PROFESSIONAL DOCTORATES

Care and compassion: An exploration of care experiences and compassion focused approaches in Forensic and Inpatient Mental Health Services.

English

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Award date:
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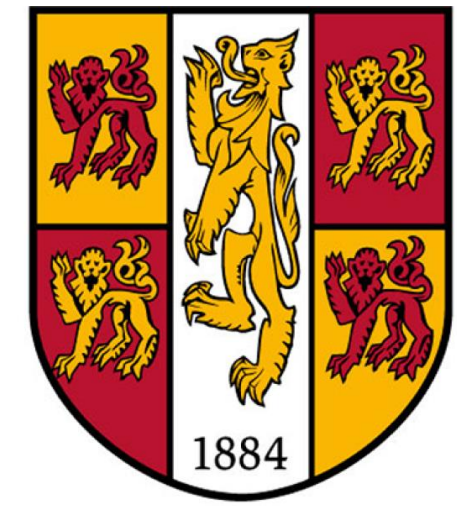
Hannah Waite

North Wales Clinical Psychology Programme

Supervised by Dr Julia Wane and Dr Carolien Lamers



PRIFYSGOL
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Submitted as partial fulfilment for the degree of

Doctorate in Clinical Psychology (DClinPsy)

June 2023

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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: Hannah Olivia Hart Waite

Date: 31st May 2023

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believed in me as much as you did and your support and guidance throughout my life is the reason I am here today. I would give anything for you to be here to see this and I hope I have done you proud. Nanna, you have been the source of light and laughter on the darkest of days. This is for you both.

Finally, in the words of Harry Styles: “We have a choice, every single day that we wake up, of what we can put into the world, and I ask you to please choose love every single day.”

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Chapter 3: Contributions to Theory and Clinical Practice

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Thesis Abstract

This thesis sought to explore how people talk about the care that they receive whilst detained within forensic mental health services and the use and effectiveness of compassion focused approaches within forensic and inpatient mental health services.

Chapter one presents a systematic literature review that synthesised twelve studies where compassion focused approaches were utilised within forensic and inpatient mental health services, delivered to both those in receipt of care and those delivering care. A narrative synthesis of the studies highlighted promising findings for the effectiveness of compassion focused approaches for the inpatient mental health population, inpatient mental health staff, adolescent offenders, and adult male offenders. Promising findings were identified across a range of mental health and criminogenic needs. Limitations included variable methodological quality of the studies reviewed and narrow population groups, resulting in difficulty in generalising findings to wider population groups.

Chapter two presents an empirical qualitative study that explored how seven males detained within forensic mental health services spoke about their experiences of receiving care under the Care and Treatment Planning approach. A Foucauldian Discourse Analysis methodology was utilised. Three main discourses emerged: “the power sits with them”, “tug-of-war”, and “it’s my care”. Alternative discourses to “the power sits with them” and “tug-of-war” were identified; “complex power systems”, and “a world removed from reality”. Power influenced the way in which care was perceived and received by the participants.

The final chapter, chapter three, considers the theoretical, research and clinical implications of both the systematic literature review and the empirical study, concluded with a personal reflection from the first author.

Chapter 1

Systematic Literature Review

Compassion focused approaches in Forensic and Inpatient Mental Health Services: A systematic review.

Hannah Waite[a]*, Dr Julia Wane[b] and Dr Carolien Lamers[c]

[a]*North Wales Clinical Psychology Programme, Bangor University, Bangor, Wales;*

[b]*North Wales Forensic Psychiatric Service, Betsi Cadwaladr University Health Board, Wales;*

[c]*North Wales Clinical Psychology Programme, Bangor University, Bangor, Wales.*

Address for Correspondence: Hannah Waite, North Wales Clinical Psychology Programme, Brigantia Building, Bangor University, Bangor, Gwynedd, LL57 2DG.

Email: hnw20rjc@bangor.ac.uk

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Abstract

Compassion focused approaches were developed to support individuals with complex and chronic mental health needs and aimed to increase the ability to develop compassion in individuals who experience high levels of shame and self-criticism. This systematic literature review explored the use and effectiveness of compassion focused approaches with people in inpatient mental health and forensic settings, who often experience these emotions. Twelve studies were reviewed, with variable methodological quality, as assessed by the Mixed Methods Appraisal Tool. Compassion focused approaches included group intervention for both patients and staff, (e.g., compassion focused therapy (CFT), mindfulness self-compassion and recovery after psychosis (RAP)) and an individual intervention for juvenile offenders aimed at reducing psychopathic traits and disruptive behaviour. The synthesis of studies indicated that compassion focused approaches were being utilised, with positive outcomes reported across all 12 studies that focused on a variety of mental health and criminogenic needs. Findings indicated that compassion focused approaches improved self-compassion and compassion for others, whilst reducing fear of threat and shame. Issues related to methodological quality and gender representation within participant samples were identified.

Keywords: compassion focused approaches; CFT; forensic; inpatient; systematic literature review

Introduction

Feeling safe and comfortable within oneself and in relationships with others can be difficult for those who experience high levels of shame and self-criticism (Byrne & Ní Ghráda, 2019). Perceived lack of safety, particularly within mental health and forensic populations, can exacerbate psychological distress (Stickley & Spandler, 2013). There is an increasing acknowledgement that people in mental health and forensic services have likely experienced greater levels of adversity and trauma within their lives, as compared with the general population (NHS Wales, 2022). These experiences detrimentally impact a person's sense of identity, belonging, learning, development and attachment (Taylor & Hocken, 2021b). The experience of trauma and adversity can hinder the ability to give and receive care and compassion, with the threat-based neurobiological system activated more frequently. This can lead to feeling frightened and vulnerable (Sweeney et al., 2015), and as a means to maintain personal safety, this can result in increased risk of violence and/or aggression (Renwick et al., 2019), leading to the development of criminogenic factors, including harmful behaviours (Taylor & Hocken, 2021b).

Low self-worth, high levels of shame and increased self-criticism are commonly present in people experiencing difficulties with their mental health (Clarke & Wilson, 2009; Gilbert & Irons, 2005). People with mental health problems who require inpatient care face further stigmatisation, prejudice and discrimination within society, resulting in an increase sense of shame and self-criticism (Watson & River, 2005). People who find themselves within forensic settings, either in secure mental health services (e.g., where psychiatric care is provided to individuals who are deemed to pose a risk to the public) or prisons, are particularly stigmatised by society (Corrigan et al., 2012; Ma, 2017; West et al., 2014). The presence and experience of stigma can often result in people

experiencing limited access to social and community support (Marshall & Adams, 2018), possibly exacerbating the experience of shame and high levels of self-criticism.

With high levels of distress experienced by both those receiving care while detained and those providing care, offering psychological interventions can be challenging (Clarke & Wilson, 2009). People detained in forensic or secure settings are often subject to a Hospital Order (Mental Health Act, 1983) as a result of Court proceedings following perpetration of an offence. A Hospital Order, including those paired with additional restrictions imposed by the Ministry of Justice, function differently to prison sentences as they do not have a clear end date. As such, indeterminate length of stay serves as an exacerbating factor for an increase in distress for those in receipt of care (Clarke & Wilson, 2009).

Staff working in these settings also experience high levels of distress, impacting their well-being and increasing the risk of burnout. Witnessing distress in those cared for as well as involvement in incidents of aggression and the need to employ restrictive physical interventions (e.g., restraint), can exacerbate the staff's distress. These experiences can reduce the quality of therapeutic relationships with the people in their care (Berry et al., 2016; Power et al., 2020). Being able to cultivate compassion as the central component of care is crucial for the safe delivery of effective treatment interventions (Crawford et al., 2013; Proctor et al., 2019).

Compassion focused approaches were initially developed to support individuals with complex and chronic mental health needs (Gilbert, 2009). Compassion Focused Therapy (CFT) adopts a multimodal approach, drawing on psychological and neuroscience concepts along with attachment theory. It aims to increase the ability to develop compassion in individuals who experience high levels of shame and self-criticism (Gilbert, 2009). CFT focuses on increasing an individual's understanding and

awareness about automatic reactions that humans experience when facing threats within their environment (Gilbert, 2009). The underlying principles of CFT are to support the client to develop motivation to increase their overall well-being, foster personal warmth and understanding and increase their individual sensitivity to their own needs (Gilbert, 2009). The evolutionary function of emotions is emphasized within CFT, with emotions organised across three overlapping motivational systems: threat, drive and soothing systems (Griner et al., 2022). The threat system encompasses emotions that help us to avoid harm, such as anger and fear, whilst the drive system comprises emotions such as pleasure and elation that promote gathering resources, competition and achievement. The soothing system promotes support, connection and rest through gaining a sense of safety (Gilbert, 2009). It is proposed within CFT that human experiences, shaped by genetics, attachment and the environment, are processed through human brains, known as 'tricky brains', that function based on these three systems. It recognises that a person is not to blame for the difficulties and suffering they experience and, consequently, the way in which the brain processes these experiences, however, a person is responsible for choosing how to relate to and manage their difficulties and suffering (Griner et al., 2022).

When shame and self-criticism are elevated, developing, increasing and maintaining self-compassion and compassion for others has been demonstrated to have a profound impact on mental health, overall-wellbeing and physiology (Harman & Lee, 2010; Neff & Germer, 2012), and are associated with reductions in the experience of paranoia (Lincoln et al., 2013). The role of basic human systems is emphasised within CFT, for example, the fight or flight system, and incorporates self-soothing techniques that support the development of empathy, self-compassion, and loving kindness in an attempt to develop an internal compassionate relationship with oneself (Beaumont &

Hollins-Martin, 2015; Gilbert, 2009). With relevance to forensic populations, CFT is about understanding how our brain is trying to protect us and how it reacts in response to perceived threat, with increasing compassion forming the foundation for how people address their harmful and offending behaviour, without punishing them for their innate human responses (Griner et al., 2022). This can support the individual to learn to cope with their difficulties and emotions and take personal responsibility for their engagement in offending behaviour (Beaumont & Hollins-Martin, 2015). There is encouraging support for CFT as a key intervention framework for people who use forensic services (Taylor & Hocken, 2021a), with evidence of reduced violence (Taylor, 2017), reduced shame, reduced psychopathic traits (e.g., impulsivity, irresponsibility, lack of empathy, guilt, or remorse and persistent violation of social norms and expectations) (Ribeiro da silva, 2019), reduction in denial relating to offending and greater risk awareness being positive outcomes of CFT in addressing criminogenic needs.

The United Kingdom (UK) government established a shared vision for compassion in healthcare, including mental health, more than a decade ago (Department of Health, 2011; 2015); however, research on compassion in mental health and forensic services remains underrepresented (Barron et al., 2017; Gerace, 2020). A limited number of literature reviews with a focus on compassion and its relevance and efficiency within mental health and forensic settings have been completed. A narrative review of CFT studies involving clinical samples (prior to 2014) was conducted by Beaumont and Hollins-Martin (2015). They reviewed 12 studies, two of which were focused on participants with mental health problems and demonstrated effectiveness of CFT in working with these participants (Gilbert & Proctor, 2006; Judge et al., 2012). Similarly, Kirby et al. (2017) conducted a meta-analysis which included 12 randomised

controlled trials (RCTs) exploring compassion-based therapies with adults across multiple countries and settings. Their findings demonstrated significant moderate effect sizes for mindfulness, self-compassion, and measures of anxiety and depression. However, their meta-analysis did not provide substantive details about the differences in the compassion-based therapies reviewed. A review by Kirby (2017) identified that CFT in particular had the greatest evidence base of the compassion-based therapies, with preliminary evidence demonstrated for people with high levels of self-criticism and mood related difficulties. More recently, Byrne and Ní Ghráda (2019) conducted a systematic literature review of third wave psychotherapies for mental health difficulties and aggression within correctional and forensic settings. Their review included only one CFT study (Laithwaite et al., 2009), indicating CFT as an effective intervention for decreasing symptoms associated with depression in men diagnosed with psychosis, who were detained within a secure hospital setting.

Previous systematic reviews have explored the use of compassion focused approaches across a variety of settings, however, differentiation between specific mental health and forensic settings is limited. The first question that this review aimed to address was: are compassion-focussed approaches used and if so, what are these approaches? Within this, inpatient mental health settings and forensic settings were explored including inpatient adult mental health, forensic high secure, adult prison and adolescent prison settings. Inpatient mental health and forensic settings were included due to similarities in the nature of the care provided to people in these settings. (e.g., people detained under legal frameworks). The second question that this review aimed to address was: what are the outcomes and/or findings from the compassion-focused approaches within these settings? The current review will, therefore, provide a narrative

synthesis of compassion focused approaches utilised and evaluated within inpatient mental health and forensic settings.

Methodology

Pre-registration

Prior to the commencement of database searches and to provide transparency and prevent duplication, the protocol for this review was registered with the International Prospective Register of Systematic Reviews (PROSPERO; ID: CRD42022375791). This systematic literature review was conducted and prepared following the Preferred Reporting Items for Systematic reviews and Meta-Analysis (PRISMA) guidelines (Page et al., 2021).

Inclusion criteria

This review explored the compassion focused approaches utilised within forensic and mental health inpatient settings, including adolescent, adult, and staff populations. Studies detailing the use and outcomes of compassion focused approaches, delivered on individual or group levels, in forensic services and inpatient mental health services were included. Only peer-reviewed articles published in English, with the full text available were included. All methodological approaches were considered.

Exclusion criteria

Studies that involved compassion focused approaches with the outcomes not clearly defined or reported were excluded. The review excluded studies involving inpatient eating disorder (ED) services as their function, purpose and aim differs from those of inpatient mental health and forensic settings, not least due to the need to address

physical health implications in the first instance. Therefore, the outcomes of CFT approaches explored within this review would likely be different to the outcomes sought in the treatment of ED's. Finally, studies without full-text available and not published in English were excluded.

Search strategy

A total of nine databases were searched: ASSIA; CINAHL; PsycINFO; MEDLINE; PubMed; The Cochrane Library; Criminal Justice Database; NCJRS; and Social Science Premium Collection. Searches were conducted on 25th January 2023 and were limited to articles published up to and including 31st December 2022. The search terms were developed to encapsulate published data, inclusive of publications from outside of the United Kingdom. The search terms were: "CFT" OR "compassion-focused" OR "compassion-focussed" OR "compassion* approach*" OR "compassion focused therap*" OR "compassion focussed therap*" OR "compassion-focused therap*" OR "compassion-focussed therap*" OR "compassion* focused therap*" OR "compassion* focussed therap*" OR "compassion*-focused therap*" OR "compassion*-focussed therap*" AND "forensic mental health" OR "forensic psychiatric" OR "forensic secure" OR "forensic service*" OR "secure service*" OR "low secure" OR "low-secure" OR "medium secure" OR "medium-secure" OR "high secure" OR "high-secure" OR "secure inpatient" OR "forensic inpatient" OR "prison*" OR "correction*" OR "custod*" OR "offen*" OR "crim*" OR "convict*" OR "detain*" OR "prison*" OR "incarcerate*" OR "inmate*" OR "jail" OR "juvenile" OR "adolescen*" OR "problem*" OR "inpatient" OR "psychiatric inpatient" OR "inpatient psychiatric" OR "inpatient mental health".

Study selection

Search results from all nine databases were extracted to ProQuest RefWorks. Duplicates were removed prior to title and abstract screening against the inclusion and exclusion criteria. Full texts were then sought for all articles identified for possible inclusion. Full text articles were screened against the inclusion and exclusion criteria utilising a bespoke screening and selection tool (Appendix 1). Reference lists and citations of identified articles were hand screened to identify further articles for inclusion.

Data extraction

Data extracted from the articles included:

- Study location
- Participant age demographic
- Participant group and sample size (including control groups)
- Environment demographic (inpatient or forensic)
- Nature of compassion focused approach (including primary focus)
- Application of compassion focused approach (individual, group or staff)
- Method of analysis
- Outcome measures utilised for quantitative studies
- Outcomes and findings relevant to this review

A narrative synthesis of extracted data was conducted. This method was selected due to heterogeneity in the studies' designs, interventions utilised, and measures utilised, with varying aims and outcomes noted across the studies.

Assessment of methodological quality

Methodological quality of each article was assessed utilising the Mixed Methods Appraisal Tool (MMAT: Hong et al., 2018), an appraisal tool designed specifically for reviewing articles utilising qualitative, quantitative, or mixed method approaches. The MMAT discourages generating an overall score, rather, it emphasises the need to provide a more detailed presentation of the ratings of each criterion to better inform the quality of the included studies. This was conducted by the first author and cross-checked by the second author to ensure validity of ratings, with full agreement between the first and second author's ratings. The MMAT involves two generic screening questions and five appraisal questions that vary dependent on the methodological approach. Due to the limited number of articles identified, all articles were included regardless of their quality as determined by the MMAT. However, their quality was considered and weighed appropriately during data synthesis and reporting.

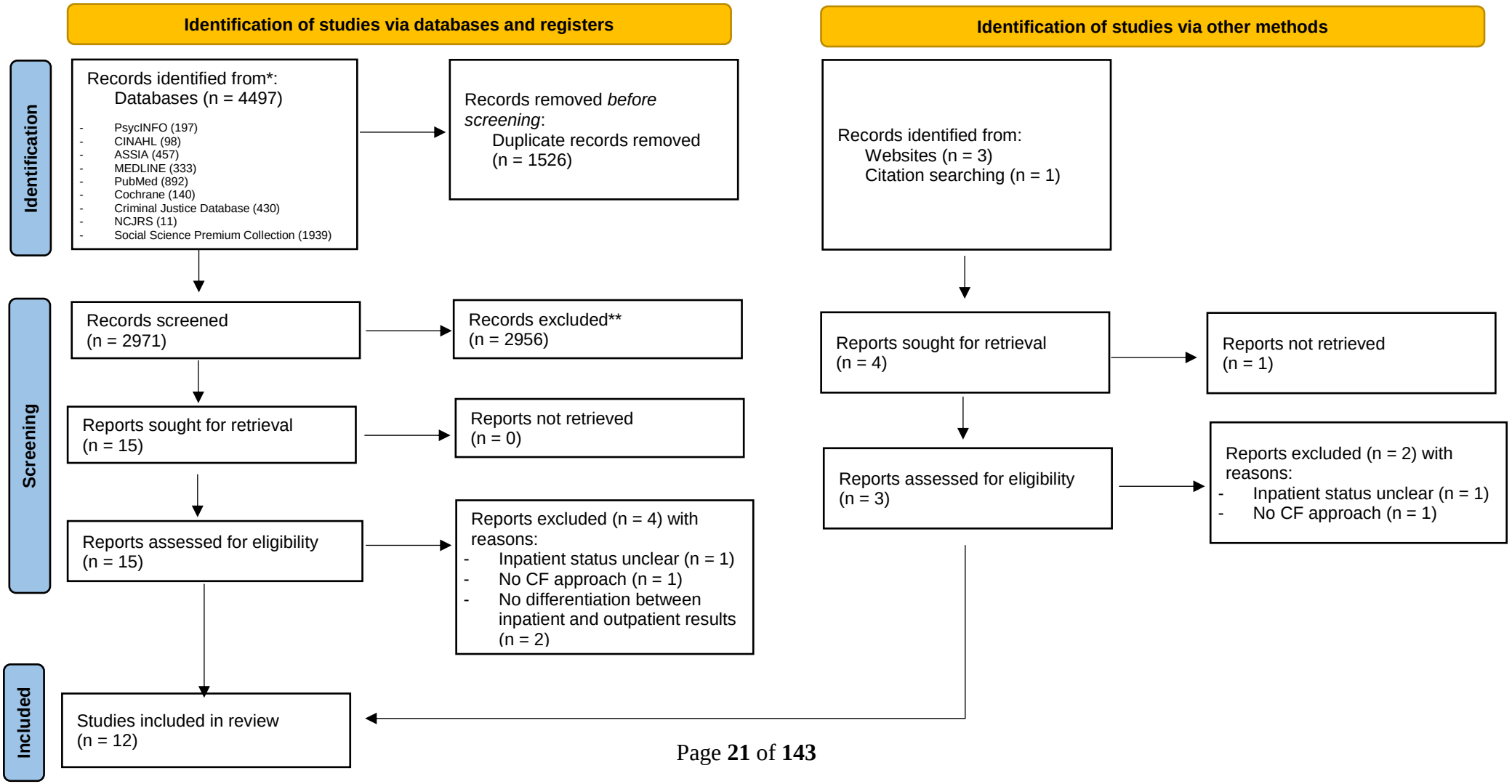
Results

Search Results

The initial database searches returned a total of 4497 articles (Figure 1). Following removal of duplicates, 2971 articles were screened by their title and abstract against the eligibility criteria, resulting in 2956 articles being excluded. Fifteen full texts were retrieved and assessed for eligibility, with four excluded (Figure 1). A further four articles were identified through secondary searches, three of which were retrieved and assessed for eligibility with two excluded. The second and third authors screened four full texts (20%) against the inclusion criteria. Twelve articles were included in the final data synthesis as they met all inclusion criteria. (Appendix 2 details for all 18 articles screened).

Figure 1

Prisma Flow Chart Diagram



Study Characteristics

Study characteristics from the 12 included studies are presented in Table 1, with their MMAT review rating presented in Table 2. Of the studies included in this review, seven involved an adult population and five involved an adolescent population (aged 14-18 years). Sample sizes ranged from one to 200, with the majority of studies involving >50 participants (n=7). One study involved a participant sample of staff (n=8), four involved mental health inpatients (n=347), one involved forensic mental health patients (n=18), one involved adult prisoners (n=14) and five involved adolescent prisoners (n=398). Settings of the included studies involved mental health inpatient (n=5) and forensic settings (n=7). The forensic settings included one study that was conducted within a high secure service, five within an adolescent prison, and one within a prison involving participants with learning disabilities. Psychometric assessments were utilised in eleven of the studies (Table 4), with comments on their internal consistency and/or reliability reported within the majority of the studies (Appendix 3).

Methodological quality

The majority of the studies (n=7) were non-randomised quantitative, with six including a control group (Frostadottir & Dorjee, 2019; Ribeiro da Silva et al., 2021a; Ribeiro da Silva et al., 2021b; Rijo et al., 2023; Sousa et al., 2022a; Stroud & Griffiths, 2021) and one which did not (Laithwaite et al., 2009). Participants were representative of the target population and the outcome measures utilised were appropriate in assessing the intended outcomes for all studies, with valid psychometric properties in the majority of the measures utilised (Appendix 3). The interventions were well described in how they were administered, as intended, in all seven studies. The MMAT criteria require that complete data sets should be available for 80% (Thomas et al., 2004) to 95%

(Higgins et al., 2016) of the participants. In relation to pre and post outcomes, complete data sets were present in six of the seven quantitative non-randomised studies, with post outcomes completed for between 85.7% and 96.6% of participants. Stroud and Griffiths' (2021) quantitative non-randomised study achieved 70.94%, not meeting the complete data set criteria. In terms of follow-up data, the MMAT criteria advise a maximum of 30% drop-out/withdrawal rate for follow-ups (Viswanathan & Berkman 2012). Five quantitative non-randomised studies included follow-ups which ranged from one month to six months (Frostadottir & Dorjee, 2019; Laithwaite et al., 2009; Ribeiro da Silva et al., 2021(1); Rijo et al., 2023; Sousa et al., 2022a). All five studies had complete data for the treatment group post intervention evaluation, with follow up rates ranging from 73.2% to 100%. Of the four studies that utilised a control group, Sousa et al. (2022a) and Frostadottir and Dorjee (2019) did not achieve a complete data set, gathering a 60.4% and 65% follow-up rate respectively. As this review was largely interested in compassion focused approaches, the studies whose data sets were identified as complete for the treatment group, were rated on the MMAT as having a complete data set. It was unclear whether confounding factors were accounted for in the design and analysis for most of the quantitative non-randomised studies (n=5), with the exception of Frostadottir and Dorjee, (2019) and Sousa et al. (2022a).

Three mixed methods studies were included in the review (Drobinska et al., 2022; Heriot-Maitland et al., 2014; Taylor 2021). All three studies provided a rationale for using a mixed methods design, and the different components of the studies were effectively integrated to answer the research question. Both qualitative and quantitative outputs were adequately interpreted, and divergences and inconsistencies in qualitative data were reported. In terms of the different components of the study adhering to the MMAT quality criteria for each methodology used, Heriot-Maitland et al (2014)

adhered to the quality criteria of the traditions for both qualitative and quantitative methodology. The quantitative aspect of the study by Drobinska et al. (2022) involved descriptive statistics alone and, therefore, did not meet the appraisal criteria for this aspect. Similarly, Taylor (2021) utilised a thematic analysis approach to the qualitative aspect and presented the themes with an absence of quotes to justify the themes.

A single case quantitative descriptive study was conducted by Ribeiro da Silva et al. (2019). The sampling strategy was relevant to address the research question with the sample being representative of the target population. Measurements utilised were appropriate, as was the statistical analysis employed.

One quantitative randomised controlled trial (Gaiswinkler et al., 2020) was included within the review. Although randomisation was not appropriately performed, the authors highlighted and addressed this within their limitations. The groups were comparable at baseline and outcome data was deemed complete. The outcome assessors were blinded within this study and all participants adhered to the assigned intervention.

Overall, the quality of the included studies was variable, as determined by the MMAT (Table 2). The main issues of appraisal involved difficulty in identifying confounders being accounted for in both study design and analysis (n=5) lack of appropriate randomisation (n=1) and lack of adherence to the quality criteria of each tradition of the methods involved within the mixed methods studies (n=2). As a result, some findings might be less reliable due to the quality of the study.

Compassion Focused Approaches

A mixture of individual (n=5) and group (n=7) approaches were utilised within the 12 studies (Table 3). The individual and group approaches were implemented and delivered as interventions of differing lengths, ranging from four sessions to weekly

sessions over an 18-month period. The length of session was reported in 10 studies, with intervention durations between 60 minutes (1 hour) and 150 minutes (2.5 hours).

Group Interventions

The seven group intervention studies all involved adult participants in inpatient mental health (n=5) and forensic (n=2) settings, with a shared aim of increasing self-compassion, amongst other outcomes (Table 3). All group interventions comprised of a main focus on skill development through experiential practice. Five of the group approaches were described as a CFT group. Each intervention differed in their format, however, all contained core sessions focusing on psychoeducation, mindfulness, compassion and imagery. Additional topics were included within the group intervention for prisoners with a developmental disability, such as understanding criminogenic need. Recovery After Psychosis (RAP) was delivered in one of the studies and comprised of three modules: understanding psychosis and recovery, understanding compassion and developing the ideal friend, and developing plans for recovery after psychosis. Experiential practice also featured within this group. Finally, the Mindfulness Self-Compassion group was delivered in one of the studies and comprised of psychoeducation about self-compassion, mindfulness, and compassion exercises. Again, this group featured experiential practice.

Individual Intervention

The five individual intervention studies involved adolescents, and all used a compassion focused approach called PSYCHOPATHY.COMP, a manualised programme designed to reduce psychopathic traits and disruptive behaviours, through the development of a compassionate motivation, in adolescent detainees with conduct disorder. The

intervention was delivered in the same way across the studies and comprised of four modules: the basics of our mind, our mind according to CFT, compassionate mind training, and recovery / relapse planning. The modules focused on themes including tricky brain, responsibility and freedom, emotion regulation systems including the threat system, flows of compassion including self-compassion and fears of compassion, and motivation. Each session was divided into three parts: grounding exercise and overview of the previous session, an exercise relevant to the session topic and a session summary.

Table 1

Summary Characteristics of Included Studies

Study	Country	Sample size	Participant demographic	Participant Setting	Compassion focused approach	Methodological Design
Drobinska et al. (2022)	UK (Wales)	8	Adults - Staff	Mental Health - Inpatient	Compassion focused therapy group	Mixed methods
Frostadottir & Dorjee (2019)	Iceland	58	Adult - Inpatients	Mental Health - Inpatient	Compassion focused therapy group	Quantitative (non-randomised)
Gaiswinkler et al. (2020)	Austria	200	Adult - Inpatients	Mental Health - Inpatient	Mindfulness self-compassion group	Quantitative (Randomised Control Trial)
Heriot-Maitland et al. (2014)	UK (Eng)	57	Adult - Inpatients	Mental Health - Inpatient	Compassion focused therapy group	Mixed methods
Laithwaite et al. (2009)	UK (Scot)	18	Adult - Inpatients	Forensic - High Secure	Recovery After Psychosis (RAP) group	Quantitative (non-randomised)
Ribeiro da Silva et al. (2019)	Portugal	1	Adolescent - Prisoner	Forensic - Prison	PSYCOPATHY.COMP	Quantitative (descriptive)
Ribeiro da Silva et al. (2021a)	Portugal	119	Adolescent - Prisoners	Forensic - Prison	PSYCOPATHY.COMP	Quantitative (non-randomised)
Ribeiro da Silva et al. (2021b)	Portugal	50	Adolescent - Prisoners	Forensic - Prison	PSYCOPATHY.COMP	Quantitative (non-randomised)

Rijo et al. (2023)	Portugal	119	Adolescent - Prisoners	Forensic - Prison	PSYCOPATHY.COMP	Quantitative (non-randomised)
Sousa et al. (2022a)	Portugal	109	Adolescent - Prisoners	Forensic - Prison	PSYCOPATHY.COMP	Quantitative (non-randomised)
Stroud & Griffiths (2021)	UK (Wales)	32	Adult - Inpatients	Mental Health - Inpatient	Compassion focused therapy group	Quantitative (non-randomised)
Taylor (2021)	UK	14	Adult - Prisoners	Forensic - Prison	Compassion focused therapy group	Mixed methods

Table 2

Summary of MMAT Quality Assessment for Included Studies.

	Drobinska (2022)	Frostdottir (2019)	Gaiswinkler (2020)	Heriot-Maitland (2014)	Laithwaite (2009)	Ribeiro da Silva (2019)	Ribeiro da Silva (2021a)	Ribeiro da Silva (2021b)	Rijo (2023)	Sousa (2022)	Stroud (2021)	Taylor (2021)
S1: Clear research question?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
S2: Data collected addresses the research question?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
2.1: Appropriate randomisation?	N/A	N/A	N	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2.2: Groups comparable at baseline?	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2.3: Complete outcome data?	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2.4: Assessors blinded?	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

2.5: Participant adherence to intervention?	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
3.1: Representative sample?	N/A	Y	N/A	N/A	Y	N/A	Y	Y	Y	Y	Y	N/A
3.2: Appropriate outcome measures?	N/A	Y	N/A	N/A	Y	N/A	Y	Y	Y	Y	Y	N/A
3.3: Complete data?	N/A	Y	N/A	N/A	Y	N/A	Y	Y	Y	Y	N	N/A
3.4: Confounders accounted for?	N/A	Y	N/A	N/A	CT	N/A	CT	CT	CT	Y	CT	N/A
3.5: Intervention as intended?	N/A	Y	N/A	N/A	Y	N/A	Y	Y	Y	Y	Y	N/A
4.1: Appropriate sampling method?	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
4.2: Representative sample?	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
4.3: Appropriate measures?	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
4.4: Low non-response bias?	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
4.5: Appropriate statistical analysis?	N/A	N/A	N/A	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A
5.1: Rationale for mixed methods?	Y	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
5.2: Effectively integrated?	Y	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y

5.3: Integrated findings?	Y	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Y
5.4: Inconsistencies in findings addressed?	Y	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	CT
5.5: Adherence to each methods quality criterions?	N	N/A	N/A	Y	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N

S = screening questions, 1 = not included (qualitative methodological questions), 2= randomised controlled trial questions, 3 = non-randomised quantitative methodological questions, 4 = quantitative descriptive methodological questions and 5 = mixed methodological questions.

Y = Yes, N = No, CT = Can't Tell, N/A = Not Applicable

Table 3

Summary of Compassion Focused Approach Evaluated in Studies.

Study	Nature of approach	Length of approach	Primary aims of approach
Drobinska et al. (2022)	Group	6 x weekly 2-hour sessions	Experiential group aiming to facilitate a safe space enabling affiliative relating to each other between participants and the development of a "compassionate mind".
Frostadottir & Dorjee (2019)	Group	8 x 2-hour sessions over a 4-week period	Effects of implicit self-compassion training on symptom change, mindfulness, self-compassion and rumination.
Gaiswinkler et al. (2020)	Group	6 x weekly 75-minute sessions	Improvement in self-compassion, physical and mental functioning and a reduction in psychiatric symptom burden.
Heriot-Maitland et al. (2014)	Group	4 sessions	Develop an understanding of CFT along with skills in mindfulness, compassion and imagery.
Laithwaite et al. (2009)	Group	10 x twice weekly sessions	To improve depression and self-esteem and social comparison, to develop compassion towards self and to reduce external shame.
Ribeiro da Silva et al. (2019); Ribeiro da Silva et al. (2021a); Ribeiro da Silva et al. (2021b); Rijo et al. (2023); Sousa et al. (2022a)	Individual	20 x weekly 1-hour sessions	To reduce psychopathic traits and disruptive behaviours in adolescent detainees with conduct disorder.

Stroud & Griffiths (2021)	Group	6 x 1-hour sessions ran in a cyclic pattern between Monday and Friday (e.g., repeating every week). Individuals could repeat sessions during their admission, so attendance was not set to just one cycle of treatment.	Improve patient outcomes.
Taylor (2021)	Group	Weekly 2.5-hour sessions over an 18 month period	Aims to support men to process and make sense of their own experience of trauma before inviting them to acknowledge their role in causing harm to others.

Table 4

Summary of Findings from Quantitative Measures Used in Studies.

Study	Measure	Subscales	Outcome (mean scores pre and post intervention)	Significance level
Frostadottir & Dorjee (2019)	Five-Facets of Mindfulness (Baer et al., 2006)		Significantly higher scores*	p = <0.001
	Self-Compassion Scale (Neff, 2003)		Significantly higher scores*	p = <0.05
	Reflection Rumination Questionnaire (Trapnell & Campbell, 1999)	Total score	Significantly lower scores*	p = <0.003
	Depression Anxiety and Stress Scales-Short Form (Lovibond & Lovibond, 1995)		Significantly lower scores*	p = <0.001
Gaiswinkler et al. (2020)	Self-Compassion Scale (Neff, 2003)	Total score Self-compassion Self-criticism	Significant improvement Significant improvement Significant improvement	p = <0.01 p = <0.01 p = <0.01
	The Medical Outcomes Study 36 Item Short-Form Health Survey (McHorney et al., 1994)	Physical component Mental component	No significant difference No significant difference	p = >0.05 p = >0.05
	Brief Symptom Inventory (Derogatis, 2001)	Global Severity Index (GSI)	No significant difference	p = >0.05

	Subjective feeling of happiness		Significant improvement	P = <0.01
Heriot-Maitland et al. (2014)	Distress and calmness rating scale (Jacobsen et al., 2011)	Distress Calmness	Significant reduction in distress Significant increase in calmness	p = 0.005 p = 0.014
Laithwaite et al. (2009)	Social Comparison Scale (Allan & Gilbert, 1995)	Total score	Significant improvement*	p = 0.036
	Other as Shamer Scale (Allan et al, 2994; Goss et al, 1994)	Total score	Significant reduction	p = 0.04
	Self-Compassion Scale (Neff, 2003)	Total score	Non-significant change	p = 0.18
	Beck Depression Inventory II (Beck et al, 1996)	Total score	Significant reduction*	p = 0.018
	Rosenberg Self-Esteem measure (Rosenberg, 1965; Rosenberg et al., 1995)	Total score	Significant improvement*	p = 0.06
	Self-Image Profile for Adults (Butler & Gasson, 2004)	Total score	Non-significant improvement	p = 0.165
	The Positive and Negative Syndrome Scale (Kay et al., 1987)	Positive Negative General Depression	Non-significant change Non-significant change Significant improvement* Non-significant change	p = 0.248 p = 0.055 p = 0.022 p = 0.056

Ribeiro de Silva et al. (2019)	Youth Psychopathic Traits Inventory-Short (Van Baardewijk et al., 2010; Portuguese version by Pechorro et al., 2015)	Total GM CU II	Significant reduction* Significant reduction* Significant reduction* Significant reduction*	p = <0.05 p = <0.05 p = <0.05 p = <0.05
Ribeiro de Silva et al. (2021a)	Youth Psychopathic Traits Inventory-Short (Van Baardewijk et al., 2010; Portuguese version by Pechorro et al., 2015)	Total GM CU II	Significantly greater decrease* Significantly greater decrease* Significantly greater decrease* Significantly greater decrease*	p = 0.000 p = 0.002 p = 0.004 p = 0.000
	Proposed Specifiers for Conduct Disorder (Salekin, 2017)	Total GM CU DI	Significantly greater decrease* Non-significant decrease* Significantly greater decrease* Significantly greater decrease*	p = 0.001 p = 0.196 p = 0.002 p = 0.008
Ribeiro de Silva et al. (2021b)	Youth Psychopathic Traits Inventory-Short (Van Baardewijk et al., 2010; Portuguese version by Pechorro et al., 2015)	Total GM CU II	Significant reduction* Significant reduction* Significant reduction* Significant reduction*	p = 0.000 p = 0.039 p = 0.026 p = 0.000
Rijo et al. (2023)	Other as Shamer Scale Brief Adolescent (Vagos et al., 2016)		Significantly greater decrease*	p = 0.000
	The Fear of Compassion Scale (Gilbert et al., 2011; Portuguese version for adolescents by Duarte et al., 2014)	Give Receive Self	Significantly greater decrease* Significantly greater decrease* Significantly greater decrease*	p = 0.000 p = 0.000 p = 0.000
	Social Safeness and Pleasure Scale (Gilbert et al., 2009; Portuguese version for adolescents by Miguel et al., 2019)		Significantly greater increase*	p = 0.002

	Self-Compassion Scale (Neff, 2003)		Significantly greater increase*	p = 0.000
	The Compassion Scale (Pommier et al., 2020; Portuguese version for adolescents by Sousa et al., 2022b)		Significantly greater increase	p = 0.000
	Youth Psychopathic Traits Inventory-Short (Van Baardewijk et al., 2010; Portuguese version by Pechorro et al., 2015)	Total GM CU DI	Significant decrease* Significant decrease* Significant decrease* Significant decrease*	p = 0.010 p = 0.018 p = 0.011 p = 0.013
	Proposed Specifiers for Conduct Disorder (Salekin, 2017; Salekin & Hare, 2016)	Total CU DI	Significant decrease* Significant decrease* Non-significant decrease*	p = 0.006 p = 0.023 p = 0.052
Sousa et al. (2022a)	International Affective Pictures System (Lang et al., 1997; Portuguese version by Soares et al. 2015)	Resting phase Reactivity phase Recovery phase	No significant change Significant change for HFms2* Significant change for HFms2 and RMSSD*	p = 0.078 p = 0.038 p = 0.0017 and 0.036
	Difficulties in Emotion Regulation Scale–Adolescent Version (Gratz & Roemer, 2004; Portuguese version for adolescents adapted from the Portuguese version for adults by Coutinho et al., 2010)	Total score Goals Clarity	Significant effects* Significant effects* Non-significant effects	p = 0.001 p = 0.018 p = 0.117
Stroud & Griffiths (2021)	Clinical Outcomes in Routine Environments–Outcome Measure (Evans et al., 2000)	Total Problem Functioning	Significant reduction Significant reduction Significant improvement	p = 0.000 p = 0.000 p = 0.000

		Wellbeing	Significant improvement	p = 0.000
		Risk	Significant reduction	p = 0.001
	Session by session Likert Scale	Threat	Significant decrease (sessions 3-6)	p = 0.000
		Self-compassion	Significant increase (all sessions)	p = 0.000
		Compassion for others	Significant increase	p = 0.000
Taylor (2021)	Guilt and Shame Proneness Scale (Cohen et al., 2011)	Negative self-evaluations	Significantly reduced feelings of shame	p = 0.005
		Negative behaviour evaluations	Significantly increased feelings of guilt	p = 0.005
	Assessment of risk and manageability of individuals with developmental and intellectual limitations who offend (Boer et al., 2013)		Significant changes in self-assessed stable and acute risk	p = 0.005

*maintained or continued to improve at follow up

Narrative synthesis

Data were extracted from the 12 studies included within this review. Four different compassion focused approaches were explored within the studies. The interventions included CFT groups for staff (n=1), mental health inpatients (n=3) and adult male prisoners with learning disabilities (n=1), RAP in a forensic high secure setting (n=1), mindfulness self-compassion group for mental health inpatients (n=1) and PSYCOPATHY.COMP delivered on an individual basis for detained adolescent offenders (n=5). The studies aimed to explore aspects of compassion focused approaches, their use and effectiveness in different settings and with different populations, including the participant experience of engaging with a compassion focused approach.

All studies demonstrated positive impacts of compassion focused approaches in targeting the clinical or forensic need identified that the approach was aimed at. Positive impacts of the compassion focused approaches included significant increases in self-compassion (n=5) and compassion for others (n=2), significant improvements in clinical outcomes (n=1), increase in social safeness (n=1), increase in happiness (n=1) and improvement in emotion regulation (n=1) (Table 4). Positive reductions in unhelpful experiences were also demonstrated within the studies, including but not limited to, significant reduction in psychopathic traits (n=5), significant reduction in distress (n=1), significant reduction in perception of threat (n=2), decreases in rumination, depression, anxiety and stress (n=1), significant decrease in shame and fear of compassion (n=1) and reductions in experiences of shame (n=1) (Table 4). The studies that collected data at a follow-up point unanimously demonstrated maintenance of positive impacts of engagement with compassion focused approaches post intervention (varying between one and six months) (Table 4). This provides support that the interventions had

longstanding and positive effects, with maintained improvements on their targeted outcomes.

Forensic settings

While all seven studies that delivered interventions within forensic settings adopted a compassion focused approach, their aims varied from reducing psychopathic traits, to reducing shame and denial along with increasing acknowledgement of responsibility. Two studies delivered group interventions and five offered an individual intervention, with compassion forming the foundation of the interventions. It should be noted that the two group interventions were designed for and delivered to adults, whereas the five studies involving an individual intervention all comprised of the same intervention (PSYCOPATHY.COMP) that was designed for and delivered to adolescents within a Portuguese prison. Due to the high representation of the individual intervention (PSYCHOPATHY.COMP) included within this review it is, therefore, difficult to generalise the findings to wider forensic populations and across services in other countries. The participants in these studies included adult male prisoners with developmental disabilities, adult male high secure patients with a primary diagnosis of schizophrenia, schizo-affective disorder or bi-polar affective disorder and male adolescents presenting with psychopathic traits detained within a prison setting. Importantly, the studies involving adults were conducted in the UK, whilst the studies involving adolescents were conducted in Portugal. Due to differences within the laws and clinical practice, the rationale for and impact of detention and diagnosis is likely to differ.

Laithwaite (2009) evaluated the RAP group delivered within a forensic high secure setting and identified significant improvements in social comparison ($p<0.05$) and depression ($p<0.05$), with no significant change to levels of self-compassion

(p=0.18) as determined by the Self-Compassion Scale (Neff, 2003) (Table 4). Of note, it was difficult to identify if confounders were accounted for and, as such, inferences about the role of RAP in achieving the reported outcomes need to be delicately drawn. The participants' median scores on the Self-Compassion Scale were compared with norms developed in a general student population and, therefore, the self-report of compassion may be different for individuals who have lacked the experience of compassion from others during critical periods in their development (Laithwaite, 2009). The participants in this study had all experienced psychosis and, therefore, the CFT intervention was targeted at people who had a primary diagnosis of schizophrenia, schizo-affective disorder or bi-polar affective disorder.

Taylor's (2021) exploration of a prison based CFT group intervention for people with a developmental disability, demonstrated significantly reduced feelings of shame (p=0.05) and significantly increased feelings of guilt (p=0.05) as assessed by the Guilt and Shame Proneness Scale (Cohen et al., 2011) (Table 4). The participants' IQ ranged from 53 to 75 (m=63.4). Qualitatively, Taylor (2021) identified five key themes from participant feedback following the CFT intervention which appeared to be associated with shifts in shame, denial and acknowledgement of responsibility, themes in line with the intended outcomes of the intervention. The 'tricky brain' descriptor provided a de-shaming understanding of problematic behaviours, while non-risk focussed aspects of the group provided a broader understanding: "we talk about all of me rather than risky me". They felt there were opportunities to explore personal adversity which facilitated trust and opportunities to explore personal experiences that facilitated risk focussed work. The flexibility of the programme content created a more responsive and engaging context which enabled a willingness to explore the therapeutic relationship and created a containing relationship. Unfortunately, these five themes were not supported with data

evidence (e.g., quotations), therefore, making inferences of their relevance and importance to understanding the impact of the CFT intervention difficult to draw.

The four studies exploring the effectiveness of PSYCOPATHY.COMP on reducing psychopathic traits in adolescent males all demonstrated significant reductions in psychopathic traits as assessed by the Youth Psychopathic Traits Inventory-Short (Van Baardewijk et al., 2010; Portuguese version by Pechorro et al., 2015). Interestingly, Rijo et al (2023) also identified significant increases in self-compassion (p=.000) following engagement with PSYCOPATHY.COMP (Table 4) and concluded that increased self-compassion and decreased fear of receiving compassion, were crucial to the reduction in psychopathic traits. Finally, Sousa et al. (2022a) evaluated the effectiveness of PSYCOPATHY.COMP in relation to improved emotion regulation, demonstrating a statistically significant effect in increasing emotion regulation (p=0.001) (Table 4). Emotion regulation is an outcome different to what the intervention was initially designed for. This could indicate secondary benefits, however, as the data set was incomplete, with lack of clarity around whether confounders were accounted for, it is difficult to glean if the improvement in emotional regulation was as a direct result of the intervention or due to extraneous factors.

Inpatient Mental Health Settings

The five studies that involved inpatient mental health populations and settings were all delivered as group interventions and comprised CFT groups for inpatients (n=3), mindfulness self-compassion group (n=1) and CFT group for staff (n=1). The four studies exploring compassion focused approaches with mental health inpatients all demonstrated positive findings including statistically significant[1] increases in self-

[1] Findings are reviewed in terms of their statistical significance (to the value of $p < 0.05$)

compassion and compassion for others, significant reductions in threat and greater reports of happiness and calmness. Significant reductions in distress, rumination, depression, anxiety and stress were also reported (Table 4). Two studies utilised a control group (Gaiswinkler et al., 2020; Stroud & Griffiths, 2021), with one study utilising a control group and a comparator group (Frostadottir & Dorjee, 2019), while two studies did not have a control nor comparator group (Drobinska et al., 2022; Heriot-Maitland et al., 2014). Appropriate randomisation in Gaiswinkler et al's., (2020) study was not facilitated, however, the authors highlighted and addressed this within their limitations, noting that the groups were comparable at baseline with outcome assessors blinded.

Inpatient sample sizes varied from 8 to 114 participants within the compassion focused approach groups. Participants were predominantly female across the four studies that reported gender, with female samples ranging from 59% to 83%. Interestingly, Drobinska et al's (2022) sample of eight staff was "majority female", perhaps indicative of the gender weighting within the mental health professions. The studies were predominantly conducted in the UK (n=3), with one conducted in Iceland and one in Austria, highlighting possible differences in mental health service provision. All quantitative studies (n=4) utilised validated outcome measures, however, the aims of each study differed.

Frostadottir and Dorjee (2019) reported significant improvements in self-compassion ($p<0.05$) as determined by the Self-Compassion Scale (Neff, 2003) and mindfulness ($p<0.001$) as determined by the Five-Facets of Mindfulness (Baer et al., 2006). They also reported significant reductions in rumination ($p=0.003$) as identified by the Reflection Rumination Questionnaire (Trapnell & Campbell, 1999) and depression, anxiety and stress symptoms ($p<0.001$) as identified by the Depression,

Anxiety and Stress Scales – Short Form (Lovibond & Lovibond, 1995) (Table 4). Despite the significant and promising findings, it is worth acknowledging the non-randomised and small sample utilised within this study. Also, there was no significant difference in the findings between the CFT group and the Mindfulness Based Cognitive Therapy (MBCT) group, therefore, the changes may not have been as a direct result of the content of the CFT group intervention. Similarly, Gaiswinkler et al. (2020) also reported significant improvements in self-compassion ($p<0.01$) and Stroud and Griffiths (2021) reported a significant reduction in Clinical Outcomes in Routine Environments–Outcome Measure scores ($p=0.000$) (Table 4). Their findings indicated a greater improvement in the CFT groups over the comparator groups (Progressive Muscle Relaxation and Treatment as Usual respectively). Heriot-Maitland et al. (2014) reported a significant ($p<0.05$) reduction in levels of distress and a significant ($p<0.05$) increase in overall calmness post-session, as determined by the Distress and Calmness Rating Scale (Jacobsen et al., 2011) (Table 4). Despite the pilot study not utilising standardised outcome measures, qualitative data focused on the participants experience of engaging within the CFT group identified themes including 'common humanity', 'understanding compassion' and 'experience of positive affect'.

Qualitatively, Heriot-Maitland et al. (2014) and Drobinska et al. (2022) reported themes focused on participants' experiences of the CFT group interventions. Differences in themes were evident between the two studies, likely due to the nature of the participant groups (e.g., one delivering care and one being in receipt of care). Within the CFT group delivered to staff (Drobinska et al., 2022), themes in common including difficulties associated with the job role and frustration with the job demands were presented (e.g., "the nature of the ward"; "slowing down is not allowed"; "it is not in our nature"; "guilt and threat"; "we are not important"). Contrastingly, the CFT group

delivered to inpatients generated themes centred around what had been gained from the interventions (e.g., ‘understanding compassion’ and ‘experience of positive affect’) with notions of the de-shaming aspect of CFT (e.g., ‘experience of common humanity’) (Heriot-Maitland, 2014). It seemed, therefore, that the focus of the CFT intervention would have differed between the studies, considering the aim of the group and the type of participants.

Similar to the forensic based interventions, it is evident that the CFT interventions delivered and evaluated within inpatient mental health services also reported promising findings for their intended outcomes.

Discussion

This review explored the use of compassion focused approaches for patients and staff in inpatient mental health and forensic services. Specifically, the review sought to identify if compassion-focussed approaches were used in inpatient mental health and forensic settings, and if so, what the approaches were along with the outcomes and/or findings of compassion-focused approaches within these settings. The synthesis of 12 studies indicated that compassion focused approaches were being utilised, with varied evidence to support their effectiveness within specific settings and populations across different outcome measures. Whilst outcomes were explored utilising a range of validated measures, providing some confidence in the findings, the methodological quality of all studies was variable, with only one RCT included, which according to the authors was not appropriately randomised. As only another six studies included control groups, caution should be applied in weighting the strength of the findings.

Positive outcomes on a variety of outcome measures were reported across all 12 studies. Findings indicated that compassion focused approaches improved self-compassion (Frostadottir & Dorjee, 2019; Gaiswinkler et al., 2020; Rijo et al, 2023; Stroud & Griffiths, 2021) and compassion for others (Rijo et al., 2023; Stroud & Griffith, 2021), whilst reducing fear of threat (Rijo et al, 2023; Stroud & Griffiths, 2021) and shame (Laithwaite et al., 2009; Taylor, 2021). These are important outcomes when considering the nature of inpatient mental health and forensic populations, given the high levels of shame and self-criticism experienced (Clarke & Wilson, 2009; Gilbert & Irons, 2005; Watson & River, 2005). However, measures specifically related to mental health showed varied outcomes, with one study reporting changes that were not statistically significant (Gaiswinkler et al., 2020), one reporting both no statistically significant change and statistically significant changes on different outcome measures (Laithwaite et al., 2019) and three studies reporting statistically significant outcomes on mental health related measures (Frostadottir & Dorjee, 2019; Stroud & Griffiths, 2021; Sousa et al., 2022a)

The review incorporated a mixture of group and individual interventions, with the individual intervention evaluated multiple times across the participant group. The majority of interventions were clearly presented and described in the papers, providing clarity and transparency in the delivery of the intervention, making replicability possible. Several studies reported improvements on specific outcomes across group and individual methods of delivery. Improvements in more general clinical outcomes, as demonstrated by Stroud and Griffiths (2021) as well as improvements in mental health measures (Frostadottir & Dorjee, 2019; Heriot-Maitland et al., 2014), indicate that compassion focused approaches could be more widely helpful. Based on the evidence thus far, future research including appropriately randomised control or comparator

groups, particularly over a longitudinal time frame, would be helpful in clearly establishing both the impact of compassion focused approaches on a variety of outcomes and the relationship between increased self-compassion and other compassion related outcomes on overall mental health and wellbeing.

Five studies explored the use of compassion focused approaches within inpatient mental health services, all demonstrating encouraging findings for CFT's effectiveness in improving compassion related outcomes. Outcome measures assessed the most prominent difficulties experienced by mental health inpatients. Inpatient mental health settings can often be places of uncertainty and shame, within which an individual may feel unsafe and vulnerable and experience high levels of self-criticism (Byrne & Ní Ghráda, 2019; Sweeney et al., 2015). The target of compassion focused approaches is to address basic human systems that have evolved to serve differing functions, for example, the fight or flight system. This helps to position people's experiences in a non-shaming and validating light (Beaumont & Hollins-Martin, 2015; Gilbert, 2009).

In addition to the issues with study design and methodological quality of the included studies, with only three of the inpatient mental health studies including a control or comparator group, it is also important to acknowledge that studies involving inpatient mental health services were comprised of predominantly female samples, including the staff participant group. Females often experience different difficulties associated with their mental health than males (Busfield, 2017) and are likely to experience inpatient settings and therapeutic relationships differently, due to gender roles and identity within society (Judd et al., 2009). Similarly, the studies involving forensic populations comprised of an all-male and predominantly adolescent sample, with most likely to have engaged in offence related behaviours as well as experiencing

difficulties with their mental health. These factors need to be considered when drawing inferences on the applicability of interventions across different gender identities.

Seven studies focused on compassion focused approaches within forensic settings, with the majority focused on individual compassion focused interventions delivered to adolescent offenders within a Portuguese prison. Despite its challenging name, the PSYCOPATHY.COMP intervention, aimed at reducing psychopathic traits in adolescents within a prison setting, demonstrated significant reductions in psychopathic traits, as assessed by the Youth Psychopathic Traits Inventory – Short, with some indication of additional benefits including increased emotion regulation (Sousa et al., 2022a), social safeness, self-compassion and compassion for others (Rijo et al., 2023). Reductions in shame and fear were also presented as an outcome. Compassion focused approaches delivered in a group setting for male prisoners with developmental disabilities and male patients detained within a high secure service also reported positive compassion related outcomes. With the lack of a control group, it is difficult to attribute the findings to the compassion focussed approach or whether other factors were of influence.

A major limitation of the included forensic population studies was an all-male population, with the majority being adolescents between 14 and 18 years of age. It is worth considering the impact of developmental stage on the delivery and impact of an intervention, particularly considering adolescents tend to be more receptive to change as a result of their brain and personality still developing (Seiffge-Krenke, 2017). Similarly, adolescent prison settings are considered especially challenging environments socially, as compared with adult prison settings, where any indication of vulnerability can be perceived as a weakness and a greater sense of threat (Gooch, 2019). Gender differences and the gender balance within the forensic population (Tomlin et al., 2021) could also

result in discrepancies. Further research surrounding females within forensic services would be helpful in order to identify the generalisability and applicability of compassion focused approaches.

A further implication of the findings for the forensic settings pertains to the high prevalence of studies included that utilised the same intervention (PSYCHOPATHY.COMP). It is, therefore, difficult to generalise these findings to wider population groups, even within forensic settings, due to the high proportion of studies involving the same intervention, service and likely, delivery method. Similarly, the evaluation of the PSYCHOPATHY.COMP intervention was conducted by members of the same research group across the five studies. This should be considered when drawing inferences on the effectiveness of such intervention due to a potential bias in the outcomes explored and presented findings.

Control and/or comparator groups were utilised in four of the forensic studies (Ribeiro da Silva at al., 2021a; Ribeiro da Silva at al., 2021b; Rijo et al., 2023; Sousa et al, 2022a), all of which evaluated the effectiveness of PSYCOPATHY.COMP, however, the requirements of randomisation were not met in any of these studies. The absence of a control or comparator group within the other three forensic studies leads to difficulties in assessing the outcomes, with consideration to confounding variables that could have influenced the outcomes.

Strengths and limitations of review

This is the first systematic literature review focusing specifically on the use of compassion focused approaches within inpatient mental health and forensic settings. The core limitation of this review is the limited number of studies included in the review and the variable methodological quality of included studies, specifically the

inclusion of only one RCT, the absence of appropriate randomisation in studies that did involve control groups and the absence of control and/or comparator groups in other studies. The focus of the current review did not seek to include outcome data relating to any other aspect of compassion focused interventions, for example motivations for engagement, reasons for attrition and comparisons with other therapeutic approaches. In addition to the limitations mentioned previously, only studies published in English were included, consequently excluding studies published in other languages and possibly other judicial and mental health service provision.

Implications and recommendations

The review highlights the use of compassion focused approaches within inpatient mental health and forensic services, with particular attention to the reported effectiveness on specific outcomes. The limited research in this area was apparent. Any compassion focused interventions designed for and delivered within inpatient mental health and forensic settings should be evaluated and shared using compassion focussed and mental health related outcomes, with particular attention to generalisability and gender differences. Future evaluations should consider the different aspects of mental health and criminogenic needs, as well as the implications and effectiveness of compassion focused approaches for professionals working within inpatient mental health and forensic settings.

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Appendix 1

Bespoke Full Text Screening Tool

Database	
Author	
Year	
Country	
Full text available?	Y / N
Full text available in English?	Y / N
CFT approach?	Y / N
Individual, group or systemic?	
Outcome detailed?	Y / N
Participant age range	
Participant demographic	
Forensic or Inpatient setting?	Y / N
	If yes, which? _____
Methodology	
Screened In or Out	In / Out

Appendix 2

Full Text Screening Results

Author	Full text available	English	Country	CFT approach	Individual or group	Outcome detailed	Participant age	Participant setting	Qual or Quant	In/Out (reason for out)
Ascone et al. (2017)	Yes	Yes	Germany	Yes	Individual	Yes	Adult	Inpatients and outpatients	Quant	OUT (1)
Cuppage (2018)	Yes	Yes	Ireland	Yes	Group	Yes	Adult	Inpatient	Quant	OUT (1)
Drobinska et al. (2022)	Yes	Yes	UK	Yes	Group	Yes	Adult	Inpatient staff	Mainly Qual	IN
Fehrman (2022)	Yes	Yes	UK	Yes	Group	No	Adults	N/A	N/A	OUT (2)
Frostadottir & Dorjee (2019)	Yes	Yes	Iceland	Yes	Group	Yes	Adults	Inpatient	Quant	IN
Gaiswinkler et al. (2020)	Yes	Yes	Austria	Yes	Group	Yes	Adults	Inpatient	Quant	IN
Heriot-Maitland et al. (2014)	Yes	Yes	UK	Yes	Group	Yes	Adults	Inpatients	Both	IN
Laithwaite et al. (2009)	Yes	Yes	UK	Yes	Group	Yes	Adults	Forensic High Secure	Quant	IN
Morley (2018)	Yes	Yes	USA	No	N/A	Yes	Adults	Forensic Prison	Quant	OUT (3)

Patel et al. (2022)	Yes	Yes	India	Yes	Group	Yes	Adults	Inpatient and Outpatient	Quant	OUT (1)
Ribeiro da Silva et al. (2019)	Yes	Yes	Portugal	Yes	Individual	Yes	Adolescent	Forensic Adolescent Prison	Quant	IN
Ribeiro da Silva et al. (2021a)	Yes	Yes	Portugal	Yes	Individual	Yes	Adolescent	Forensic Adolescent Prison	Quant	IN
Ribeiro da Silva et al. (2021b)	Yes	Yes	Portugal	Yes	Individual	Yes	Adolescent	Forensic Adolescent Prison	Quant	IN
Rijo et al. (2023)	Yes	Yes	Portugal	Yes	Individual	Yes	Adolescent	Forensic Adolescent Prison	Quant	IN
Sousa et al. (2022a)	Yes	Yes	Portugal	Yes	Individual	Yes	Adolescent	Forensic Adolescent Prison	Quant	IN
Stroud & Griffiths (2021)	Yes	Yes	UK	Yes	Group	Yes	Adult	Inpatient	Quant	IN
Taylor (2021)	Yes	Yes	UK	Yes	Group	Yes	Adult LD	Forensic Prison	Both	IN
Zhang et al. (2019)	Yes	Yes	Africa	No	N/A	Yes	Adult	Inpatient	Quant	OUT (3)

1 = Not able to differentiate between inpatient and outpatient, 2 = not empirical research, 3 = not CFT approach

Appendix 3

Reliability and/or Validity of Psychometric Assessments Utilised in the Studies.

Measure	Validity / Reliability
Assessment of risk and manageability of individuals with developmental and intellectual limitations who offend (ARMIDILLO) (Boer et al., 2013)	Poor inter-rater reliability with regard to violent incidents (0.28) and moderate for sexual incidents (0.55) High predictive validity with high accuracy (AUC = 0.77–0.90)
Beck Depression Inventory II (Beck et al, 1996)	High test-retest reliability (Pearson r = 0.93). High internal consistency (α = 0.91)
Brief Symptom Inventory (BSI 18; Derogatis, 2001)	High internal consistency (α = >0.80) for GSI
Clinical Outcomes in Routine Environments–Outcome Measure (CORE-OM; Evans et al., 2000)	Hhigh internal reliability (α = 0.94) for clinical samples and good levels of test-retest reliability (r = 0.9).
Compassion Scale (CS; Pommier et al., 2020; Portuguese version for adolescents by Sousa et al., 2022b)	Good psychometric proprieties in the Portuguese version for adolescents. Good internal consistency for total score (α = 0.88)
Depression Anxiety and Stress Scales—Short Form (DASS-21; Lovibond & Lovibond, 1995)	High internal consistency for depression (α = 0.88), anxiety (α = 0.82), and stress (α = 0.90) scales.
Difficulties in Emotion Regulation Scale–Adolescent Version (DERS-AV; Gratz & Roemer, 2004; Portuguese version for adolescents adapted from the Portuguese version for adults by Coutinho et al., 2010)	High internal consistency for the overall scale (α = 0.89 - 0.93) and good for the subscales (α=0.71 - 0.89) variable across studies.

Distress and calmness rating scale (Jacobsen et al., 2011)	No validity or reliability ratings reported
Fear of Compassion Scale (FCS; Gilbert et al., 2011; Portuguese version for adolescents by Duarte et al., 2014)	Good internal consistency (α = 0.84 – 0.92)
Five-Facets of Mindfulness (FFMQ; Baer et al., 2006)	High internal consistency (α = 0.75 – 0.91).
Guilt and Shame Proneness Scale (GASP) (Cohen et al., 2011)	Adequate reliability (>0.55)
International Affective Pictures System (IAPS; Lang et al., 1997; Portuguese version by Soares et al. 2015) used with Physiological measure – standardised procedure (ECG)	No validity or reliability ratings reported
Medical Outcomes Study 36 Item Short-Form Health Survey (McHorney et al., 1994)	High internal consistency (α > 0.90)
Other as Shamer Scale (OAS; Allan et al., 1994; Goss et al., 1994)	High internal consistency (α = 0.82 – 0.89)
Other as Shamer Scale Brief Adolescent (OASB-A; Vagos et al., 2016)	Good internal consistency (α = 0.90)
Positive and Negative Syndrome Scale (PANSS; Kay et al., 1987)	Good reliability (r > 0.80)
Proposed Specifiers for Conduct Disorder (PSCD; Salekin, 2017; Salekin & Hare, 2016)	Very good psychometric properties and a high convergence with the YPIS reported without ratings.
Reflection Rumination Questionnaire (RRQ: Trapnell & Campbell, 1999)	High internal consistency (α = 0.94).

Rosenberg Self-Esteem measure (RSE; Rosenberg, 1965; Rosenberg et al, 1995)	Excellent internal consistency (α = 0.92) and good test-retest reliability (0.85 -.088)
Self-Compassion Scale (SCS; Neff, 2003)	High internal consistency for SCS subscales (α = 0.77– 0.92)
Self-Image Profile for Adults (SIP-AD; Butler & Gasson, 2004)	High internal consistency (α = 0.898)
Social Comparison Scale (SCS) (Allan & Gilbert, 1995)	High internal consistency (α = 0.88 - 0.89)
Social Safeness and Pleasure Scale (SSPS; Gilbert et al., 2009; Portuguese version for adolescents by Miguel et al., 2019)	High internal consistency (α = 0.90)
Youth Psychopathic Traits Inventory-Short (YPI-S; Van Baardewijk et al., 2010; Portuguese version by Pechorro et al., 2015)	Acceptable internal consistency (α – 0.69 – 0.79)

Chapter 2

Empirical Study

Tug-of-War: A Foucauldian Discourse Analysis of care and treatment planning experiences within a Forensic Mental Health Service.

Hannah Waite[a]*, Dr Julia Wane[b] and Dr Carolien Lamers[c]

[a]*North Wales Clinical Psychology Programme, Bangor University, Bangor, Wales;*
[b]*North Wales Forensic Psychiatric Service, Betsi Cadwaladr University Health Board, Wales;*
[c]*North Wales Clinical Psychology Programme, Bangor University, Bangor, Wales.*

Address for correspondence: Hannah Waite, North Wales Clinical Psychology Programme, Brigantia Building, Bangor University, Bangor, Gwynedd, LL57 2DG.

Email: hnw20rjc@bangor.ac.uk

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Abstract

With the recent drive for services who cater for people with offending backgrounds to adopt a more psychologically informed approach, it is integral to understand how being in receipt of care and treatment is talked about. As such, seven people who were detained and receiving care within a Forensic Mental Health Service (FMHS) were interviewed. When an individual is detained within a FMHS, their daily life is restricted by the Mental Health Act (1983) and, within Wales, their care is managed with a Care and Treatment Planning approach (CTP) under the Mental Health Measure (MHM, 2010). The interviews explored people's discourses of being in a FMHS and receiving care, as directed by the MHM and CTP approach. The interviews were analysed using Foucauldian Discourse Analysis (FDA), with particular attention paid to the Foucauldian concepts of knowledge, power, objectification, subjectification and surveillance. Three main discourses emerged: "the power sits with them", "tug-of-war", and "it's my care". Alternative discourses to "the power sits with them" and "tug-of-war" were identified; "complex power systems", and "a world removed from reality". The intricate legal and medical paradigms that interrelate within FMHS were evident throughout the discourses, with participants acknowledging the wider power structures at play. Their experiences were shared through a lens of perceived powerlessness, with an evident desire and drive to gain more power and control over their own care and lives.

Keywords: forensic mental health; Foucauldian discourse analysis; care and treatment; secure care

Introduction

People cared for within Forensic Mental Health Services (FMHS) are likely to have experienced the adverse consequences of power structures at multiple points and within multiple contexts throughout their lives (Levenson et al., 2016). They might have also been the ones in a position of power in certain situations; a position that likely contributed to the grounds for their admission to FMHS. With detention often arising as a consequence of mental health difficulties and contact with the criminal justice process, people within FMHS find their lives constrained by the Mental Health Act (MHA; 1983) and by restrictions imposed by the Ministry of Justice (MoJ), dictating the access to and restriction from the world outside of hospital (Coffey, 2006; James, 2010).

This intersectionality between the medical and legal paradigms creates a complex, multi-faceted and multi-layered power structure. People in FMHS, therefore, find themselves cared for against their will, with mental health and judicial legislation defining their care and treatment (Haines et al., 2018), and thus encountering these power structures (Johansson & Holmes, 2023). The complexity of power is rooted within legal frameworks that form the foundation of detention and care provided within FMHS. Boyle (2022) proposed that the legal power exercised by the MoJ involves coercion through arrest, imprisonment and hospitalisation: a familiar experience for most people cared for in a FMHS.

Foucault (1998) positioned power as a productive mechanism for how we see ourselves and others which results in a discursive knowledge for how people are expected to behave in specific situations. The MHA (1983) supports the use of a medical model of care for those in a FMHS and understands people's thoughts, feelings, and behaviours from a medical or categorical perspective (Haines et al., 2018). People's presenting emotional and behavioural difficulties are understood in the context of

"symptoms" of an internal pathology or dysfunction (Johnstone & Boyle, 2018), with their identity dictated by an external structure of power, encapsulated within the medical paradigm and through medicalised discourses. Medicalised discourses can cause tension for people in receipt of care, with knowledge conceptualised within the medical model directly influencing their care pathway.

From a Foucauldian perspective, conceptualising an individual's experience of the world through the lens of 'criminality' and 'mental health symptoms' could lead to an objectification of the people, who in turn internalise this discourse leading to their subjectification (Gutting, 2005). An example of objectification within the medical model occurs when using the term 'patient'[2] to describe an individual receiving care in FMHS. This can lead to the subjectification of the person perceiving themselves as 'ill'. The judicial system objectifies them as 'criminals', leading to the subjectification of being 'bad'.

Knowledge, as positioned by Foucault**,** is a crucial factor in power relationships (Dreyfus & Rabinow, 1983; Gutting, 2005). The staff in FMHS are holding the knowledge about the histories of the people they care for, whilst navigating the legal and medical parameters within which they can operate. Tension also exists for staff in FMHS who are required to manage the risk posed by patients towards others (Pouncey & Lukens, 2010), which is an area where patient involvement is often marginalised within practice (Haines et al., 2018).

Recent service development campaigns within FMHS have emphasised the importance of providing person centred care and greater inclusion for service users (Haines et al., 2018). In Wales, the Mental Health Measure (MHM, 2010) was introduced for those requiring care and treatment from secondary mental health care

[2] The term patient will be used in this paper, as this is the terminology used in most research of this client group. The FDA implications of this term are acknowledged.

services, including those detained within FMHS. The MHM (2010) provides a legal framework, similar to the Care Programme Approach (CPA) utilised in England, and outlines how the person is to be involved in the development of their care plan, the decision making and the outcomes that they are seeking (NHS Wales, 2022; Quality Network for Forensic Mental Health Standards, 2021; Scottish Government, 2021). Part 2 of the MHM (2010) stipulates that a Care and Treatment Plan (CTP) is required that outlines how factors associated with an individual's care needs will be addressed by services to assist their recovery. With national standards and governmental guidance, the MHM (2010) forms part of the multi-layered power structure within FMHS (Department of Health, 2005). The CTP approach is governed, enforced, and monitored by government agencies and was developed to identify and support individuals who would otherwise fall through the gaps of services. In essence, the CTP approach facilitates the surveillance of people, as a means of providing care, thus demonstrating the complexity of power structures at play within the CTP approach.

The interplay between the power exercised by FMHS staff via the MHA (1983) and on behalf of the MoJ, and the intent behind the CTP to enhance service user involvement and a more person-centred approach, requires further exploration. It is proposed that Foucauldian concepts are well suited to examine these power dynamics and elucidate the discourses of those in receipt of care in FMHS.

With a significant investment in terms of time and funding invested in FMHS, coupled with the recent drive for FMHS to adopt a more psychologically informed approach (De Pau et al., 2021; Saltman & Bankauskaite, 2006), considering the role of power, on an individual and structural level, is relevant to ensure that the intentions of the CTP are not hampered by other drivers. Barnao et al. (2015) reported that people detained within a FMHS are concerned about restrictions placed on their liberty, with a

disempowering nature that is often experienced as punitive (Hinsby & Baker, 2004). Understanding how people talk about receiving care and their involvement in the CTP approach could assist in the development of more effective care that is considerate of the complex role of power. This study explored how people in FMHS talked about being in receipt of the MHM (2010) CTP approach, by utilising Foucauldian Discourse Analysis.

Methodology

Ethical approval

Ethical approval was granted by the School of Health and Behavioural Sciences Ethics Committee at Bangor University and West Midlands - Coventry and Warwickshire Research Ethics Committee (Appendix 1). This research was then registered with Betsi Cadwaladr University Health Board's Research and Development Department.

Epistemological position

As people receive care under the MHA (1983) with a CTP when in a FMHS, their life is governed by legislation and governmental guidance. Therefore, their engagement with a CTP has an implicit power imbalance, in which others set the parameters of their day-to-day functioning. Foucault has been particularly interested in understanding the power dynamics as they emerge in large institutions such as prisons and hospitals. In FDA the contextual meaning of larger quantities of language such as conversations and the social aspects of communication (Johnstone, 2018) shed light on the positions where knowledge is held and who exerts power based on this knowledge. A social constructionist epistemology is adopted by FDA, perceiving knowledge as a compilation of human-made constructions (Burr, 2003; Galbin, 2014). Foucauldian Discourse Analysis tries to ascertain the position of power, specifically where power is

a major source of social discipline and conformity (Foucault, 1998). Foucault developed the notion of 'disciplinary power' that could be observed in the administrative systems and social services, such as prisons and psychiatric services. Foucault concluded that the disciplinary power systems of surveillance and assessment no longer required force or violence, as people learned to discipline themselves and behave in expected ways (Foucault, 1998). Therefore, utilising FDA and considering the Foucauldian concepts of knowledge, power, subjectification, objectification, and self-surveillance in relation to a person's experience of the CTP approach could assist in fostering new insights into how values, beliefs and assumptions are developed and communicated by people in receipt of care in FMHS, with a particular focus on the CTP.

Participants

Potential participants were recruited via purposive sampling from local services and screened against the inclusion and exclusion criteria by their Responsible Clinician (RC) and a clinical psychologist. The inclusion criteria were:

- currently or previously (discharged within last three years) detained within a High, Medium or Low Secure FMHS under the Mental Health Act (1983) with Ministry of Justice restrictions;
- their care falls or fell under the responsibility of His Majesty's Prison and Probation Service (HMPPS; e.g., transferred prisoners or remand prisoners);
- a person whose care falls under the responsibility of their allocated NHS Responsible Clinician (RC);
- aged over 18 years and currently residing in Wales and under the care of the local Health Board;

- currently stable in their mental health (as assessed by their RC and Multi-Disciplinary Team) and agreement from RC that they are fit and able to participate in the research;

- able to give informed consent.

The exclusion criterion was:

- currently engaged in or are awaiting court proceedings and not currently resident within Wales.

Participants who met the inclusion criteria were contacted by the clinical psychologist or care co-ordinator and provided with an introductory letter explaining the nature of the research, accompanied by the Participant Information Sheet (PIS, Appendix 3) and an opt-in form (Appendix 3). People expressing an interest in participating returned the opt-in form to the clinical psychologist or care coordinator and were then contacted by the first author to further discuss participation in the research.

Within FDA, sample size is not considered an important factor as the interest lies within the use of language rather than commonality of themes (Potter & Wetherell, 1987). Due to the nature in which language is used, and the way in which FDA is carried out, important variations in linguistic patterning can emerge from a small number of people (Johnstone, 2018). Due to the nature and accessibility of the participant group, a sample size of six to ten was thought to be achievable. A total of seven adult males, all residing in a medium secure FMHS, expressed an interest in participating, all of whom provided written consent to participate. After consent was obtained, a further cooling off period of two weeks was observed, to avoid any sense of

coercion. Due to the nature of FMHS and the small population group resident within these environments, information pertaining to participant demographics was not collected and therefore is not provided within this paper. This was to ensure confidentiality and anonymity due to the increased likelihood of identification.

Participants were given a £20 gift voucher for their time.

Interviews

Each participant attended one semi-structured interview which entailed questions that facilitated them talking about living within a FMHS and their experience of the CTP approach. The interviews were conducted on a one-to-one basis with the first author in a private room within the FMHS. Over-arching, open-ended and non-leading questions were utilised, as determined by the interview guide (Appendix 4). Interviews lasted between seventeen and fifty-seven minutes. Interviews were audio recorded and transcribed.

Reflexive account

Reflexivity is utilised within research to recognise and observe the potential implications afforded by utilising a particular approach to researching a topic (Tuval-Mashiach, 2017). Adopting reflexivity within the research process can provide transparency around potential areas of the author's bias and fosters consideration to the position the author takes in the research that is integral to the authenticity and analysis of the findings (Reid et al., 2018).

The first author's clinical experience was largely rooted within FMHS, with this experience cultivating a passion for supporting individuals who find themselves often without a voice. At the time of the interviews, the first author was employed as a trainee clinical psychologist and undertaking a clinical placement within the FMHS from which

participants were recruited. The desire to understand the experience of care within FMHS from the perspective of the person receiving care and the first author's interest in power structures, particularly those rooted within the legal framework and within forensic mental health care, contributed to the research question. The first author's views and beliefs about people receiving care in FMHS has likely provided unconscious identification of discourses from the data set. This unconscious identification would be rooted within prior knowledge through research and clinical experience. At the time of the interview, none of the participants were involved in clinical work with the first author. While participants were assured that taking part in the research would not impact their care, the first author was part of their FMHS team and therefore in a position of power when conducting the research with participants. A notable age difference between the first author and some of the participants was evident, potentially influencing the power dynamic within the interviews. The first author was a white female, conducting research with a male population, which might have added an additional power dynamic.

In order to mitigate the first author's bias, clinical and academic supervision was accessed throughout this research to draw attention to, and awareness of, possible underlying motives for defining certain discourses. The second author was employed as a consultant clinical psychologist within the FMHS, whilst the third author was a clinical psychologist who had no prior experience in FMHS and offered expertise in FDA.

Data analysis

As Foucault was reluctant to prescribe the analytic process, multiple analysis approaches to undertaking FDA are available. Georgaca and Avdi's (2011) five step

analysis process was utilised, with particular attention paid to the presence of Foucauldian concepts (power, knowledge, surveillance, subjectification and objectification) evident within the transcripts.

Georgaca and Avdi's (2011) five steps to FDA are as follows:

1. Identification of discourses (participants' construction and how this is located within discourses)
2. Rhetorical strategies (discursive agenda - use of language and management of interaction serving interpersonal functions)
3. Positioning (identities made relevant through language in relation to the interaction and to wider discourses e.g., how are they positioned and how do they position others?)
4. Practices, institutions, and power (the role of discourse in maintaining or challenging dominant institutions and practices)
5. Subjectivity (subject position adopted by participant within specific discourses and how this translates to how an individual thinks, feels and experiences themselves)

The interviews were transcribed with pauses and hesitancies included. Interviewer observation of tone of voice was also added. The interview transcripts were read multiple times to ensure familiarity with the data and to allow for the emergence of underlying discourses in relation to the participants' receiving care under the CTP approach. Researcher triangulation processes were utilised, involving the first author analysing all transcripts and the second and third authors analysing two transcripts each, providing their interpretations of the data and identifying any emerging discourses. Meetings were held to discuss the emergence and identification of prominent discourses, with perspectives shared openly by all three authors. This triangulation was

conducted in an attempt to reduce the risk of research biases and to ensure credibility of the research. Possible differences and alternative discourses were also monitored for during the analysis.

Findings

Three main discourses were identified with two alternative discourses highlighted. The Foucauldian concepts of knowledge, power, surveillance, subjectification and objectification are illustrated where appropriate.

The overwhelming use of the term 'you', rather than 'I', throughout the interviews was noted and could be interpreted as the participants adopting a discourse reflecting the staff team's knowledge and power, with a complying subject position adopted by them.

1. The power sits with them

The most dominant discourse adopted by the participants, when speaking about being cared for under the CTP approach, centred around the care team holding the power. This was spoken about with reference to the care team as a whole and for individual team members. The participants spoke about who made the decisions regarding their care and the restrictions imposed by the care team, expressing clear knowledge of the power positions:

> *It's obviously quite restrictive erm in terms of what you can have and what you can't have, what you can do, where you can go etcetera (Tim).*

> *He's my consultant, he's the one that decides what happens (El).*

As relinquishing power to another person or group can be an uncomfortable position to adopt, one that evokes a sense of powerlessness, particularly for those

detained under the MHA (1983) (Carlin et al., 2005), some participants expressed hesitancy about the power held by staff and seemed to want to readdress the balance and maintain some sense of control over their lives:

It's not up to the care team, well it is cause they give you permission (John).

This notion of giving permission can be understood in relation to Foucault's position on power existing within a relationship (Foucault, 1998), which John was trying to rebalance. One participant explicitly stated that the power sat within the care team:

It's like a power trip. The staff have the power (Simon).

Simon hinted that he viewed the staff's use of power as excessive, without reference to any knowledge on what their power was based on. Staff were objectified as a body of power. His comment indicated knowledge about the relational intricacies of power within the staff-patient relationship, with all power held and utilised by the staff, rendering Simon and his peers powerless. These repeated experiences of powerlessness, coupled with the objectification by members of the care team, resulted in subjectification for Simon:

> *Well every day you don't exercise you fail don't you. You know, every day you do, you overeat, you fail and every day you do this you fail, you just fail don't you (Simon).*

Participants articulated a tension between the knowledge held and shared by the care team about their treatment plan and this not being relevant nor taken from the participant's perspective. Simon expressed his knowledge that the imposed restrictions would not be beneficial for his recovery and rehabilitation:

> *What they do is they strip away your ability to do things, they tell you for four or five years 'no you can't do this, you can't do that' and after four or five years you might start believing it, so then when it comes to when you you actually leaving, you can't actually do the simplest things like phone up the social*

security, cause you're so dependent on it cause they've told you for five years that you can't make a cup of tea for yourself (Simon).

The knowledge on which the staff based their statements and exerted their power was being questioned. Knowledge held by staff appeared to be held as 'higher', more important, and the knowledge held by the participants was being ignored:

They just wanna tell you what they wanna tell you and what you say doesn't matter (Bigz).

Others attempted to share their knowledge about themselves with the staff team, in order to inform and enhance the staff's understanding, hoping that the staff used their power to amend any intervention plans:

Defend my corner really init. To tell them how I really feel I'm doing (El).

The power of the staff team was seen as based on the knowledge that the care team held about the participants and was gained through constant surveillance:

I know that everything's jotted down anyway, notes are taken daily by the nursing staff (Drake).

The knowledge obtained about them via this surveillance, its interpretation and subsequent sharing with other members of the care team, was questioned by the participants for its validity and accuracy ('*summarise'* and '*believe'*):

They sort of summarise what they erm where they believe you're up to and obviously what they erm may be looking for next (Tim).

They see you a lot, so basically you get an insight on what their obviously erm … seeing you and how you are on the ward and how you interact with your peers and obviously the staff, your behaviour… (Drake).

Drake's observations indicated the subjectification that occurred, with seeing oneself through the lens of those in power and the object state allocated by the staff to the participants.

1.a Complex power systems.

The idea of complex power systems being at play within the experience of CTP formed an alternative discourse to 'the power sits with them'. Participants were knowledgeable about other power structures that influenced their care:

> *Anybody who <u>needs</u> (emphasised) to be involved in the meeting, so it could be also be authorities er for example er MAPPA could be also have a say in certain things that happen (Tim).*

> *Mainly it's doctor that decides stuff and that, … cause of the section I'm on as well, he he's pretty much deciding what's happening … it's better than having the MoJ deciding cause they seem to be a bit slower with things … so I'm quite happy for him to decide what happens (El).*

Participants were aware of influences outside of their immediate care team, such as the judicial system, that exercised power over those exerting power over them:

> *I know that it would be hard to, sort of, for them, the doctors and such, to give you an exact date or whatever but at the start it's a it you're a bit in limbo with it (Sid).*

> *I'm on a section 37 though, we can't forget that, I haven't I haven't been put on a 41 so the judge ordered me to hospital to get better … (Bigz).*

There was evidence of objectification of the people involved in detention in John's description of tribunal members and how his voice was not heard:

> *They [tribunal] decide if you should be detained under the Mental Health Act … … … they're scary, different, and they're sort of they're in control because like one of them speaks and then they go round everyone and all that like … (John).*

This objectification of the care team was also present in Bigz' statement, where he pointed out his knowledge that the powers of the care team members were limited by more powerful systems:

> *The impression that I got is that they were just doing it cause they had to because they made it quite clear that it's under the Welsh government that they had to do it once a year (Bigz).*

Bigz held the NHS accountable for the restrictions placed upon him, objectifying the care team as agents of the wider power structure:

> *The NHS is denying me the right to see them (Bigz).*

2. Tug-of-war

A second discourse created by the participants expressed a desire to be involved in their own care and their CTP, wanting to be heard and given more power:

> *I think erm I could be more involved sometimes, I don't know why, I'm not too sure how to explain it but I just feel like I could be more involved in them (Tim).*

> *So my role would be that I'm sort of almost like responsible for taking care of my own health erm but then accepting er the help that's offered from the people who work with me (Tim).*

Tim expressed ambivalence about his knowledge on how best to achieve more involvement in his care and CTP. Gaining power meant accepting and valuing personal knowledge, but within the parameters of needing to accept assistance from others, thus limiting his power. Tim's use of the word 'role' indicated subjectification as he carried out a position within his own care as directed by those in power.

Participants talked about their involvement in the CTP as beneficial, but with the caveat that having knowledge and insight into one's problems was required to engage in the process:

> *Obviously it's your care, it's your treatment and your your planning for the future so it is good if you've got capacity to be involved and obviously you have your say and obviously listen to what erm the care team have to say erm … yeah so it's a good thing to be involved in if you've got capacity to (Drake).*

While Drake demonstrated knowledge of the CTP approach and the aim of the CTP meetings, he adopted a medical discourse regarding a person's mental capacity, which acknowledged the power of others to judge and limit his involvement in the CTP if he was deemed not to be capacitous, thus demonstrating a level of subjectification.

Tim described how the person's knowledge of their problems was required in order to exert power over their CTP and recovery, situating self-knowledge as central to the tug-of-war:

> *If you have a greater understanding and insight into your own problems already erm it helps because then you can focus on what, you know, what you need to do (Tim).*

While participants described a level of choice and power in their engagement with the CTP, they also knew that this power and their related choices were constrained and only accepted if they were in line with the care team's knowledge, as they ultimately held the power:

> *It's your choice to get out of bed ha, erm it's your choice to engage, erm and do things, erm but at the end of the day it all rolls down to the care team cause they have the overall end decision (John).*

This knowledge influenced their decision-making process as their actions would have consequences if not in line with the CTP and the mapped-out care trajectory. They required knowledge of their CTP, its trajectory, and the staff's decisions in order to ensure that they 'behaved' in line with expectations. This required self-surveillance whereby the participants adopted the position of an external other to monitor their behaviour:

> *You take that feedback and you learn from it and you've got to do whatever you've got to do to basically better yourself and obviously move on from that so you can make progress (Drake).*

The 'tug of war' discourse was further illustrated where some participants desired more power and control, however, were hesitant to enact this power due to perceived consequences from those with more power. Here, Bigz and Simon positioned the power and control within the care team whilst objectifying and 'othering' the care team as a way of gaining power within the relationship:

> *From my side, … I'm free, it's it's those, it's them, it's the rules, their schedules are holding me back … but then again they are allowed to use that against me (Bigz).*

> *In a way I should be on the roof protesting, it's my duty really (Simon).*

Contrastingly, others acknowledged that the power was held within the care team and subjected themselves to the discourse of compliance and cooperation. Tim's earlier use of the word 'role' referred to play acting or adopting a role external to oneself, reflecting subjectification and conforming to what was expected by those with power:

> *My role really is I'm being cared for really, and trying to get to where I don't need to be cared for (John).*

The participants saw gaining trust from the staff team as something that might impact on the level of power and control they experienced. There were further reflections on a level of subjectification, and knowledge required to play the tug-of-war:

> *They give you more, if they have more trust in you and give you more chances to prove that you, you know, … erm … that you're of right mind, do you know what I mean? It's all about trust really (El).*

Others were resisting gaining control via trust, although acknowledging the benefits of submitting themselves to this subjectification. They seemed to be accumulating knowledge on how best to engage with the system:

> *I just don't trust them, and I should. Yeah, I should trust them yeah? I should turn to them whenever I need help but I don't know if that's the right thing to do (Bigz).*

2.a A world removed from reality.

An alternative discourse that emerged to engaging in the 'tug-of-war' discourse, was that of 'a world removed from reality'. The earlier description from Tim that he played a '*role'*, John's reference to '*centre stage*' and Simon's description of a '*pantomime*', inferred that the encounters of the participants in a FMHS were like a play and very different from the outside world. Simon referred to the '*real world*' as a separate world to the one he was experiencing:

> *It's your meeting so it's about you erm so the role is well you could say centre stage couldn't you (John).*

> *Well it's just like, you know, … … … a pantomime isn't it … it doesn't translate to anything in the real world (Simon).*

Here, the FMHS setting was objectified as a theatre, with the subjectification to play a '*role'* accepted, rather than engage in the 'tug of war'. The objectification

experienced in this unreal world, was expressed by Simon when he spoke of his experience of the CTP approach:

> *We're products aren't we … … … well we we're the products yeah. you know, were coming into the factory one end and gonna hopefully come out the other end (Simon).*

Hörberg et al. (2012) explained that receiving care in a FMHS involved constant searching in the absence of a definite way out. Simon's notion of '*hopefully'* indicated a lack of clarity or certainty (knowledge) about when the process would end. As a result of the power imbalance, the participants were forced to adapt to the rules and regulations, giving up the struggle with the care team and care system (Hörberg & Dahlberg, 2015) and play along. Through objectifying the staff, as indicated by Simon, some tried to manage their sense of powerlessness by constructing it as gaining knowledge on how to deal with people in the 'outside' world:

> *Well, in a way I think the staff are paid to be d***heads … … … … so when you encounter d***heads in the real world you are equipped to deal with them, so instead of turning to violence you turn to other strategies (Simon).*

Interestingly, Drake adopted a slightly different stance in the alternative discourse, acknowledging the separation between the inside and outside worlds whilst inferring the benefit of being in the inside world, albeit with hesitancy:

> *I suppose getting away from the outside world and coming into this environment probably can help you (Drake).*

3. It's my care.

The final cautious discourse that emerged from the interviews was 'it's my care'. In conjunction with engaging in the previous discourses, two participants also positioned themselves as central in the power relationship:

Well it's about me init hahahaha (laughing). Erm … it's all … it's all me really, my care, my treatment … on the whole it's its about, it's about yourself, you know what I mean, where you wanna get, how do you need to get there, what you need to do, what you need to achieve (John).

Well it's all about me really (El).

John and El generated an additional discourse that afforded them an alternative position to objectifying the staff or experiencing subjectification. There was uncertainty about claiming this discourse position, expressed in laughter and checking in with the interviewer for approval. This discourse emerged later in the interviews, perhaps indicative of the strength of the earlier discourses, particularly "the power sits with them" and perhaps demonstrating a tentative desire to regain some power in relation to their position as an individual in receipt of care.

A third participant also engaged with this discourse. Sid showed knowledge about the impact this positioning might have on the perceptions and objectification by others:

Not to sound erm big headed but it's all about me isn't it (Sid).

Similar to the previous discourses, the participants moved back to using 'you' rather than 'I' when discussing their involvement in their care, indicating an uneasiness to really own this discourse. John started his response with 'me', evidently with hesitation, before switching halfway through to 'you'. The use of 'you' appeared a more comfortable subject position for John to adopt, perhaps influenced by the constant shifting in position of power within relationships and his position in the CTP as a passive participant.

Discussion

Seven males, who were detained within a FMHS, talked about being cared for within a FMHS and their involvement in the CTP approach. Three main discourses emerged, 'the power sits with them', 'tug-of-war' and 'it's my care'. The 'the power sits with them' discourse, referring to the care team, was the most prominent discourse, with tentative engagement and a sense of uncomfortableness. The knowledge of other power structures impacting on their lives, resulted in the emergence of an alternative discourse 'complex power systems', thereby diminishing the power of the immediate care team. The 'tug of war' discourse described the positioning undertaken by participants to ascertain some sense of power. Rather than engaging in this tug of war, an alternative discourse of 'a world removed from reality' was inferring that the CTP approach and life within a FMHS were not like the 'outside' world, whereby adopting a different position, that of actor, participants aimed to gain a sense of control. The final hesitant emerging discourse was 'it's my care', where uncertain and tentative engagement by a small number of participants demonstrated a possible desire to obtain or regain power in their position as a person in receipt of care.

Foucault's position on power, including the intricate relationships between power, knowledge, subjectification, objectification and surveillance, offered a unique perspective on how participants talked about the CTP approach during their time in FMHS. The dominant discourse elicited was predominantly concerned with power, who holds the power over another person. The power held within the medical paradigm was a result of the participants 'handing themselves over', sometimes involuntarily, to the clinical expertise of the care team, particularly the doctor in charge (Foucault, 1976). The participants clearly articulated their experiences with reference to knowledge held

by others being seen as more important than theirs, often obtained via surveillance and interpreted through the objectification of those being cared for.

Simms-Sawyers et al. (2020) reported that people detained within FMHS often report a sense of powerlessness and experience high levels of coercion. While people receiving care in FMHS can choose to do as they wish, they do not typically do this as their care is mapped out for them by people in positions of power, who refer to their clinical expertise and knowledge (Kanyeredzi et al., 2019). This seemed present within the discourses articulated by the participants, with reference to being able to make independent choices whilst being aware of the consequences of making choices not in line with the care team's plans. Hörberg et al. (2012) found that people detained within FMHS adapted their behaviour in a strategic way to conform with the manner that was expected of them, perhaps as a way of trying to escape the system that was viewed as punishing and containing. This stance was reflected in the tug of war and a world removed from reality discourses. Surveillance, both self-surveillance and surveillance by the care team, was a shared narrative within the participants experiences. Foucault (1998) stipulated that this disciplinary power, the power evident within FMHS, was exercised through its invisibility, whilst at the same time forcing the person being cared for to always be visible. This surveillance resulted in the individual being observed and judged against a set of expected norms, as defined by their care team (Khan & MacEachen, 2021).

Foucault's position and understanding of power demonstrates the complexities and difficulties related to recognising and interpreting power within relationships, especially when power fluctuates constantly (Hörberg & Dahlberg, 2015). Whilst exploring the discourses, it was evident that the manifestation of power, particularly in the context of the legal and medical paradigms, was difficult to navigate, with

participants exploring how to engage with these power systems. Tug-of-war conceptualises this difficulty, with the notion of power shifting from one end to the other and with no clearly defined way of how to obtain and maintain a position of power. Ultimately, the participants evidenced difficulty in adopting a personal position of power, with fluctuations in talking about themselves using 'me' and 'you' subject positions. They articulated a notion of constant searching in order to obtain more power and control over their care.

Bressington et al. (2011) found that ineffective communication, coercive approaches and an absence of feeling safe formed barriers to positive relationships between the care team and the people being cared for, something required to foster meaningful engagement with the CTP. While Forensic Mental Health Services in Wales attempt to involve the person being cared for in their CTP, (Mann et al., 2014), participants sensed that the care team did not view them as nor responded to them as people, but rather created an object position based on the care team's knowledge and power. Objectification, as defined by Foucault, was apparent within the interviews, both in terms of participants objectified by staff and participants objectifying staff as a means of managing powerlessness.

Clear, effective and supportive communication between the care team and the person being cared for can be hindered by the care team's attachment to their professional boundaries, including but not limited to their skills, experience and clinical knowledge (Haines et al., 2018; Waring et al., 2015). This notion was shared by the participants as they often referred to receiving feedback from the care team on their observations and ideas for the next steps, with a lack of space for their own voice to be heard, resulting in a lack of collaborative communication. Within healthcare settings, including FMHS, staff are required to be extra vigilant about how the power they hold

can impact on the way they demonstrate genuine availability, provide feedback and are open and honest in their approach (Hörberg et al., 2012).

The participant sample that contributed to this research comprised of an all-male population who had received care under the MHM (2010) CTP approach within Wales. Therefore, findings should be interpreted with this in mind and are not representative of a wider population, e.g., females, people with different gender identities, people cared for outside Wales under different governmental and care and treatment guidelines. Other participant samples from the wider population of people detained within FMHS could draw on different discourses, influenced by their individual experiences and identity within FMHS.

This research was concerned with the discourses directly associated with the experience of FMHS and the MHM (2010) CTP approach and, therefore, did not aim to uncover the possible other experiences that could have shaped the participants' discourses, such as previous experiences of the criminal justice system (e.g., being arrested, detained in custody, involved in court proceedings) and possibly non-forensic mental health services. The literature surrounding this population group would also indicate that they could have previous experiences of adverse childhood experiences (ACEs) and difficult life circumstances, including but not limited to low socio-economic status, involvement with social services and difficult educational experiences (McKenna et al., 2019; Rex, 1999). People who find themselves in FMHS have likely been objectified by multiple power structures across multiple contexts within their life and have also likely objectified others in relation to interpersonal offending behaviour and coping with complex power structures that have influenced their life trajectory (Bradford et al., 2014). These factors are likely to have shaped the discourses that the

participant group held, given the likelihood of having experienced powerlessness in other settings.

In conclusion, the privileged insight into how people detained within a FMHS spoke about their care offered a unique understanding into the role of power within a FMHS, where power was perceived to be held by those delivering care. Power influenced the way in which care, particularly the CTP, was perceived and received by the participants. Understanding the discourses of power by those receiving care, particularly within FMHS where power structures are multi-faceted and function across multiple levels, can provide perspectives on how care can be delivered with the implicit intentions of involvement with the CTP. Care staff work tirelessly to improve the lives of the people they care for and strive to deliver care in a person-centred and compassionate way. Ascertaining the perspective of the people and systems that hold power were not investigated, but insights into their discourses might enable further conversations on how to ensure that the CTP offers the best chance for people to move forward outside a FMHS. Education and openness around the role of power, who holds it and how it is used, should be an integral component of service development. Ultimately, people should be encouraged and facilitated to hold more power over their lives, their decisions and, when residing in FMHS, their care and treatment.

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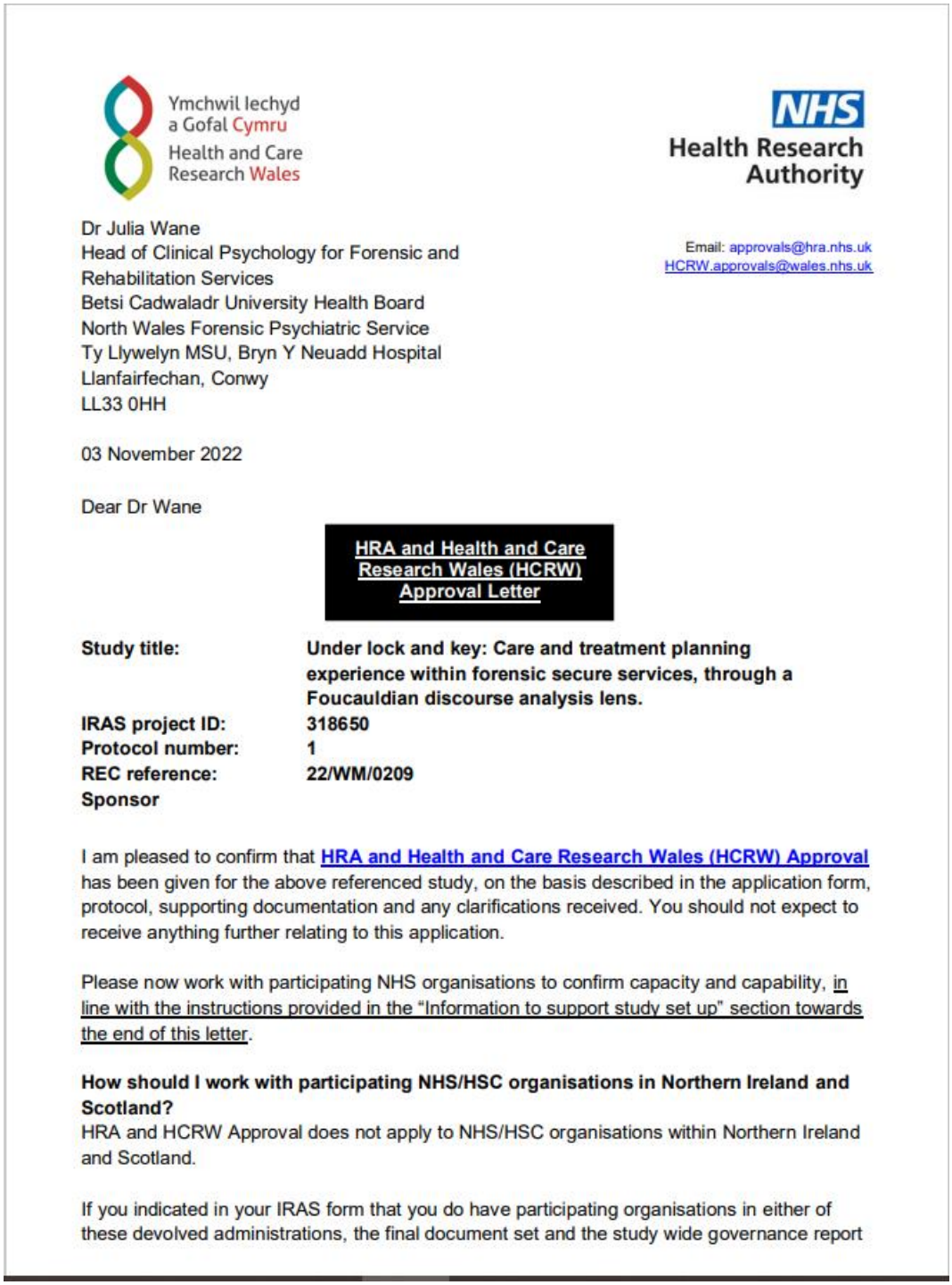
Appendix 1

Confirmation of HRA Ethical Approval



Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Julia Wane
Head of Clinical Psychology for Forensic and Rehabilitation Services
Betsi Cadwaladr University Health Board
North Wales Forensic Psychiatric Service
Ty Llywelyn MSU, Bryn Y Neuadd Hospital
Llanfairfechan, Conwy
LL33 0HH

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

03 November 2022

Dear Dr Wane

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

Study title:	**Under lock and key: Care and treatment planning experience within forensic secure services, through a Foucauldian discourse analysis lens.**
IRAS project ID:	**318650**
Protocol number:	**1**
REC reference:	**22/WM/0209**
Sponsor	

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

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

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report

(including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **318650**. Please quote this on all correspondence.

Yours sincerely,
Amber Slack

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Dr Huw Roberts*

Appendix 2

Participant Information Sheet

Participant Information Sheet

Care and treatment planning experience within forensic secure services.

1. Invitation to research

My name is Hannah Waite and I am a Trainee Clinical Psychologist. I am employed by Betsi Cadwaladr University Health Board and studying on the North Wales Clinical Psychology Programme at Bangor University to become a clinical psychologist. I need to do research as part of my Doctorate in Clinical Psychology qualification.

We would like to invite you to take part in a piece of research aimed at understanding your experience of being involved in the Care and Treatment Plan approach whilst you have been living within a Forensic Secure Service (either currently or previously). Our research project wants to hear about your experiences of being involved in your care whilst living within a forensic secure service, particularly your involvement in the Care and Treatment Plan approach.

2. Why have I been invited?

You have been invited to take part in this research as you have experience of the Care and Treatment Plan approach within a Forensic Secure Service. To make sure you were eligible, Dr Julia Wane, consultant clinical psychologist reviewed your medical notes. This meant that she checked your age, detention status and information about whether your care falls under an NHS Responsible Clinician. She did not look at any other information in your medical records, nor your nursing notes.

We are keen to hear from people who are currently or have previously lived within a Forensic Secure Service. This group of people are often not asked to take part in research. We hope to offer you the opportunity to talk about your experiences, opinions and ideas about the care and treatment plans that support you. By hearing your story, we can develop the academic theory and evidence base further and potentially use the information to inform and change services.

Other people have been invited to take part in this research, however the interviews will just be between you and me, Hannah Waite.

3. Do I have to take part?

It is up to you to decide if you want to take part. This information sheet will describe the study and if you are interested in taking part after reading this, then I, Hannah Waite will be able to answer any further questions that you may have.

You will have seven days from receiving this information to decide if you would like to meet with me to talk about taking part. With this information pack, you will also find an opt-in letter with a pre-addressed envelope. If you decide that you do not wish to take part in this research, you do not need to do anything. If you do not return the opt-in letter, then you will not be contacted again.

If you decide that you would like to take part and would like to find out a bit more, then please sign the opt-in letter and post it via the internal mail within the seven days of receiving this information letter.

If you decide you are interested in taking part and return the opt-in letter, then you will be contacted by me, Hannah Waite, within the next seven days. You will be able to ask me any other questions you may have. After that extra information, you will have a further seven days to decide if you would like to take part or not. Should you decide you would like to take part in interview, I will then meet with you and ask you to complete and sign a consent form to show you agreed to take part.

If you have decided to take part, but change your mind, you can decide to pull out from the point of giving to consent up until fourteen days after the interview. You do not need to tell us why you have pulled out.. You can withdraw from the research by contacting me either in person or via a letter sent in the internal mail addressed to Hannah Waite, Psychology Department.

If at any point during your involvement in the research I have any concern about your safety, mental or emotional well-being, then I will talk to a member of nursing staff on shift or your named psychologist .

4. What will I be asked to do?

If you consent to take part, you will be invited for one interview. If you currently live at Ty Llywelyn, the nursing team will observe you for one hour before the interview starts, the same as if you were to go on section 17 leave or would leave the ward for an activity. This is to make sure that you are feeling well enough to participate.

This interview will take about one hour and will be audio recorded. You will be referred to by your first name during the interview. You will be asked to give me a pseudonym (i.e., a name that you choose that isn't yours) when I type up the interview. That way I can make sure that the information you have shared during the interview is kept anonymous and that you cannot be identified.

During the interview you will be asked questions about your experience of being involved in the Care and Treatment Plan approach. If you have a history of offending, you will not be asked any questions about any offences.

The interview will take place at Ty Llywelyn MSU in one of the interview rooms. The interview will take place on a date and time that suits both you and me.

The interview will be recorded using a Dictaphone (given to me by Betsi Cadwaladr University Health Board – BCUHB or Bangor University). I will put the recording in a Betsi Cadwaladr University Health Board computer and delete the interview immediately from the dictaphone. I will also make some notes of the things you say during the interview.

I will then type out everything you have said, now replacing your real name with your chosen name. I will then look at all the information provided by everyone who has taken part in the research, and I will write up the analysis into a research paper. This paper will submitted to Bangor University for examination for my Doctorate in Clinical Psychology qualification.

As the research is being conducted in Wales, the invitation to participate letter, information sheet, opt-in letter and consent form can be made available in Welsh if you would prefer.

Due to the recent difficulties related to Covid19, if all non-essential face-to-face contact is stopped then the interviews can be conducted via Skype. If this is to happen, I will arrange a time and date that suits you, to conduct the Skype interview. Access to Skype will be facilitated on the Ty Llywelyn iPads, in an interview room on the ward. If you are a participant residing elsewhere, you will be invited to come to an interview room in Ty Llywelyn. If we have to use Skype, a Skype address will be provided to you at the time.

5. Are there any risks if I participate?

This research is being undertaken completely separately to any aspect of care you receive at or from Ty Llywelyn MSU, therefore no aspect of your care will be affected.

Due to the nature of the interview questions where you will be asked to think about your experience of living within a secure service, there is the potential for the research topic to trigger unpleasant or distressing memories. You have the right to stop the interview at any time and you will be offered support, should you wish to receive it. Should you require support, a member of nursing staff on shift or your named psychologist will be contacted.

6. Are there any advantages if I participate?

There are no anticipated direct advantages to you for taking part in this research. However, you sharing your experiences will help us to understand how we can improve care and treatment planning in Forensic Secure Services.

As a thank you for taking part in this research, you will be offered a payment of £20 in the form of either a Tesco gift voucher or an Amazon gift voucher. We have chosen to offer you a Tesco or Amazon gift voucher as we know that you can spend it within the security guidelines of Ty Llywelyn. If you do not currently reside in Ty Llywelyn then you will still be offered the same form of payment to ensure fairness and equality of opportunity between all participants. The researchers and related organisations (NHS, Bangor University, Coventry and Warwickshire Research Ethics Committee) have no interest in the companies of either Tesco or Amazon.

7. What will happen with the data I provide?

We will need to use some personal information from you in order for us to do this research project. This information will include your name, so we can contact you. People who do not need to know who you are will not be able to see your name or contact details. Your information will be given a code number and your real name will be replaced in the interview by your chosen name. We will keep all information about you safe and secure in the office of the psychologist at Ty Llewelyn. 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.

8. 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.
- You will be asked to choose a name that you will be referred to in the write up of the research. This is to make sure that any quotes used in the write up cannot be linked to you by your legal name.

9. 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/
- our leaflet available from **www.hra.nhs.uk/patientdataandresearch** that Hannah Waite will be able to provide for you
- by asking one of the research team

10. What will happen to the results of the research study?

I, Hannah Waite, will be writing a report for examination for my Doctorate in Clinical Psychology qualification. The results of this research will be anonymous, so that you can not work out who took part in the study. I will also be required to attend an examination called a Viva to speak about the research with the assessors. The organisation, Betsi Cadwaladr University Health Board (BCUHB), will be named and referred to within the write up of the research. If you volunteer to participate in this research, you will be referred to as *'people currently or previously detained under the*

Mental Health Act (1983) within North Wales' within the final report. Following this examination, there is potential for the research to be published in a professional journal that is read by other people working in forensic services, so they can read and learn from your experiences. We also hope to share the results of this research with the clinical team involved with the North Wales Forensic Psychiatric Service to help them to improve the service. This will be done either via a presentation or via sharing of the final research paper.

11. Who has reviewed this research project?

The research proposal and ethics have been reviewed by my supervisors, Dr Julia Wane (Consultant Clinical Psychologist, Ty Llewelyn) and Dr Carolien Lamers (Lecturer at the North Wales Clinical Psychology Programme, Bangor University). Ethical approval has been obtained from Bangor University, the HRA and Coventry and Warwickshire Research Ethics Committee.

12. Who do I contact for support?

If you are currently living in Ty Llywelyn and would like support during the interview process, you can stop the interview at any time and ask to speak with a member of the nursing team on shift or your named psychologist. After the interview has finished, should you require any support, you can ask a member of the nursing team on shift for help or request to speak with your named psychologist.

If you are currently living in the community or another environment then please contact your care co-ordinator if you require any support following the interview. If you require support during the interview process, you can stop the interview at any time and request to speak with a member of the nursing team or psychology at Ty Llywelyn. You can also contact the following organisations for support:

- NHS 111
- Mind Infoline - 0300 123 3393
- SANEline out of hours between 4pm and 10pm – 0300 304 7000

13. Who do I contact if I have concerns about this study or I wish to complain?

If you have any questions or concerns regarding this research you can ask your Psychologist or Care Coordinator to contact me on your behalf and I will contact you. You can also contact me via post: Hannah Waite, Psychology Department, Ty Llywelyn MSU, Ysbyty Bryn Y Neaudd, Llanfairfechan, LL33 0HH.

You can also contact the research supervisors, Dr Julia Wane and Dr Carolien Lamers by writing to them. Their addresses are:

- Dr Julia Wane, Psychology Department, Ty Llywelyn MSU, Ysbyty Bryn Y Neaudd, Llanfairfechan, LL33 0HH.

- Dr Carolien Lamers, North Wales Clinical Psychology Programme, Bangor University, Brigantia Building, Penrallt Road, Bangor LL57 2AS.

If you have contacted me, Julia or Carolien with your concerns, and are still unsatisfied with how your query has been addressed and/or you wish to raise a further concern, please contact Huw Roberts, College Manager, College of Human Sciences, who is the Bangor University contact for complaints regarding research. You can contact Huw Roberts via the following:

Telephone: 01248 383163
Email: huw.roberts@bangor.ac.uk

You can also contact the NHS Patient Advice Service through the following:
Email: **BCU.PALS@wales.nhs.uk**
Phone: 03000 851234

THANK YOU FOR CONSIDERING PARTICIPATING IN THIS PROJECT

Appendix 3

Opt-In Letter

Opt-In Letter

Care and treatment planning experience within forensic secure services.

I have received the information pack and I have decided that I would like to participate in the above research. I would like to be approached by the researcher, Hannah to discuss my involvement in this research study.

I also understand that choosing to speak with the researcher about potential participation or actual participation in this study will have no effect (positive or negative) on me or my care.

I understand that this letter will be shredded once received in order to maintain confidentiality.

Name: _____

Signed: _____

Date: _ _ / _ _ / _ _ _ _

Appendix 4

Interview Topic Guide

Interview Topic Guide

Care and treatment planning experience within forensic secure services

The interviews will involve over-arching questions with supplementary / prompting questions as needed. The proposed questions are as follows:

- Can you tell me about your MDT / CTP meetings, what do you know about them? What are they for? What is their purpose? What do they mean to you?
- What happens in the CTP meetings?
- How are you involved in the CTP planning/meetings?
- What is it like to be involved in a CTP meeting?
- Who else is involved in the meetings?
    - What is like to hear other people talk about you in the CTP meetings?
    - How do you know what will be spoken about in the CTP meetings?
- How do you know what the team's viewpoint is on your progress within the CTP meetings?
- How transparent do you feel the communication surrounding your care is/was?
- How involved do/did you feel in the CTP meetings?
- What was/is your role in the CTP meetings and your care overall?

Supplementary / prompting questions could include:

- Could you tell me a bit more about that?
- What does that mean to you?
- How did you feel about that?

Appendix 5

Evidence of transcription and analysis process

Person	Evidence from Transcript	Level 1 – Language as constructive: Discourses	Level 2- Language as functional: Rhetorical strategies (action orientation / function of construction)	Level 3 - Positioning	Level 4 – Practices, institutions and power	Level 5 - Subjectivity (subject positions impact subject's thoughts, feelings and behaviours)
I	***So my first question is… what is it like living here?***	**/**	**/**	**/**	**/**	**/**
T	Erm … I suppose er… … it's different (laughing) different to a normal community setting I'll say erm obviously … you meet lots of different people erm who've got various problems, including myself, erm … and it's obviously quite restrictive erm in terms of what you can have and what you can't have, what you can do, where you can go etcetera. Erm it's obviously more	Societal Connection Risk management Controlled Obvious / certain Biomedical and Person centred	Differentiates hospital from 'normal world' Not alone On receiving end of restrictions, dictated to by others in control	Not 'normal' Positions self as part of a wider group who are under the control of another group Mental health dictates needs that are	Patient to follow the rules and abide by restrictions set out by the other group. 'Controlled' discourse maintains power of institution. Knowledge	Living in an 'abnormal' environment under the control of the system / staff? Controlled Objectification/Subjectification: people with problems, like myself/ seen as a mental health issue (what about the whole person?)

	focussed on your mental health in terms of what you your needs are but yeah (sigh) erm It's… it can be quite sort of erm (tut) quite a lot of uncertainty about what your future ah so you can be sort of left a little bit erm not doing much erm … unless your able to uh keep yourself occupied and focussed on what's ahead of you so … yeah	Uncertain Responsibility	Care from others focused on your needs, Defined as needs by others: objectification Your job to stay on track	addressed by other group Certainty is created by following what you need to do.	Lack of power / control Lack of knowledge Self-surveillance	
I	***Okay. What do you find helpful about living in this environment?***	**/**	**/**	**/**	**/**	**/**
T	Erm I suppose … if the your care team is helpf you know is quite open about er your problems. If you have a greater understanding and insight into your own problems already erm it helps because then you can focus on whats you know what you need to do and how to erm so the the the care team, individuals in the care team, whether it's your named nurse or (breath in)	Open discourse – hesitant. Psychological	Attributes responsibility to care team to dictate what is needed Attributes responsibility to self to follow care team's objectives and make them	Requires guidance from those in position of power Gain knowledge	No certainty that the information will be shared openly. Responsibility of care team to objectify care pathway. Patient as a guided participant in their care.	Developing insight and understanding about what they want and need you to do can be helpful. Can only progress if the team are open with you – no control or certainty over their openness.

	psychologist, the doctor erm more or less have the same objective er in hand so you can sort of (inaudible) go along with that, its quite easy to follow erm as long as they're not saying different things it's (laughing) you know it's okay so, yeah.	Collaborative Rule / procedure driven	your own objective.		Knowledge Subjectified	
I	***Okay. Do you think there is anything that could make living in this environment more helpful?***	/	/	/	/	/
T	erm … yes. I suppose there's always uh things that makes it more helpful … erm … despite, you know, the circumstances I think erm… I think there should be more erm … more things to do with the community, linked to the community, (sigh) erm to do with your family if it's you, know, if that's okay erm to do yeah especially to do with the outside in terms of compared to begin in hospital so youre more sort of erm … focussed on erm	Uncertainty Separated Inside vs outside Removed from society.	Desire for connection to 'outside' world Knowledge about what is needed	Separated Removed from society Disconnected	Care should occur in the context of wider society not just within hospital Asking if it's okay – lack of power	Removed and therefore disconnected from society. Has ideas (knowledge) about what would be helpful but hesitant to suggest / reliant on 'okay' from powers above.

	community based activities whether it's erm links to a a college erm university erm (tut) or especially things like charities as well er charity work uh voluntary work so people come in and take you out to do activities, yeah.	Guided/controlled			Not objectified – seen as a person instead	
I	***Is there anything else you want to say about living here?***	/	/	/	/	/
T	… erm … … … … … No.					
I	***okay, there's no problem if there's not, I just wanted to make sure I'd given you enough space t(interrupted)***	/	/	/	/	/
T	that's fine, yeah.					
I	***okay. So my next question is about the care and treatment plan so can you tell me about your care and treatment plan and multi-disciplinary team meetings, what do you know about them?***	/	/	/	/	/

T	er so from what I know about them, so basically they are held every 12 months erm … … they can be reviewed well yeah every six every six to twelve months as far as I am aware so uh obviously they have different meetings in between as well but that can be sort of included as part of your … uh … … as part of your sort of … treatment pathway so if there is something come up they need to discuss it earlier then that can happen. But (breath) in terms of generally it's basically to erm … (breath in) set goals uh for your treatment pathway so if you have a particular … uh … any particular needs you have in terms of your condition your mental health, your mental mental illness condition … erm mental disorder whatever people call it (small laugh), erm then then they can erm set goals in	Not confident Medical discourse Procedural discourse Issues about what to call the particular needs, what are the implications of the options?	Recognises procedures that happen around him. Emphasises that procedure mainly involves the 'other' (e.g., care team) and he is a passive participant. Objectification: you have needs?	Other group set the goals – goals are dictated to me.	Knowledge, but perhaps questioning self, what I know (yes) Different knowledge Privileged knowledge Finding the right language, not fluent Power and knowledge The procedures occur in the context of an institution that ultimately holds the power and dictates – they hold information and knowledge about you that they use to create goals for	Treatment pathway belongs to me but they dictate it The care is for me but I am a passive participant in my care

	terms of what needs to be done over the 12 months or the the certain times that that needs to be done so whether it's like any sort of uh … psychology therapy, yeah psychology therapy, any sort of medical needs you might need attending to erm … things like activities you might want to do erm things you need to … uh build up uh maybe something like confidence erm (tut) also things like … things to do with your family so whether it's how much contact you have with your family on a daily basis or … erm … also things like you might need help with, things like finances or erm benefits for example so that that's there so it may be your social worker or your community link that helps you with things like that erm … and also I suppose it's the goals for setting for the future in terms of your discharge or to or referral to		Power -who decides		you – passive participant.	

	low secure so they'll be setting step by step goals to towards reaching those goals, yeah.				They set the goals: power	

Appendix 6

Example of quotation evidence for discourses

Discourse 1 – The power sits with them (staff) (power and knowledge)

Participant	Quote	Foucauldian concept
Sid	… know I know that it would be hard to, sort of, for them, the doctors and such, to give you an exact date or whatever but at the start it's a bit you're a bit in limbo with it …	Power – the doctor decides when he can leave
	… gives you an understanding on what you've been doing … erm … … … what you need to do …	Knowledge - held by them
	… psychology team, community team, your named nurse, erm the … doctor, and usually like the ward manager or someone like that (cough) and you'll go through with them and each erm each individual parts erm or people will sort of say how they think you're doing and erm … like your progression and stuff like that and tell you what, what, what they've written down …	Subjectification – by others Knowledge – their knowledge of him is important
	… at the beginning though it was hard to get an answer of when you'll be discharged but … … … … … all the questions about like your care and treatment are answered, basically what you need to do in terms of psychology erm … what you could do with the OT team …	Knowledge – they share their knowledge with him so he knows what he has to do
Drake	Obviously having psychiatrists and the psychologists and obviously the nursing team who you can speak to and talk to like maybe get advice from and obviously help you to make progress and for you to get back on track and back out in the community …	Knowledge – held by other and shared with him to help him progress
	… take some of the boredom off their hands and stuff init and give them something to focus on and enjoy …	Power – staff have the power and control Objectification – of staff and their role

	… they look into what you have been up to since you've been in erm or since before your CTP, erm the progress that you've made, erm, you know, and obviously what the plans are for the future and what you need to do …	Surveillance and power – staff watch him to see what he is doing and what he needs to do
	… then what it is you need to do to get to erm the step down that it is in the future that you're going to …	Knowledge – held by staff about what he needs to do
	… they see you a lot, so basically you get an insight on what their obviously erm … seeing you and how you are on the ward and how you interact with your peers and obviously the staff, your behaviour …	Surveillance – by others
	… you take that feedback and you learn from it and you've got to do whatever you've got to do to basically better yourself and obviously move on from that …	Subjectification and knowledge – using their knowledge to better himself
	… obviously you do get to see your psychiatrist sometimes, maybe once a week if you're lucky, if its not your CTM that you see them in you'll see them on the ward from time to time so obviously you can find out information or have an idea of what erm is gonna be discussed in the meetings …	Power – held by psychiatrist
	… I know that everything's jotted down anyway, notes are taken daily by the nursing staff …	Surveillance – constantly under surveillance by those in power
	… she (psychiatrist) was talking clearly and transparently about basically what the next step is, what what erm is gonna happen next and obviously to do the paperwork and stuff and what's gonna happen after that and she gave me a time period as well …	Power – held by psychiatrist
	… doing whatever it is necessary that I need to do to basically move on to the next step from the current position that I'm in erm … … … if there's anything I need to change or work on that is where I	Subjectification – of self Knowledge – gained from those in position of power

	will find out and obviously from then onwards I can make the right choices and decisions … … just being able to listen to erm whatever it is that the doctors and the team are saying, whether its positive or negative, and taking all that in and using that to make progress for what comes next in the future …	Power – held by doctors and team – they know best.
El	… there's a lot of rules but you've got to have rules … … an you've got to abide by them … … He's my consultant, he's the one that decides what happens and to be fair he always has an answer for any problems … … I go in with some questions, they'll be honest and then you just slowly build up your leaves, your time for leave and stuff and they gi they give you more, if they have more trust in you and give you more chances to prove that you, you know, … erm … that you're of right mind… … how they think you're doing and what they think they need to ha happen to make things better for you and that … … it's interesting because … of course you go in there asking questions about things you want to happen and that but you also just found out what people have been seeing you as you know, and how they think you are doing … … they've all got a different opinion of me isn't it … so mainly it's doctor that decides stuff and that,… … cause of the section I'm on as well, he he's pretty much deciding what's happening … … to show them that I'm making progress really …	Objectification and subjectification – abiding by rules Power and knowledge – held by psychiatrist Knowledge – shared Power, objectification, subjectification and surveillance – from others Knowledge and power – held by others; from a place of care? Power – held by others; have to ask for stuff. Surveillance – from others Knowledge – it isn't static Power – held by psychiatrist and governed by law? Surveillance – inviting to ensure he is meeting the objectified rules.
Bigz	… I had a manager tell me, late last year quite soon after I arrived in (hospital	Power and knowledge – held

	name redacted), that I would be discussing options in regards to transferring me to an open rehab the week after erm and that never happened, that was not the case and then I've come on to (ward name redacted) and shortly after arriving on (ward name redacted) I've had a manager here also (emphasised) tell me that I would be possibly getting transferred to erm to (hospital name redacted) which is open rehab, but its not true cause when I take it to my consultant she says I am nowhere near (emphasised), I don't fit the curriculum to be moved on just yet…	and shared by others in position of power
	… I can't go until I've got community leave and that's gonna be down to the team and the consultant…	Power – held by team and consultant
	… for the team to discuss … erm the possible routes that are best for you …	Knowledge and power – held by the team
	… so if I want a new person on my visitor list I have request it at CTM, in the CTM, and they will either grant or deny …	Power – held by team
	… anything can happen in them. You don't know what they're gonna come out with next…	Knowledge – privileged and held by team = uncertainty
	… From my side, … I'm free, it's it's those, it's them, it's the rules, their schedules are holding me back … but then again they (emphasised) are allowed to use that against me …	Power – held by others and is restricting progress
	… The psychologist HAS mentioned that MAYBE we could erm have some sort of session in between, and I'm all for that, if it means getting some work done quicker, though obviously I've got to structure with her so we wouldn't be stepping on her toes …	Power – held by psychologist
	You ask a question and you do get an answer but does that answer necessarily mean what it is, or is that answer the truth? Probably not.	Knowledge – unclear Power – consultant is most powerful

	… no one should have mentioned (unit name redacted; open rehab) to me without the consultant saying it because it's getting my hopes up yeah … … they just wanna tell you what they wanna tell you and what you say doesn't matter …	Knowledge and power – their knowledge is higher and his doesn't matter
John	… all the team meet … erm it's where you get to attend and have a discussion, you can put your requests on paper so they discuss them before you get in erm, sometimes you have a discussion with them or reasons why you're you're your requests haven't been granted … … it's just sort of yeah "well you do that" … … it's just know where I stand, … and what I have to do to get to the next part of my journey… … all my reports wasn't complete in time like so that that was a frustrating part because you go in there and yo y y y y you've not a clue what's been written or what's been said, what you've been assessed for and all that like, you might have an idea but until you see it in paper, on paper, it's not set in stone so to say … … all eyes on you … … you sit there and then it's like "have you got anything to say" and you're just like "yeah I've got this to say about the report" and then they go round and you have to listen to everyone else's, you know what I mean, and then I I it should be at the end where your (inaudible) to say "well I want this out of you" erm "I want you to do this", "we will work towards this with you" and all that like, you know what I mean, where as it should be more it should have been more discussed in my, but it was less of a discussion.	Power and knowledge – held by the team; He requests and they grant / deny Power – dictated to by staff Power – they tell him what he needs to do Interaction between sharing knowledge and power held by the team Surveillance by the team Power – held by the team; he is not usually in control, they are – he is powerless. Power – held by the team.

	(H – who is it that usually has the control then?) … well the whole room apart from you. … it's your choice to her out of bed ha, erm it's your choice to engage, erm and do things, erm but at the end of the day it all rolls down to the care team … … … … … … … … cause they have the overall end decision. … it's not up to the care team, well it is cause they give you permission hahaha, you know what I mean, so you you you're quite, you're limited cause of the environment so I I I it comes down I think in a sense it's just all about the choice, the right, the wrong choice, you know what I mean, cause you can make the right choice to take your depo every month or you could refuse it and then you'd have, you'd be going against the care team.	Power – held by the team. He tries to have power but if it is not the same as what the team want then he is powerless.
Simon	… you know the staff they disturb you in the morning, they just wake you up … … it's like torture you know. They they shine a torch in your face like every hour throughout the night so you can't sleep an that. … just so people like yourself can justify their wages. … they just get together and talk about your care (emphasised) … You know, it's like a power trip. The staff have the power. … well I just thought, you know, bunch of amateurs, dealing with peoples liberty which is really important … … well they let you know, if you ask them and they'd probably let you know, but it it's to do with how … how far uh along you are in your care pathway and how much freedom you're allowed.	Power - held by staff Objectification of staff Power – sits with the staff Power – held by the staff Power - held by staff Knowledge and power – held by staff Power – held by staff; he doesn't have any.

	… I'm like a (age redacted) year old guy who's got to ask somebody for a bowl of Weetabix, that's not care is it. Well what they do is they strip away your ability to do things, they tell you for four or five years 'no you can't do this, you can't do that' and after four or five years you might start believing it, so then when it comes to when you you actually leaving, you can't actually do the simplest things like phone up the social security, cause you're so dependent on it cause they've told you for five years that you can't make a cup of tea for yourself and then they complain of staff shortages.	Objectification Subjectification Surveillance Power – held by staff; they tell him!

Chapter 3

Contributions to Theory and Clinical Practice

Concluded with Personal Reflections

Introduction

This thesis sought to contribute to developments in understanding how people talk about the care that they receive whilst detained within forensic mental health services (FMHS) and explore the use and effectiveness of compassion focused approaches within forensic and inpatient mental health services. Chapter one presented a systematic literature review that explored the use and effectiveness of compassion focused approaches within forensic and inpatient mental health settings. Chapter two presented a qualitative empirical study exploring how people in receipt of care within FMHS talk about the care and treatment planning approach, from a Foucauldian Discourse Analysis (FDA) perspective. This final chapter considers how the systematic literature review and qualitative empirical study contribute to theory and clinical practice, concluding with reflections from the first author on their experiences of working within forensic mental health services and undertaking this research.

"The compassionate mind is the mind that transforms."

Paul Gilbert

Contributions to and implications for future research and theory development

Systematic literature review

The systematic literature review considered the use and effectiveness of compassion focused approaches within forensic and inpatient mental health services. Compassion focussed approaches are being delivered within forensic and inpatient mental health services, with promising findings pertaining to the effectiveness of compassion focussed approaches across multiple target outcomes (e.g., self-compassion, compassion for others, increased wellbeing, reduction in disruptive behaviour and reduction in offence related presentations). Bressington

et al. (2011) stipulated that people in receipt of care need to be able to trust the care team in order to feel safe, with the therapeutic relationship being central to the experience of care and treatment. The presence of compassion within the delivery of care supports the development of genuine and trusting relationships (Lathren et al., 2021), with trust leading to improved clinical outcomes (Birkhäuer et al., 2017). Future research considering the experience of compassion, with a specific focus on professional relationships, from the perspectives of both the person delivering care and the person receiving care, would contribute to understanding the role of compassion within care relationships.

The systematic literature highlighted promising findings for compassion focused approaches in addressing a range of mental health and criminogenic needs. Future research could consider evaluating compassion focused approaches, across a variety of delivery methods (e.g., group, individual and systemic interventions) within forensic and inpatient mental health services. Evaluation of compassion focussed approaches on specific criminogenic factors and specific mental health difficulties would also be helpful.

Further evaluating the impact of compassion focused approaches on areas such as self-compassion, compassion for others and overall well-being within the forensic and inpatient mental health population would contribute to the growing evidence base. Future studies may also include a variety of population groups including females within FMHS, males in inpatient mental health services and staff. Exploring the impact of compassion focused approaches on how people talk about their experience of care, from an FDA perspective, would also be interesting and would further highlight the complexities within environments that function with multi-layered and multi-faceted power structures.

Empirical study

People residing within FMHS are often underrepresented within the literature and evidence base, although this is slowly changing. Their voices and experiences are integral in understanding how care is received. Recent drives within FMHS have centred around person-centred care, with an emphasis on greater inclusion for the service user (Haines et al., 2018). However, the overpowering need for FMHS to manage the risk posed by patients towards others causes tension (Pouncey & Lukens, 2010), with patient involvement often marginalised within practice (Haines et al., 2018). The empirical study supported this notion, identifying a theme of 'they hold the power', referring to the care team. A notion of being stuck in a tug-of-war, wanting more power whilst acknowledging the wider power structures at play was also evident.

The literature surrounding people within forensic and inpatient mental health services would indicate that they could have previous experiences of Adverse Childhood Experiences (ACEs) and difficult life circumstances, including but not limited to low socio-economic status, involvement with social services and difficult educational experiences (McKenna et al., 2019). These factors are likely to have, in some way, shaped the discourses that the participant group held, given the likelihood of previous experiences of being 'cared-for' or restricted in one way or another. Similarly, experience of ACEs within this population group would likely indicate existence of established discourses, prior to entering FMHS (Rex, 1999). For example, people who find themselves in FMHS have likely been objectified by multiple power structures across multiple contexts within their life and have also likely objectified others in relation to interpersonal offending behaviour and coping with complex power structures that have influenced their life trajectory (Bradford et al., 2014).

With the recent drive for FMHS to adopt a more psychologically informed approach (De Pau et al., 2021; Saltman & Bankauskaite, 2006), considering the Power Threat Meaning Framework (PTMF) in relation to FMHS could be useful. A key recommendation from the

Division of Clinical Psychology that contributed to the development of the PTMF was "to support work, in conjunction with service users, on developing a multi-factorial and contextual approach, which incorporates social, psychological and biological factors" (Division of Clinical Psychology, 2013; p. 9). The PTMF holds the assumption that emotional and behavioural difficulties are understandable responses to often very adverse environments and serve as protective functions (Boyle, 2022). It adopts the stance that the person experiencing distress is an expert of their own experience, therefore placing them at the centre of their care. Foucault positioned knowledge as a prerequisite to power (Van Dijk, 2009), with the PTMF holding the individual's knowledge of their own experience as the most powerful. Boyle (2022) stated that within the PTMF, a central role is given to the operation of power in linking the social environment to the difficulties of the emotional and behavioural nature. The PTMF positions the commonality of power relations, and the centrality of knowledge and meaning, as a core factor in shaping how people understand themselves (Boyle, 2022). Given that the legal and medical paradigms underpin care delivery within FMHS, gaining insight from individuals who operate within and adopt the medical model within their work, such as psychiatrists and medics, would facilitate contributions focused on understanding the challenges brought about by how people are trained within the medical model and the implications this has in relation to the delivery of care.

People cared for within FMHS are detained against their will, with medicine and law framing their care and treatment (Haines et al., 2018). Power is undeniably held within the intersectionality of the medical and legal frameworks, frameworks that dominate all aspects of care and treatment. The medical and legal paradigm, therefore, ultimately renders the staff that work within them as gatekeepers of the power. As a result, healthcare professionals, particularly doctors, are often intrinsically and extrinsically viewed as directly accountable

for the conditions of an individual's care (Haines et al., 2018). Future research could explore the experiences of people working within care teams and the way that they speak about delivering care, including how they talk about their role and the patient role within the CTP, again using a FDA perspective. Other approaches could also be considered to understand the lived experience of staff better. Consideration to staff's positioning of their role within the CTP and their use of knowledge and power would provide additional insights into the impact of the multi-layered and multi-faceted power structures that operate within FMHS. Similarly, further research exploring the perspectives of the wider power structures, including the Ministry of Justice and members of the public, would contribute to understanding the implications of power from a perspective that is governed by the legal framework.

Implications for clinical practice

Systematic literature review

Compassion focused approaches are currently being utilised within forensic and inpatient mental health services, with promising evidence in support of their effectiveness. A main implication for clinical practice identified through the systematic literature review concerns exploring the impact of compassion focused approaches across multiple domains. Firstly, compassion focused interventions, when evaluated, should be explicit in their method of delivery. Information pertaining to the delivery of the intervention should be made available, with a focus on content and structure. Secondly, outcomes could be monitored with validated measures, appropriate for the population group and outcome need. Thirdly, with promising outcomes, compassion focused approaches could be delivered to all people within forensic and inpatient mental health services, regardless of their role (e.g., staff and patient).

Another clinical implication is that of availability of compassion focused approaches. Staff teams could be trained in compassion focused approaches and supported to adopt a

compassion focused approach to their work. Supervision and space for reflection as part of a compassionate focussed service is likely to benefit staff and patients.

Given the sense of shame and self-criticism experienced by people within forensic and inpatient mental health services, care should be taken in maintaining a compassionate approach throughout the development of any compassion focused intervention. For example, considering the name of the intervention and ensuring it reflects compassion will be integral to the effective implementation.

Finally, the core principles of compassion focused therapy could form the foundation of all compassion focused approaches. The current literature review indicated positive outcomes for all interventions, both individual and group interventions, and for both adolescents and adults. Despite utilising different approaches, all interventions had a main focus on skill development through experiential practice. Topics delivered within sessions consisted of psychoeducation around the theoretical underpinnings of compassion focused approaches, mindfulness, compassion practices and imagery. Interventions aimed at addressing specific mental health or criminogenic needs could also include additional specific topics that address such needs.

Empirical study

The findings from the empirical study reflected the expected presence of power within FMHS, evident to the people in receipt of care. Power, or the lack of, was positioned as problematic for the people receiving care, with discourses centred around power being held by the care team and the participants adopting a 'role' whereby they were better able to manage their sense of powerlessness. Given the intricate complexities of the legal and medical paradigms that underpin FMHS, consideration to how power is utilised, enforced and

received, as well as where power originates from and is held, is integral to understanding the impact of power on the recipients of care.

Kanyeredzi et al. (2019) stated that people receiving care can effectively choose to do what they wish, however, do not typically do this as their care is mapped out for them by people in positions of power utilising clinical expertise. A key implication for clinical practice is that of genuine involvement of the person receiving care within their care and treatment planning. An explicit acknowledgement of power differentials should be present and spoken about openly with the person in receipt of care.

At times, people detained within a FMHS may be perceived as too mentally unwell to participate and contribute to decision making regarding their own care (Livingston et al., 2012). Efforts should be made to include people in their care and treatment planning at all times. This can be achieved in a sensitive manner at times of increased distress or difficulty, with advocating for their thoughts and feelings previously shared. Maintaining open and honest communication around an individual's care trajectory, regardless of the perceived level of distress is of utmost importance in maintaining their involvement with their own care.

Finally, Foucault positioned knowledge as a crucial factor in power relationships (Dreyfus & Rabinow, 1983; Gutting, 2005). The people receiving care should be acknowledged as experts of their own experience, with their knowledge shared, listened to and respected.

Personal reflections

Providing care to people formed a natural part of my life from a young age, having cared for my grandparents. I loved being with them, learning from them and supporting them in ways that enabled them to maintain their independence for as long as possible. During school I

encountered some difficult relationships, relationships that sparked a desire to understand human behaviour and people's intentions within interpersonal relationships and the world more generally. Naturally, I developed an interest in people's minds and often wondered how it came to be that some people saw the world through a completely different lens than me.

As a result of life experiences that need not be elaborated on here, at the young age of 18, I found myself drawn to engaging with, learning from and supporting people who experienced difficulties with their mental health. I gained my first role as a Healthcare Assistant (HCA) within an inpatient mental health service. Very early on in my career I was exposed to situations that required me to hold power, often holding power in professional relationships with the people who I was providing care for, people often much older than I who undoubtedly had much more life experience. There was an expectation that I held knowledge; knowledge that would render me more powerful within these professional relationships. I felt a sense of responsibility to conduct my job, as dictated by the job description, whist experiencing an uncomfortableness with my position as a person of power, noticing that the people for whom I was providing care were rendered powerless. I also experienced interpersonal situations within my professional role where I was rendered powerless: difficult experiences that only recently I have been able to hold with self-compassion and space for understanding. This was the start of my curiosity into power positions and social constructions of individual roles within relationships.

Fast forward to 2018, with a fire ignited from my learning on the BSc Forensic Psychology degree and work experiences within forensic services, I embarked on a journey as an Assistant Psychologist within a medium secure service, whilst undertaking an MSc in Forensic Psychology. A maturation of my thinking sparked an interest to explore the real-world implications of social constructions, particularly how people detained within FMHS, a population group I was growing ever fond of working with, were understood by others.

Undertaking a Masters qualitative thesis, exploring discourses of the wider public about people in receipt of FMHS, I uncovered narratives that I knew deep down existed within society, yet often avoided to acknowledge. I realised that the people whom I was supporting had a voice, but their voices were not heard, respected or understood. This felt true also within my employment. It seemed as if a tokenistic platform was provided where their voice could be heard, yet this was rarely the case, with knowledge held by 'professionals' deemed more powerful, again rendering the person cared for as powerless. I felt a strong urge to advocate for those people and was unsure on how to do this, feeling powerless as a result of objectification by the wider power system: HCAs are also perceived as lacking theoretical knowledge, however, often hold the most knowledge about an individual they are providing care for (aside from the individual themselves). I often engaged in challenging conversations, perhaps intending to educate the wider society and protect the people with whom I worked. This is where the idea for the current thesis was born.

Undertaking the empirical research with a familiar population group in a familiar environment had its difficulties. My personal views and beliefs around the provision of care for people within FMHS often came to light, sometimes as a reminder for why I had opted to do this research and sometimes as a reminder to take a step back and utilise supervision. Similarly, I felt anxious about being able to capture the words of the participants in a way that would be meaningful, whilst remaining objective and thoughtful. Supervision provided by Dr Julia Wane and Dr Carolien Lamers proved valuable, with them helping consolidate my thoughts and think about things from an FDA perspective. Given my personal interests, the social constructionist epistemology and attentiveness to power, FDA seemed an appropriate methodological approach to the empirical research. Throughout the duration of the research process, I was acutely aware of my positioning, both as a researcher and also as a part of the care team. Acknowledging my role in the power structure of the forensic service proved

integral in deepening my ability to collect data objectively, albeit an uncomfortable acknowledgement. I feel privileged to have been a part of the research process, gathering data through semi-structured interviews and writing my interpretations within this thesis. I feel that the participants have invested their power in me to take their words and do them justice in a way that will contribute to developments within the thinking around FMHS and the care and treatment planning approach.

An interesting discussion around the term utilised to describe people in receipt of care featured on multiple occasions throughout the research process. Variations in the terminology are evident within the literature, with terms including 'patient', 'service user' and 'client'. The term 'patient' was adopted within this thesis due to its overwhelming use within the literature, particularly the literature surrounding FMHS. It felt uncomfortable deciding on a term to refer to a group of people, without direct input from members of that particular group. Throughout my clinical experience, the term 'patient' has almost always been utilised to describe the people in receipt of care. This seemed to be derived from the medicalised discourses that surround people in receipt of care, positioning them as 'unwell' and 'in need of care'. With specific reference to people in receipt of care within FMHS, considerations to the comfortableness of the term 'patient' over the term 'prisoner' have also featured in my thinking, reflecting on the way in which we, as human beings and as professionals, opt to utilise language that makes us feel more comfortable, with acknowledgement to the social constructions and discourses surrounding people who offend.

Reflecting on my experiences of working within forensic and inpatient mental health services across multiple service levels, the importance of compassion features throughout. It became apparent quite early on in my career that the people I was working with had likely lacked compassion throughout their lives, both self-compassion and compassion from others. I often noticed an uncomfortableness from the person in receipt of care when provided with

kindness and compassion. Similarly, recognising the importance of self-compassion and compassion for others within my role as a professional has featured throughout my career. My experiences of working within forensic and inpatient mental health services have proved challenging at times, considering the difficult nature of a ward environment, influenced by uncomfortable power structures, and navigating trauma held both individually (e.g., within the people cared for and the people providing care) and within the system. I had not been able to conceptualise this in a way that made sense until I became more familiar with CFT, through having teaching during training and subsequently attending workshops about CFT and compassionate approaches within forensic and inpatient mental health services. Exploring the use and effectiveness of compassion focused approaches within forensic and inpatient mental health services, through the systematic literature review, has demonstrated to me the importance of compassion within my work, for people receiving care, people providing care and individually.

People often ask me why it is that I am so invested in working within FMHS. I could answer this question through writing a book on the privileged experiences I have had and the incredible people I have met through my time working within these environments. For now, I will say, we are all human and all deserve to be cared for with kindness and compassion, regardless of our life trajectories.

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