Whilst the commissioning of out-of-area services for women may be unavoidable, supporting meaningful connection with family and community teams is of vital importance in minimising the impact of the actual and felt distance from home. Care Co-ordinators should seek to involve women in negotiating the frequency and type of contact, to best support their needs whilst in services. A collaborative approach to carer support could draw upon the knowledge and expertise of the women, their families, community and inpatient teams to ameliorate the impact of a loved one being out-of-area. Future research should explore the impact of implementing routine enquiry of women's experiences of their inpatient journey, and whether this impacts on their narratives and emotional connection to their experiences.

Conclusions

This study is thought to be the first involving women from across the secure care pathway, from high secure through to the community. It provides a unique insight into the experiences of women from North Wales who have been in out-of-area secure inpatient services. The women described the difficulties they encountered when

residing a great distance from their homes and families, and shared distressing stories of their experiences in hospitals. Amidst this, women had some valuable experiences in hospitals and wanted their stories to shape future service provision. The women shared messages of harm, hope and home, and the powerful impact that meaningful connections with others can have on the women who are sent away.

References

Aneurin Bevan University Health Board Chief Executive. Letter in response to Freedom of Information request to Róisín Galway. Dated 19 February 2020.

Barnao, M., Ward, T., & Casey, S. (2014). Looking beyond the illness: Forensic service users' perceptions of rehabilitation. *Journal of Interpersonal Violence, 30*(6), 1025-1045. https://doi.org/10.1177/0886260514539764

Bartlett, A., Somers, N., Fiander, M., & Harty, M. A. (2014). Pathways of care of women in secure hospitals: Which women go where and why. *The British Journal of Psychiatry, 205,* 298-306. https://doi.org/0.1192/bjp.bp.113.137547

Betsi Cadwaladr University Health Board Information Governance Manager. Letter in response to Freedom of Information request to Róisín Galway. Dated 7 January 2020.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development.* New York: Basic Books.

Canning, A. H. M., O'Reilly, S. A., Wressell, L. R. S., Cannon, D., & Walker, J. (2009). A survey exploring the provision of carers' support in medium and high secure services in England and Wales. *The Journal of Forensic Psychiatry & Psychology, 20*(6), 868-885. https://doi.org/10.1080/14789940903174154

Cardiff and Vale University Health Board Information Governance. Letter in response to Freedom of Information request to Róisín Galway. Dated 24 February 2020.

Ching, H., Daffern, M., Martin, T., & Thomas, S. (2010). Reducing the use of seclusion in a forensic psychiatric hospital: Assessing the impact on aggression, therapeutic climate and staff confidence. *The Journal of Forensic Psychiatry & Psychology, 21*(5), 737-760. https://doi.org/10.1080/14789941003681361

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

Cwm Taf Morgannwg University Health Board Freedom of Information Officer. Letter in response to Freedom of Information request to Róisín Galway. Dated 25 February 2020.

Denison, S., Pashley, S., & Daddow, B. (2019). *Women's Secure Blended Service Pilots: the national context* [PowerPoint slides]. SlidePlayer. https://slideplayer.com/slide/17453278/

Duke, L. H., Furtado, V., Guo, B., Vollm, B. A. (2018). Long-stay in forensic-psychiatric care in the UK. *Social Psychiatry and Psychiatric Epidemiology, 53*(3), 313-321. https://doi.org/ 0.1007/s00127-017-1473-y

Durcan, G., Hoare, T., & Cumming, I. (2011). *Pathways to unlocking secure mental health care*. Centre for Mental Health. *https://www.centreformentalhealth.org.uk/sites/default/files/2018-09/Pathways_to_unlocking_secure_mental_health_care.pdf*

Gallop, R., McCay, E., Guha, E., & Khan, P. (1999). The experience of hospitalization and restraint of women who have a history of childhood sexual abuse. *Health Care for Women International, 20*(4), 401-416. https://doi.org/10.1080/073993399245683

Goldsmith, D. F., Oppenheim, D., & Wanlass, J. (2004). Separation and reunification: Using attachment theory and research to inform decisions affecting the

placements of children in foster care. *Juvenile and Family Court Justice, 55*(2), 1-13. https://doi.org/10.1111/j.1755-6988.2004.tb00156.x

Hywell Dda University Health Board Freedom of Information Officer. Letter in response to Freedom of Information request to Róisín Galway. Dated 28 February 2020.

Kennedy, H. G. (2002). Therapeutic uses of security: Mapping forensic mental health services by stratifying risk. *Advances in Psychiatric Treatment, 8*, 433-443. https://doi.org/10.1192/apt.8.6.433

Mental Health Act (1983). London: Department of Health.

Mental Health Act. (2007). London: Department of Health.

National Assembly for Wales. (2005). *Report of a review of adult mental health medium secure units in Wales.* Health Inspectorate Wales and Health Commission Wales (Specialist Services). http://www.wales.nhs.uk/SITES3/documents/477/MSUwebfinal.pdf

NHS England. (2019). NHS Long Term Plan Implementation Framework. https://www.longtermplan.nhs.uk/wp-content/uploads/2019/06/long-term-plan-implementation-framework-v1.pdf

NHS England. (n.d.). *Mental Health Secure Care Programme.* Retrieved 19 October 2020, from https://www.england.nhs.uk/mental-health/adults/secure-care/

NHS England. Letter in response to Freedom of Information request to Róisín Galway. Dated 23 January 2020.

NHS Wales. (2020). 8th Annual Position Statement 2019-2020. NHS Wales Quality Assurance Improvement Service. https://nccu.nhs.wales/qais/position-

statements/position-statement-19-20/ps-documents/qais-annual-position-statement-2019-20/

Padgett, D. K. (2012). *Qualitative and Mixed Methods in Public Health.* Thousand Oaks, CA: SAGE Publications.

Pashley, S., Denison, S., & Moore, H. (2019, April). *Exploring the lived experience of women in secure care services.* [Conference Resource]. National Conference: Women in Secure Care, London, England.

Powys University Health Board Executive Director of Primary Care, Community and Mental Health Services. Letter in response to Freedom of Information request to Róisín Galway. Dated 13 March 2020.

Scholes, A., Price, O., & Berry, K. (2021). Women service users' experiences of inpatient mental health services and staff experiences of providing care to women within inpatient mental health services: A systematic review of qualitative evidence. *International Journal of Nursing Studies, 118,* 1-14. https://doi.org/10.1016/j.ijnurstu.2021.103920

Schwandt, T. A. (1998). Constructivist, Interpretivist Approaches to Human Enquiry. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The Landscape of Qualitative Research: Theories and Issues* (pp 221-259). Sage Publications.

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

Together for Mental Wellbeing. (2014). Briefing: Service user involvement in mental health research. https://www.together-uk.org/wp-content/uploads/downloads/2014/06/Service-User-Involvement-briefing.pdf

Van Daalen-Smith, C., Adam, S., Hassim, F., & Santerre, F. (2020). A World of Indifference/Un Monde D'Indifference: Canadian Women's Experiences of Psychiatric Hospitalization/Experiences Canadiennes d'hospitalization psychiatrique au Canada. *Issues in Mental Health Nursing, 41*(4), 315-327. https://doi.org/10.1080/01612840.2019.1661047

Welsh Health Specialised Services Committee Corporate Governance Manager. Letter in response to Freedom of Information request to Róisín Galway. Dated 12 May 2021.

Women in Prison. (2017). Women in Prison: Key facts. https://www.womeninprison.org.uk/research/key-facts.php

Appendices

Contents

Appendix 1.

Summary of information obtained from Freedom of Information requests

Information from NHS England, response letter dated 23 January 2020.

Table 3.

NHS and independent sector secure beds commissioned by NHS England for women

Level of security	NHS	Independent sector	Total
Low	270	400	670
Medium	325	170	495
High	50	0	50

Information from response letters from Welsh Health Boards and WHSSC.

Table 4.

Women from Wales in secure inpatient services

Health Board	Number of female beds	Number of women in secure/forensic beds	Number of women out-of-area	Cost in 2018/19
Aneurin Bevan University Health Board	0	5 low secure	<5	£1,982,755 (2018/19)
Abertawe Bro Morgannwg University Health Board (ABMUHB) / Swansea Bay University Health Board	10	<5 low secure	<5	£11,132
Betsi Cadwaladr University Health Board	0	28 all levels	13 in England	£2,698,288 2018/19
Cardiff and Vale University Health Board	0	4 low secure 5 – medium secure 1 – high secure	1 in England	£700k indicative annual spend for 4 low secure patients
Cwm Taf Morgannwg University Health Board	0	11 low secure	(less than 5)	£1.38 million
Hywell Dda University Health Board	0	7	(less than 5)	£361,573.56 for low secure patients
Powys University Health Board	0	Not stated as number is too low	All in England	£780,698
WHSSC	N/A	13	7 in England	(not requested)

Appendix 2.

Participant Consent Form

Women out-of-area_v2.0

IRAS ID: 282544

Study Number:

Participant Identification Number for this trial:

CONSENT FORM

Title of Project: **Far from home: Women's experiences of being in secure forensic inpatient services.** Name of Researcher: Roisin Galway

Please initial box

1. I confirm that I have read the information sheet dated..... (version 2.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time up to the point of submission of a written report by the lead researcher as part of their doctoral thesis without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that demographic information (provided by my Care Co-ordinator) and data collected during the study, may be looked at by individuals from the research team, or from the Health Board, where it is relevant to my taking part in this research. I give permission for these individuals to have access to this information. ☐

4. I understand that the interview will be audio-recorded. The recording will be deleted after it has been fully transcribed. ☐

5. I understand that the information held and maintained by-Betsi Cadwaladr University Health Board may be used to help contact me or provide information about my health status. ☐

6. I understand that anonymised quotes from my interview may be included in any write-up of the research findings, which will be submitted to Bangor University and for publication in a journal. ☐

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

Name of Participant	Date	Signature
Name of Person	Date	Signature taking consent

When completed: 1 for participant; 1 for researcher site file; 1 to be kept in medical notes.

Appendix 3.

Participant Information Sheet

Participant Information Sheet (PIS)

Far from home: Women's experiences of being in secure forensic inpatient services. [English version]

Introduction

We are inviting you to take part in a research study. This research study is part of a doctoral thesis which will be submitted for academic assessment to Bangor University by the lead researcher.

Before you decide whether you want to take part, it is important for you to understand why the research is being done and what it will involve.

Please take some time to read the following information carefully. Please discuss it with your care team.

You are free to decide whether or not to take part in this research.

Please contact us if there is anything that is not clear, or if you would like more information.

What is this research about?

We want to talk to women from North Wales about their experiences of being in out-of-area secure inpatient services.

This includes women who are currently in out-of-area services and women who have previously been in such services and have returned to North Wales.

Secure services include low, medium and high secure hospitals.

If you choose to take part, you will be offered a £20 voucher to thank you for your involvement in the research.

Why have I been invited to take part?

You have been invited to take part in this research because you are a woman from North Wales who is either:

- currently in an out-of-area secure inpatient service,
- or you have previously been in an out-of-area secure inpatient service.

You are free to decide whether or not to take part in this research.

The care that you receive from your care team will not be affected, whether or not you choose to take part in this research.

Your decision to take part or to not take part in this research will not effect any legal proceedings related to your care.

What will the research involve?

You will be invited to meet with a member of the research team to answer some questions about your experiences. We hope that we will be able to meet face-to-face however, if social distancing measures are still in place, we would like to talk to you either via a video conferencing service (e.g. Skype), or over the telephone. All interviews will take place in a private room, within the hospital that you are currently in.

In the interview, you will be invited to talk about your experiences of being in secure inpatient services outside of North Wales.

The interview will be audio-recorded on a Dictaphone and transcribed, so that the research team can see if there are any themes that come up in all of the interviews. The recordings will be transferred from the Dictaphone onto a password-encrypted USB and then deleted from the Dictaphone. The recordings will be transcribed – which means they will be typed out word-for-word, and anonymised.

All information relating to anyone who takes part in the research will be anonymised. This means that you will not be named and that you will not be individually identifiable in any written reports, should you choose to take part.

The findings of the research will be written up and submitted to Bangor University as part of the lead researcher's doctoral thesis. This will also be submitted for publication to an academic journal. These write-ups will include anonymised quotes from the interviews.

The audio recordings and the interview transcripts will be stored securely and kept for five years following completion of the research, and then they will be destroyed.

Confidentiality

The experiences that you talk about during the interview will remain confidential and will not be routinely shared with your care team.

However, if you disclose any issues that suggest that you might be a risk to yourself or to others, or at risk from others, the interviewer will need to share this with your care team. You will be informed of this.

Contact details

If you are interested in taking part in this study, please contact the researchers on 03000 852 940 and ask to speak to Dr Julia Wane or Róisín Galway.

If you have any further questions about the study, please do not hesitate to contact us.

How we will use information about you, if you choose to take part.

How will we use information about you?

We will need to use information from you and your Mental Health records for this research project. The research team will be given information from your Mental Health records by your Care Co-ordinators, with your consent. No member of the research team will access your Mental Health records directly. This information will include:

- Your age
- Your ethnicity
- Where you are from (county only)
- Your parental status (i.e. do you have children)
- Your preferred spoken language
- Your Mental Health Act (1983) status
- The length of time you have been in secure services
- The length of your current admission
- Index offence category (where relevant)

This information will be used to describe our participant sample as a whole; for example, we might be able to report that half of the women who took part were first-language Welsh speakers. This information will not be used to describe you as an individual in any of the written reports relating to this research. All information will be stored securely and will only be accessed by members of the research team.

People will use this information to do the research or to check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?

You can find out more about how we use your information:

- at www.hra.nhs.uk/information-about-patients/
- by asking one of the research team
- by ringing us on 03000 852 940 and asking to speak to Dr Julia Wane or Róisín Galway.

Appendix 4.

Interview schedule

1. Can you tell me about your experience of being in secure hospitals outside of North Wales?
   Possible prompts: How do you feel? How do you cope?

2. Can you tell me about your journey through inpatient services?
   Possible prompts: admission, step-up, step-down.

3. Can you tell me about your experience of being a Welsh patient in hospitals in England?
   Possible prompts: How do you feel? How do you cope?

4. Can you tell me about your experience of maintaining contact with your Care Co-ordinator and other services from North Wales involved in your care?
   Possible prompts: How do you contact them? How would you describe your relationship with them?

5. Can you tell me about your experience of maintaining contact with any loved ones back home?
   Possible prompts: family, children, friends, partner, visits, phone calls, letters.

Appendix 5.

Data analysis process

1. Data transcribed verbatim from audio recordings.
2. Data anonymised and identifiable information, including service names and specific locations, redacted.
3. Read through transcript of first case (Seren's interview).
4. Re-read the transcript and noted descriptive comments.
5. Re-read the transcript and noted linguistic comments.
6. Re-read the transcript and noted conceptual comments.
7. Read through all three sets of comments and noted emergent themes.
8. Made a list of emergent themes in chronological order.
9. Organised emergent themes in three ways – using abstraction, contextualisation and polarisation.
10. Extracted quotes from the transcript demonstrating the superordinate themes.
11. Repeated steps 3 – 10 for the remaining six transcripts.
12. Made a list of all superordinate theses across the seven transcripts and printed them out, looking for patterns across the data and organising them by similarity.
13. Identified three main themes.
14. Organised themes by collective superordinate themes and identified the most saliant quotes from the data.

Appendix 6.

Sample extract from transcript analysis

Exploratory comments[2]	Original transcript	Emergent themes
Traumatising – emphasising the impact, again has this had a lasting effect on her? Putting her in – this was done to her Repetition of horrible Stuck – no way out This is what they're like – she's met their kind before, she knows what happens after this, she has a template for what kind of staff/service this is Hopeless, feeling trapped Used to it – it became what she expected, it kept happening? New normal – this was how her life was now Helpless and hopeless – she feels that she has to accept this is how things are done, becomes passive? Uncertainty Remained in secure clothing the whole time How did this impact on her identity and sense of who she was? Did she become a patient and all that this meant to her? Did she loose the things that made her her unique self? Never - absolute Repetition of very – emphasising how small the ward was Limits to where she could go If she could walk anywhere, where would she like to go? Would she just keep walking? Or would she stick within the boundaries of where she is told she can go? Staff were lovely – how does this fit in to it being horrible? They were lovely in their approach when they forcibly changed her clothes without her consent?! Spent the majority of time on enhanced observations – why? How did she feel about being on observations? Was this fulling a need for her? A need to feel attended to, like staff are available and won't leave her, the responsibility for her risks are in someone else's hands? What did coming off observations mean to her? How did she react? Nice to have a good relationship with the staff – emphasising a contrast with some of her other experiences in services	P: Again, it's, you know, traumatising when people are changing you out of your clothes and putting you in secure clothes, it's horrible. So horrible. And then I think I just, I just lay on the floor for like, four hours just crying because, I was like, shit I'm stuck here, this is what they're like. And don't know how long I'm gonna be on here. And yeah, it was just horrible. [pause]. But obviously, you know, after a while you get used to it. [pause]. And it just became the new normal. I: So, was that kind of similar to what your whole experience on that ward was like? P: Erm, it was and it wasn't, you know, but I mean, the entire time I was on that ward, which was 11 months, erm, I was in secure clothing. I wa-, yeah, I never wore my own clothes once. Erm, had no leave at all. Not that I'd actually had any leave before, but, yeah, and it was a very, cause it was only four bedded, it was very very small. So you had the lounge and you had the bedrooms and that was it, you know, you couldn't really walk anywhere. The staff there were lovely, but I – I spent the majority of time in that hospital either on a 2- or a 3:1. Erm, but I had very good relationships with the staff there, which was nice.	*Traumatic experiences* *Feeling stuck* *Hopeless* *Rules and assumptions* *Trauma experiences becoming the norm* *Helpless and hopeless* *New normal* *Becoming passive* *Experience of uncertainty* *Loss of individuality* *Sense of self* *Environmental limits and boundaries* *Inconsistencies in view of others* *Constant observations* *Risk management* *Importance of positive relationships with staff*

[2] Key - Descriptive comments, Linguistic comments, Conceptual comments

Appendix 7.

Research Ethics Committee approved protocol

The hypotheses

As this research has a qualitative design, there are no hypotheses. The research aim is to explore the experiences of women who are either currently, or have previously been, in out-of-area secure inpatient services.

Participants: recruitment methods, age, gender, exclusion/inclusion criteria

Inclusion criteria: • Women • Adults (18+ years) • From North Wales (classed as residents of North Wales and therefore patients in BCUHB) • Currently residing in, or have previously resided in, out-of-area secure forensic inpatient services, including NHS and independent sector low, medium and high secure services. For the purpose of this study, the terms woman and women will refer to any person residing in a women's service and may therefore include individuals who identify as non-binary or transgender.

Exclusion criteria: • Men • Anyone under the age of 18 years • Anyone who has only been in secure inpatient services within North Wales (i.e. inpatient rehabilitation services) • Any women who are not deemed by their Responsible Clinician to have capacity to consent to participation • Any women who are not deemed to be physically or mentally well enough to participate in the research by their Responsible Clinician or care team.

The sample will be recruited from a distinct population. The women will initially be approached through their named care co-ordinator from either the Community Forensic Team or the Community Rehabilitation Teams (CRTs), depending on where they currently reside. The researcher has liaised with the managers of these teams, whom have agreed to support the recruitment process. The Community Forensic Team care co-ordinate women in medium and high secure services. The CRTs care co-ordinate women in low secure services and inpatient rehab services, in addition to women in the community. The CRTs are often heavily involved with women at the beginning and towards the end of their journey through secure inpatient services. There are two CRTs in BCUHB, in the East and Central areas; there is no team in the West however, women in need of rehab support are care co-ordinated by the Central team, as required.

Research design

The research will utilise a phenomenological design. The objective of the research is to explore the experiences of women who are either currently, or have previously been, in out-of-area secure inpatient services. Therefore, qualitative methodology is considered to be the most appropriate method to answer the research question.

Procedures employed

Potential participants will be invited to participate in a semi-structured interview. All interviews will be conducted by the Principal Investigator. As previously stated, the plan is for these interviews to be conducted face-to-face at the unit or hospital at which the individual women reside. However, due to the impact of covid-19 and social distancing guidance, it is possible for interviews to alternatively be conducted remotely either over the telephone or video conferencing. All interviews will be audio-recorded in full on a Dictaphone.

Measures employed
No standard measures or questionnaires will be utilised in this research.

Venue for investigation
As previously stated, the data will either be collected through interviews conducted within the unit or hospital where the participants reside, or remotely via the telephone or video conferencing. The rationale for conducting the interviews within the unit or hospital where the women reside is based on numerous factors. Firstly, many of the participants may not have permission to leave the ward or hospital where they reside, and the process for requesting permissions for section 17 leave can be lengthy. It is therefore considered to be more appropriate for the Principal Investigator to travel to the unit or hospital to conduct the interview, rather than expecting the women to travel to another location. In addition, this would be the least resource-intensive option for the units or hospitals themselves, as many of the women may need to be escorted by (a) member(s) of staff when leaving the hospital grounds. Secondly, the decision has been made in consideration of risk factors. The participant population are likely to be deemed to pose a risk to themselves and/or others, therefore in the interest of safety and security for all involved, it is most appropriate for the interviews to take place within the secure environments of the units or hospitals where the women reside. The population of interest reside in numerous NHS and independent sector units or hospitals across North Wales and England. As previously stated, the women residing in North Wales live in NHS inpatient rehabilitation units or an independent sector low secure unit. All other women from North Wales reside in NHS or independent sector low, medium or high secure units or hospitals across the border in England.

Estimated start date and duration of the study
Recruitment will commence following approval from NHS REC and BCUHB. It is anticipated that recruitment will start no earlier than 01/08/2020. The write-up will be submitted as part of a doctoral thesis in Spring 2021.

Data analysis
The interview recordings will be transcribed verbatim. The researcher will familiarise themselves with the data through the transcription process, recording any initial observations. The working plan is to utilise IPA to analyse the qualitative data gathered from the interviews.

Potential offence/distress to participants
It is expected that participation in the research is unlikely to cause distress. The semi-structured interview questions will be designed to be open-ended. None of the questions will overtly focus on topics which may cause distress, for example the participant's offending history or trauma history. However, it is acknowledged that it may be distressing for participants to talk about any difficult experiences that they have had whilst in secure inpatient services. If a participant became distressed, the interview would be paused, or suspended if needed, and members of staff from the ward or unit would be informed in order to provide the best support for the participant at that time, in line with their existing care plans. If during the interviews any participants disclose incidents of current or historical abuse, either within services or in the community, the BCUHB safeguarding procedure would be followed and the ward

staff would be informed, where appropriate, in order for them to follow their own safeguarding procedures. The participant's care co-ordinator would also be informed of any disclosures. Participants will be informed directly of any need to breach confidentiality and where needed the interview will be terminated.

Procedures to ensure confidentiality and data protection

Bangor University and BCUHB policies and procedures for data storage will be adhered to for the duration of the research. Any documentation containing participant names and corresponding anonymised numbers will be stored separately to anonymised transcripts in locked filing cabinets in the Chief Investigator's office. Electronic copies of the data will be password protected and stored on an encrypted USB stick. Patient information (including signed consent forms) will be destroyed 3 months after the written research report is submitted for academic marking in Spring 2021. Anonymised research data (transcripts) will be retained for five years following completion of the research, as stated in the Bangor University Research Data Management Policy, and then destroyed. All data will be anonymised and no participant identifiable information will be stored on electronic files. Following the end of the project, all data from the project will be stored in the Chief Investigator's office.

****How consent is to be obtained***

Women identified as meeting the eligibility criteria will be provided with a copy of the Patient Information Sheet (PIS) and consent form. This will include information on what participation in the study will involve, how the data will be stored and collected, how participants can withdraw from the research and how the data will be used and published. It will also be emphasised that any decision to participate, not participate or withdraw from participation will not impact of the women's care or service provision. Prospective participants will be invited to contact the Principal Investigator to express an interest in participating, or if they have any further questions about the research.

Approval of relevant professionals (e.g., GPs, Consultants, Teachers, parents etc.)

The women who express an interest in participating in the research will be asked for consent for the Principal Investigator to contact their Responsible Clinician. With consent, the Responsible Clinician will be contacted to confirm that the women have capacity to consent to participation in the study and are mentally and physically well enough to do so. The Gatekeeper in BCUHB will also be informed of the women's participation in the research.

Payment to: participants, investigators, departments/institutions

Participants will be offered a £20 payment for their participation in the research. For the majority of participants, a voucher payment would be appropriate. However, some of the women in secure services may not have access to their own monies therefore, arrangements would be made for their individual hospital accounts to be credited. No payments will be made to departments or institutions. The research team will not be paid for their involvement in the research.

Chapter three

Contributions to Theory & Clinical Practice

Contributions to Theory and Clinical Practice

This chapter includes critical reflections on the literature review, empirical papers and research process, focusing on the implications for clinical practice and future research.

Implications for clinical practice

The findings from both papers highlight the need for idiosyncratic and detailed risk assessments to inform effective interventions for women in prison and secure services. In the literature review, this relates to the development and facilitation of interventions which reduce women's recidivism. In the qualitative research, this was highlighted in the narrative disconnect between the women's internal distress and services' risk management interventions in response to self-harm and suicide behaviours.

Risk assessment tools have been designed to predict the nature, frequency, severity and likelihood of future harm towards others (Craig, Browne & Beech, 2008). Despite the growing literature acknowledging gender-specific criminogenic needs, few risk assessment tools have been developed and validated for use with women (Geraghty & Woodhams, 2015). The efficacy of a risk assessment tool in correctly assessing the likelihood of future violence and recidivism is also referred to as predictive validity. Many widely used risk assessment tools combine clinical judgment and actuarial assessments focusing on static risk factors, for example previous offence history, to overcome the weaknesses of each approach when used individually, also referred to as structured professional judgment. Tools such as Historical Clinical Risk (HCR-20; Webster, Douglas, Eaves & Hart, 1997), demonstrated to have high predictive validity, are widely used structured professional judgment tools, informing appropriate service provision, intervention, and release or discharge planning. Critics argue that most

widely available risk assessment tools do not capture factors contributing to women's offending, including trauma, victimisation, and interpersonal issues.

Geraghty and Woodhams (2015) conducted a systematic review of the predictive validity of risk assessment tools used with women who offend. Fifteen eligible studies were identified, evaluating twelve different risk assessment tools used in prisons and forensic inpatient settings. The Level of Service Inventory (LSI-R; Andrews & Bonta, 1995) was found to have the highest statistical level of positive prediction of both general and violent recidivism (Rettinger, 1998); however, these findings were not replicated across studies using this tool. Overall, risk assessment tools were found to be more accurate in predicting general recidivism than specific violent behaviours in women. Geraghty and Woodhams (2015) concluded that the available risk assessment tools are not yet adequate for fulfilling the goals of enhancing public safety, being cost-effective, identifying future risk and identifying treatment targets for women (Harris & Hanson, 2010).

Few risk assessment tools incorporate specific assessment of an individual's risk of harm to themselves. Several dedicated tools have been developed, for example the Manchester Self-Harm Rule (Cooper et al., 2006); however, Quinlivan et al. (2017) found that clinicians' risk ratings had either equal, or higher, predictive validity than the available tools in predicting future self-harm in adults. Campbell (2017) evaluated the predictive validity of the HCR-20 Female Additional Manual (FAM; de Vogel, de Vries Robbe, van Kalmthout & Place, 2014) in assessing risk of self-harm in a group of women residing in inpatient mental health services in England. Campbell (2017) found that overall, higher numbers of positive ratings on the HCR-20 FAM was indicative of future self-harm; however, most individual items were not independently associated with more frequent self-harm. Specific items within the FAM, including the final risk

judgment for self-destructive behaviour, increased the predictive validity of the original HCR-20 in predicting women's future self-harm.

Combined with the findings of the current literature review and qualitative research, these studies highlight an overwhelming need for the development of new risk assessment tools, based on an understanding of the criminogenic needs of women and their pathways to offending. These tools could then be used by professionals working with women in prisons and forensic inpatient settings, to enhance the understanding of individual need, informing both structured interventions and service responses to incidents of harm.

Literature Review

The current literature review highlighted a particular lack of UK evaluations of offence-specific interventions with a focus on recidivism, conducted within women's prisons and forensic inpatient services. Six of the 35 Ministry of Justice (MoJ) accredited custodial and community programmes are offered to women (Correctional Services Accreditation and Advice Panel; 2021) and only two were specifically developed for women: Choices, Actions, Relationships and Emotions (CARE), and Control of Violence for Angry Impulsive Drinkers – Group Secure Women (COVAID-GSW). Interestingly, no evaluations of either programme were identified within the current systematic review. An article describing the CARE programme (Smith, Tew & Patel, 2015) was yielded however, it was excluded as it was not an evaluation, and therefore did not meet inclusion criteria.

Whilst it is positive that accredited gender-responsive offence-specific interventions are offered within prison and probation services in England and Wales, the efficacy of these programmes is unclear. In recent years, the restructuring in Her Majesty's Prison

and Probation Service (HMPPS) and National Offender Management Services resulted in changes to the way that offender programmes were accredited. Between 1999 and 2008, the Correctional Services Accreditation Panel (CSAP) was an independent public body, tasked with accrediting 'gold standard' interventions for people convicted of offences in England and Wales. CSAP used ten demanding accreditation criteria, including evidencing that the intervention methods are likely to have an impact on recidivism, and that ongoing evaluation will be undertaken to evaluate effectiveness (see Maguire et al., 2010 for a detailed review). In 2008, CSAP became "an advisory non-statutory body within the MoJ" and there were concerns about the impact of significant changes, including panel membership, on the influence of the panel (p. 38, Maguire et al., 2010). The current process for accreditation is unclear, with limited reference to it in the public sphere. The MoJ (2018) website reports that CSAP make recommendations to HMPPS about whether to accredit programmes, based on criteria drawn from the available evidence-base. A response to a Freedom of Information request made by the first author (MoJ, response letter dated 11 May 2021) noted that accreditation criteria are derived from the Principles for Effective Interventions, requiring demonstration that programmes:

Box 1.

1. Are evidence-based and/or have credible rationale.
2. Address factors relevant to reoffending and desistance.
3. Targeted at appropriate participants.
4. Develop new skills.
5. Motivate, engage and retain participants.
6. Delivered as intended by staff with appropriate skills and quality assured via: a) a quality assurance plan, and b) by providing quality assurance findings.
7. Evaluated via a) an evaluation plan, and b) by providing results of evaluation every five years.

Based on this understanding of the accreditation process, it is acknowledged that both CARE and COVAID-GSW developers met the necessary criteria and demonstrated that the interventions were deemed to have an impact on recidivism. There may also be existing published evaluations of both interventions that were not yielded in the current review due to the search terms used, or the limited number of databases searched. Another hypothesis is that these interventions are in their infancy and evaluations were being undertaken, then paused due to the COVID-19 pandemic. In 2020, the National Research Committee suspended all primary research within HMPPS, to reduce the demand on staffing resources during the pandemic (MoJ & HMPPS, 2021). Plans outlining incremental transitions to resuming research within HMPPS have been published (MoJ and HMPPS, 2021), therefore suspended evaluations may soon resume, including any ongoing evaluations of the aforementioned programmes.

It is hoped that in the future, the number of accredited evidence-based interventions developed for women in the criminal justice system in England and Wales will grow, to support women to recognise their individual risk factors contributing to their offending, and help them to develop and implement skills, so they may live lives without offending.

Empirical research

Within the data, there was an absence of expression of distress, with women focusing on self-harm and suicidal behaviours in their narratives around reasons for admissions and transitions within secure services. This was reflected in how services responded to their distress, using physical interventions and removal of means as attempts to manage the risks women posed to themselves. The women experienced these risk

management practices as further contributing to their distress. This highlighted a lack of understanding of the functions of self-harming behaviours, as a form of coping with and communicating internal distress.

One of the issues identified within the literature is the lack of agreed definition of self-harm, also referred to as deliberate self-injury or parasuicidal behaviours. Beasley (p. 29, 2003) suggested that self-harm is “any behaviour engaged in by an individual, regardless of intent, that results in deliberate harm to their body or interference with their vital functioning”. Whilst a comprehensive discussion of the idiosyncratic functions of self-harm is beyond the scope of this paper, it is acknowledged that the function can vary between individuals and between incidents of self-harming behaviours. One interpretation is that self-harm and suicidal behaviours are an attempt to solve the problem of overwhelming emotional pain and distress (Linehan, 1993). Such behaviours can also be effective in eliciting help from others, including mental health professionals; though the help received rarely resolves the problems that the individual was responding to. This mirrors the experiences of the women interviewed in the current research, with services implementing procedures to manage their risks, without asking the question of ‘why’ or talking to them about their distress. The author interpreted that this external invalidation of their distress by staff perpetuated the women’s invalidation of their own distress, resulting in a narrative focused on the consequences of their harming behaviours, lacking emotional expression.

Pejorative language used in the discourse surrounding self-harm and suicidal behaviours are indicative of the ongoing stigma and lack of understanding of the functions, often labelling acts as ‘manipulative’ or ‘attention-seeking’ (National Institute for Clinical Excellence, NICE; 2004). These views are particularly damaging when held by individuals employed to provide care and support to people who self-harm,

including mental health professionals in secure services. As Sandy and Shaw (p.64, 2012) stated “perceiving it negatively may interfere with the quality of care offered to service users as well as perpetuate their need to engage in more self-harming acts”.

Sandy and Shaw (2012) conducted interviews with 61 mental health nurses working with individuals who self-harm in secure inpatient services across London. Using Interpretative Phenomenological Analysis (IPA), the authors identified overarching themes of positive and negative attitudes relating to self-harm. Some staff recognised the negative impact that restrictive risk management practices, including constant observations, had on the people they worked with, whereas others saw these practices as the only means of preventing harm. Nurses highlighted the importance of engaging clients in meaningful activities, offering choice as a means of empowering service users who have been repeatedly disempowered by their experiences (Sandy & Shaw, 2012). Meaningful activities were described as important motivating factors in reducing self-harm and engendering hope, similarly identified by women in the current research. A need for specialist training was the most frequently discussed sub-theme under positive attitude, with nurses recognising that their difficulties in working with this client group were compounded by their lack of understanding of self-harm and how best to respond to it. Sandy and Shaw (2012) concluded that training is needed to improve understanding and increase mental health nurses’ skills to manage self-harm behaviours in secure settings, which should then improve the attitudes they hold about service users who self-harm.

It is hypothesised that offering women in secure services opportunities to talk about their internal distress would change their own understanding of their behaviours and encourage the development of alternative coping strategies. Supporting women to understand and regulate their distress, rather than attempting to prevent their harmful

coping behaviours, may facilitate improved therapeutic relationships and expedite progression through secure services, demonstrating compassionate and individualised care that the women interviewed so desperately sought.

Implications for future research and theory development

Literature Review

The literature review highlighted the different types of interventions offered to women who offend. There are many ways in which these interventions could be categorised, for example based on the target population, the theoretical underpinning, or defined by the professional group who deliver the intervention, to name a few. The current review broadly categorised interventions as offence-specific and non-offence-specific, with the former defining interventions explicitly targeting offending behaviour, and the latter defining any other type of intervention offered to people who offend e.g., substance misuse interventions. In theory, these categories are separate and mutually exclusive however, in reality the boundaries are blurred. By offering an intervention to individuals convicted of offences, regardless of the specific focus, it may impact on recidivism and risk. The categorisation used within this review was intended to differentiate between interventions which have the primary aim of reducing offending behaviours, and those which have alternative primary aims e.g., reducing substance use, or improving social skills.

There were several interventions which sat within the blurred boundaries between the two chosen categories, specifically anger-management interventions (Eamon, Munchua & Reddon, 2001; Taylor, Novaco & Brown, 2016). It was not obvious whether these interventions met the criteria for inclusion in the current literature review. It could

be argued that anger-management interventions are not offence-specific, as they target anger generally, rather than relating to a specific offence category e.g., violent offending. On the other hand, it could also be considered an issue of semantics: in substituting the term anger-management for violence, the level of uncertainty shifts.

The literature around anger and offending behaviour is vast however, there is inconsistent evidence regarding the role of anger in violent offending. Howells et al. (2005) stated that the experience of anger is not necessary nor sufficient for violent offending to occur. The experience of anger as an emotion does not always result in aggressive or violent behaviour, and acts of violence can occur in the absence of anger (Henwood, Chou & Browne, 2015). However, higher levels of anger have been found to occur within offender populations (Spielberger, 1991), and therefore should be considered a contributing factor to violent offending.

Anger-management programmes may propose a somewhat simplified approach to violence reduction, emphasising the importance of anger and neglecting other factors contributing to violent behaviours. Differentiating from anger, aggression can be defined as “any behaviour directed toward another individual that is carried out with the proximate intent to cause harm” (p. 28, Anderson & Bushman, 2002). The General Aggression Model (Anderson & Bushman, 2002) rejects the dichotomous categorisation of aggression, for example impulsive and premeditated aggression, considered an oversimplification of complex cognitive, emotional, and bio-social processes. The model describes the role of an individual’s present internal state in the initiation of aggression, including cognition, arousal, and affect, with the latter incorporating all emotions rather than anger exclusively. Life Minus Violence Enhanced (LMV-E; Ireland et al., 2009) is a cognitive-behavioural violence reduction programme, underpinned by the General Aggression Model. Facilitated over 125

sessions, LMV-E incorporates seven modules focusing on different aspects of violent behaviours including emotional acceptance, information processing and interpersonal skills. This represents a broader, more comprehensive understanding of violence and aggression than traditional anger-management interventions. LMV-E developers propose that the programme is gender-neutral, and a recent small sample evaluation in a women's prison, not yielded by the current review, found significant improvements in trait anger, emotional control, and impulsivity, though the changes varied between participants (McKeown & McCrory, 2019). LMV-E is currently under review for efficacy and CSAP accreditation.

Several evaluations of the Beyond Violence programme were included in the current review. Kubiak, Kim, Fedock and Bybee (p. 197, 2012) describe Beyond Violence as fulfilling the need for interventions for women that "effectively modify aggressive behaviour as well as the underlying precursors of such aggression". This highlights the interrelation between violence reduction programmes and anger-management programmes, even on a surface level; it is anticipated that an in-depth comparison of programme content would reveal even greater similarities. A systematic review of the efficacy of anger-management interventions in reducing recidivism in male offender populations, identified that the content of the included violence reduction programmes was typical of anger-management interventions, with additional focus on victim empathy and risk management (Henwood et al., 2015).

One identified difference between anger-management and violence reduction interventions is the intensity of delivery, with the latter often being higher intensity in session frequency and programme duration (Henwood et al., 2015). This was partially consistent with the findings of the current review, as the two anger-management interventions were shorter in duration than the violence programmes. However, in one

of the anger-management interventions (Taylor et al., 2016), sessions were facilitated twice weekly, whereas some of the violence interventions were facilitated weekly and for a greater number of weeks.

Henwood et al.'s (2015) review concluded that anger-management interventions were associated with a larger effect on risk reduction than higher-intensity violence reduction programmes, though it was acknowledged that violence reduction programmes were facilitated with participants presenting with higher levels of risk and offending, therefore the results may be reflective of this, rather than specific treatment effects. A similar review has not been found relating to women who offend. Based on a review of this information and discussion between the authors, it was considered appropriate to include evaluations of anger-management interventions within the current review.

Empirical research

One of the main challenges of conducting the qualitative study was navigating the layers of approval processes, obscuring access to potential participants. The present research presented unique challenges, with participants holding dual patient status as both NHS patients in North Wales and patients in the commissioned NHS or independent sector service, where they were residing at the time of the interview. Appendix 1 illustrates a summary of the ethical approval processes required for a typical participant within this research. Whilst this illustration depicts a linear process, this is a simplification of the processes actually experienced.

NHS patients are encouraged to participate in research, to improve the care and treatment that they themselves and other patients receive (National Institute for Health Research, NIHR, [no date]). Beyond this, there are additional guidelines which apply

to Welsh patients residing in commissioned services. In Wales, Continuing Healthcare (CHC) is an entitlement for individuals with a primary health need, ensuring that their care and treatment needs are met through the commissioning of appropriate services (NHS Wales & Welsh Government, 2014). The National Framework for Implementation provides guidance on how CHC should be implemented by Health Boards across Wales for mental health, Learning Disability, transition of care from paediatrics to adult services, specialist nursing care and community equipment. Welsh Health Specialised Services Committee (WHSSC) work on behalf of Health Boards to implement the Framework and commission specialist services, including medium and high secure provision. Commissioned services have numerous contractual obligations under the Framework, including ensuring that "the views of patient[s] are sought and actively used to inform service improvement and development" (p. 53, Velindre University NHS Trust, [no date]).

Whilst recognising the paramount importance of patient safety and ethical research practice, the layers of permissions required to recruit the target population for the current research created significant delays. Difficulties navigating the different NHS and independent sector ethical approval processes was laborious and repetitious. There were nuances in the processes, even within a single organisation, and there were difficulties identifying the appropriate points of contact as an outside researcher.

The barriers to accessing this population and facilitating their participation in research contribute to understanding the dearth of research involving people in secure services, especially involving those in commissioned services, and studies conducted by outside researchers. The process could be streamlined by improving communication within organisations, between central research departments and local services, to reduce duplication of approval processes. It is also acknowledged that the particulars

of this research were exceptional and are unlikely to be encountered by researchers conducting single-site projects within an individual organisation. However, improving the process and researcher experience may increase the frequency and quality of research, enhancing the understanding of distinct populations, such as the women interviewed in this study.

Reflections on the Research Process

The challenges presented by the approval processes and participant recruitment were overcome through perseverance and determination, motivated by a desire to share the stories of women in secure services and contribute to service development. Upon commencing the doctorate at Bangor University, I learned that there was no NHS secure service provision for women in North Wales. I was struck by the distances between commissioned services and women's areas of origin, reflecting on my own experiences of living away from family. These experiences of living away from home were through my own choice, moving for work and study, and with unlimited opportunity for contact and visits. This is diametrically opposed to the experiences of women in secure services, who do not choose to be in hospital, nor choose where they reside, and have limited opportunities to initiate contact with loved ones. Reflecting on my experiences of restrictions during the COVID-19 pandemic, I recognise the impact that Welsh border closures have had on families maintaining contact during such an unprecedented time. My hope was that by evidencing the impact these experiences had on women, professionals may identify opportunities to improve service users' experiences, contributing to service development.

It was of paramount importance that the interviews and data were handled sensitively, being receptive to hearing the women's individual stories and the impact of their

unique experiences. Some parts of the women's narratives were particularly distressing to hear and left a lasting impression. As an IPA novice, I struggled to remain solely in the role of interviewer, wanting to respond as I would to a client in clinical practice. IPA emphasises a separation between data collection and analysis, as recommended by Smith, Flowers and Larkin (p. 66, 2009) "resist the urge to interpret what you are being told while the interview is still underway". At times, use of summaries and reflections to show empathic understanding marked a move away from IPA interviewing, and towards a therapeutic interaction. This was done with the intention of helping the participant feel comfortable in sharing their stories, by validating their responses to their difficult experiences. On reflection, this did not appear to negatively impact on the data collected and may have contributed to participants' engagement in the interview process. It also demonstrates the hermeneutic circle, encouraging participants to reflect on and make sense of their experiences which, as previously discussed, they had minimal experience of. The circle was completed through subsequent analyses, by attempting to make sense of the sense made by participants (Smith et al., 2008).

The interview process prompted reflection on my own practice when working in secure inpatient services and prisons. I responded to my initial anger towards individual professionals described in the women's stories, and guilt for my own involvement in equivalent incidents, by applying the assumptions of Dialectical Behaviour Therapy to myself, adopting a dialectical stance (Linehan, 1993). Staff are doing the best that they can within the parameters of their roles and wider system approaches, *and* staff and services would benefit from developing alternative approaches to risk management, which are more compassionate and responsive to service user need. Shifting focus from the individual to the system, further ignited my devotion to the research, using

this opportunity to share the women's stories and make recommendations for service development. If nothing else, this has contributed to the author's own professional development and increased understanding of the impact of these experiences on women in secure care, carrying these stories into future clinical practice and ensuring that they are not forgotten.

Concluding comments

Whilst there were many challenges to conducting both the systematic literature review and qualitative research, both make important contributions to the existing literature surrounding women in prison and forensic inpatient services. The literature review highlighted gaps in the available evidence for offence-specific interventions offered to women; and the empirical research gave dedicated space to the voice of women in out-of-area inpatient forensic services. Underlying these difficulties is the need for accurate and meaningful risk assessments for use with women, to inform decision-making processes surrounding risk management, and the facilitation of evidence-based interventions. Future research is required to expand upon these findings and advance service provision for women who find themselves in prisons and forensic services, often a great distance from their homes and families at such times of need.

References

Anderson, C. A., & Bushman, B. J. (2002). Human aggression. *Annual Review Psychology, 53*, 27-51.

Andrews, D., & Bonta, J. L. (1995). *The Level of Service Inventory-Revised.* Toronto, Canada: Multi-Health Systems.

Beasley, S. (2003). Deliberate self harm in medium security. *Nursing Management, 6*(8), 29-33.

Campbell, L. (2017). Do scores on the HCR-20 and FAM predict frequency of self-harm in females within a secure psychiatric hospital? [Doctoral thesis, University of Birmingham]. University of Birmingham Library. https://etheses.bham.ac.uk/id/eprint/7698/1/Campbell17ForenClinPsyD_v1_Redacted.pdf

Cooper, J., Kapur, N., Dunning, J., Guthrie, E., Appleby, L., & Mackway-Jones, K. (2006). A clinical tool for assessing risk after self-harm. *Annuals of Emergency Medicine, 48*, 459-466.

Correctional Services Accreditation and Advice Panel (2021). *Currently Accredited Programmes.* Ministry of Justice. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960097/Descriptions_of_Accredited_Programmes_-_Final_-_210209.pdf

Craig, L. A., Browne, K. D., & Beech, A. R. (2008). *Assessing risk in sexual offenders: A practitioner's guide.* West Sussex: John Wiley & Sons.

de Vogel, V., de Vries Robbe, M., van Kalmthout, W., & Place, C. (2014). *Female Additional Manual (FAM). Additional guidelines to the HCR-20^{V3} for assessing risk for violence in women. English version.* Utrecht, The Netherlands: van der Hoeven Kliniek.

Eamon, K. C., Munchua, M. M., & Reddon, J. R. (2001). Effectiveness of an Anger Management Program for women inmates. *Journal of Offender Rehabilitation, 34*(1), 45-60. https://doi.org/10.1300/J076v34n01_04

Geraghty, K. A., & Woodhams, J. (2015). The predictive validity of risk assessment tools for female offenders: A systematic review. *Aggression and Violent Behavior, 21*, 25-38. http://dx.doi.org/10.1016/j.avb.2015.01.002

Harris, A. J. R., & Hanson, R. K. (2010). Clinical, actuarial and dynamic risk assessment of sexual offenders: Why do things keep changing? *Journal of Sexual Aggression, 16*, 296-310.

Henwood, K. S., Chou, S., & Browne, K. D. (2015). A systematic review and meta-analysis on the effectiveness of CBT informed anger management. *Aggression and Violent Behavior, 25,* 280-292. https://doi.org/10.1016/j.avb.2015.09.011

Howells, K., Day, A., Williamson, P., Bubner, S., Jauncey, S., Parker, A., & Heseltine, K. (2005). Brief anger management programs with offenders: Outcomes and predictors of change. *The Journal of Forensic Psychiatry & Psychology, 16*(2), 296-311. https://doi.org/10.1080/14789940500096099

Ireland, J. L., Ireland, C. A., Morris-King, S., Turner, P., Graham-Kevan, N., & Xuereb, S. (2009). *Life Minus Violence-Enhance.* Psychological Services, Mersey Care NHS Trust, Liverpool.

Linehan, M. M. (1993). *Cognitive-Behavioral Treatment of Borderline Personality Disorder*. New York: Guilford Press.

Maguire, M., Grubin, D., & Losel, F. (2010). 'What Works' and the Correctional Services Accreditation Panel: Taking stock from an inside perspective. *Criminology & Criminal Justice, 10*(1), 37-58. https://doi.org/10.1177/1748895809352651

McKeown, A., & McCrory, S. (2019). Life Minus Violence Enhanced (LMV-E) with women in custody: single-case experimental design. *Journal of Criminological Research, Policy and Practice, 5*(4), 295-306. https://doi.org/10.1108/JCRPP-08-2019-0055

Ministry of Justice. Letter in response to Freedom of Information request to Róisín Galway. Dated 11 May 2021.

Ministry of Justice. (2018). *Offending behaviour programmes and interventions*. Ministry of Justice and HM Prison and Probation Services. https://www.gov.uk/guidance/offending-behaviour-programmes-and-interventions

Ministry of Justice and HM Prison & Probation Service. (2021). *COVID-19: The National Research Committee's Medium-Term Plan.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/946338/NRC_COVID-19_medium-term_plan_Updated.pdf

NHS Wales & Welsh Government. (2014). Continuing NHS Healthcare the National Framework for Implementation in Wales. [online]. Accessed on 5 May 2021 on: https://gov.wales/sites/default/files/publications/2019-04/continuing-nhs-healthcare-the-national-framework-for-implementation-in-wales.pdf

National Institute for Clinical Excellence. (2004). Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. National clinical guidelines 16. NICE: London. Accessed on 29 May 2021 on https://www.nice.org.uk/guidance/cg16/evidence/full-guideline-189936541

National Institute for Health Research. [no date]. Engagement and Participation in Research: Involve Patients [online]. Accessed on 12 April 2021 on: https://www.nihr.ac.uk/health-and-care-professionals/engagement-and-participation-in-research/involve-patients.htm

Quinlivan, L., Cooper, J., Meehan, D., Longson, D., Potokar, J., Hulme, T., Mardsen, J., Brand, F., Lange, K., Elena, R., Page, L., Metcalfe, C., Davies, L., O'Connor, R., Hawton, K., Gunnell, D., & Kapur, N. (2017). Predictive accuracy of risk scales following self-harm: Multicentre, prospective cohort study. *The British Journal of Psychiatry, 201*, 429-436. https://doi.org/10.1192/bjp.bp.116.189993

Rettinger, J. L. (1998). *A recidivism follow-up study investigating risk and need within a sample of provincially sentenced women* [Unpublished doctoral dissertation]. Carleton University: Ontario, Canada.

Sandy, P. T., & Shaw, D. G. (2012). Attitudes of mental health nurses to self-harm in secure forensic settings: A multi-method phenomenological investigation. *Online Journal of Medicine and Medical Science Research, 1*(4), 63-75.

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

Smith, N., Tew, J., & Patel, P. (2015). The CARE programme: An accredited offending behaviour programme specifically for female offenders at risk of violence.

Journal of Aggression, Conflict and Peace Research, 7(4), 275-286. https://doi.org/10.1108/JACPR-02-2015-0164

Spielberger, C. D. (1991). *State-Trait Anger Expression Inventory revised research edition, professional manual.* Odessa, FL: Psychological Assessment Resources.

Taylor, J. L., Novaco, R. W., & Brown, T. (2016). Reductions in aggression and violence following cognitive behavioural anger treatment for detained patients with intellectual disabilities. *Journal of Intellectual Disability Research, 60*(2), 126-133. https://doi.org/10.1111/jir.12220

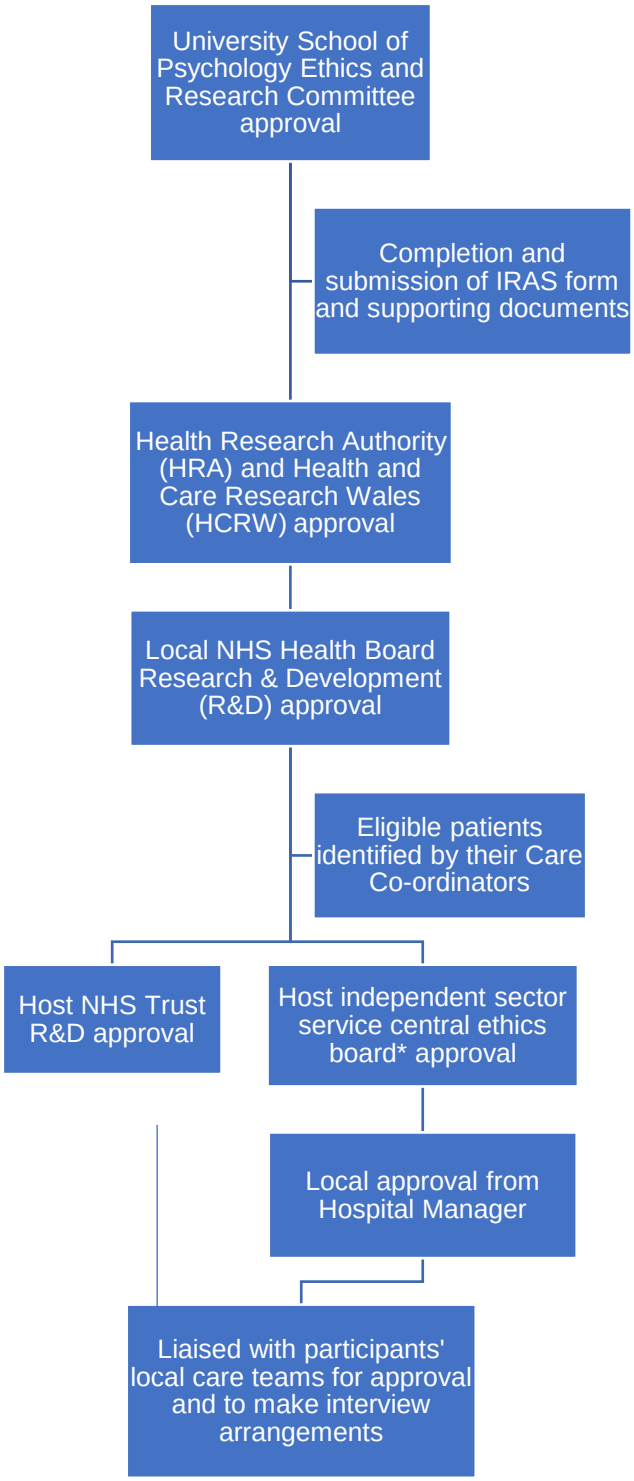
Velindre University NHS Trust. [no date]. *Framework schedules/clauses which need to survive FA termination. Commissioning agreement template.* Welsh Health Speclialised Services Committee.

Webster, C. D., Douglas, K. S., Eaves, D., & Hart, S. D. (1997). *HCR-20: Assessing risk for violence (version 2).* Burnaby, British Columbia: Simon Fraser University and Forensic Psychiatric Services Commission of British Columbia.

Appendices

Appendix 1.

Summary of ethical approval processes undertaken during empirical research.



* Ethics board has been utilised as an umbrella term to describe the various ethical committees within the independent sector services, which were titled differently in each service.

Word Count

Thesis summary	290
Literature review	
Abstract	192
Main text	5,657
Tables and figures	1,465
References	1,690
Appendices	623
Empirical study	
Abstract	170
Main text	7,544
Tables and figures	565
References	811
Appendices	4,084
Contributions to theory and practice	
Main text	3,956
Tables and figures	74
References	840
Appendices	40
Title pages, acknowledgements, contents	905
Exclusive total (main text only)	16,797
Inclusive total (all elements)	28,847