Exploration of Forensic Mental Health Service Users' Experiences of Collaboration and Strength-Based Approaches in their Care

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Chapter 1

Forensic Mental Health Service User Involvement in Risk Assessment and Management: A Mixed-Methods Systematic Review

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Abstract

This review aimed to synthesise existing research on forensic mental health service user involvement in risk assessment and management. Specific aims were to establish how service users are involved in these processes, the barriers and facilitators to this and whether or not, it is helpful to service user recovery. Four databases were searched on the 14th April 2024, resulting in the inclusion of seven studies. Quality appraisal of included studies was conducted using the Mixed Methods Appraisal Tool (MMAT). A 'best fit' framework was used to synthesise findings. The quality of included studies varied from 40-100%. A framework was developed from the data, consisting of six themes: *Who is this for, Power, Misunderstood, Moving forward, Becoming a team, and Joined approach to individualised care.* According to staff and service users, meaningful and timely engagement with foundations in trusting relationships can facilitate collaboration despite the complex reality of forensic mental healthcare.

Introduction

Risk Assessment and Management in Forensic Mental Health Settings

Forensic mental health (FMH) services aim to rehabilitate a restricted population in inpatient and community settings. FMH inpatient services consist of high, medium and low-security hospitals, with level of security matched to patient risk of violence. Individuals using these services are considered to suffer from a mental disorder as defined in the Mental Health Scotland Act (Scottish Government, 2015), whether or not they are managed under its provisions and come to the attention of the criminal justice system or whose behaviour poses a risk of such contact; including those treated and detained under a criminal section of mental health legislation (Forensic Network, 2022).

In Scotland, the FMH inpatient population has remained remarkably consistent since 2013 when Census data was first collected. According to the Forensic Network (2022), the population was 522 in 2013, and the most recent available Census data is from November 2022, when the population was 504. Female patients numbers have ranged from 35 to 65 in this same time frame.

Risk assessments are key to international FMH practice, informing case formulation, planning and decision-making (Doyle et al., 2014). Structured Professional Judgement (SPJ) is the internationally recommended approach to risk assessment, combining the use of empirically validated guidelines on risk of violence, with professional knowledge and discretion (Doyle et al., 2016). Assessment of risk using SPJ then yields an individual risk management plan.

In the UK, FMH risk assessment importantly contributes to clinical and legal reviews such as, the Care Programme Approach (CPA), which involves collaborative review and identification of specific interventions to meet service user need whilst accounting for safety and risk (The University of Manchester, 2006), and is a key component of judicial decision-making when the person is subject to a restriction order by the court.

Risk of violence is primarily assessed using a deficit-focused approach whereby a person's historical, clinical and contextual risk factors are identified and rated. Risk assessment is professionally led by staff specifically trained in the proficient use of SPJ. However, since 2007, the Department of Health state that risk assessment should be informed by the service user, their carers and trained staff members who know them best, to facilitate an individualised, asset-focused approach. At that time, the Department of Health further stated that service users should be involved in each part of this process and afforded opportunities to lead in both the identification of risk and what support or treatment may contribute to risk management. Principles of collaboration have reassuringly been highlighted in more recent FMH literature (Wagstaff, 2018), however, given that risk assessment and management plans serve to protect the public, and the person, it remains of utmost importance that they are carried out collaboratively in line with best practice. This serves to highlight the challenging dual role of care and public protection held by professionals in FMH (Markham, 2018).

Forensic Mental Health Service User Involvement

In recent years there has been increased focus on recovery-oriented care in mental health (McKeown et al., 2016); the necessary components for which are involvement, belief in rules and social norms, relatedness, commitment to work-related activities, and concern about indeterminacy of stay (Nijdam-Jones et al., 2015). The literature increasingly describes a paradigm shift from the established biomedical expert-dominated approach to this person-

centred, holistic approach (Jørgensen et al., 2022). The aim of recovery-oriented approaches are individual well-being, resource, and desire to achieve a meaningful and hopeful life, informed by the individual's experiential knowledge (Leamy et al., 2011).

The Independent Forensic Mental Health Review (Scottish Government, 2021) indicates that the shift towards recovery-orientated care should also be implemented in FMH. Although, it is recognised that there is a tension between individual recovery and control exercised by FMH services; with the latter potentially impacting negatively upon individual autonomy, choice and growth (Quinn et al., 2023). Recovery approaches can be further complicated in FMH by service users' previous offending. The legal and social implications of which often excludes the person from future opportunities and correlates with reduced self-esteem; thus, challenging the development of hope and self-acceptance as central principles of recovery (Drennan & Alfred, 2013). These findings indicate complex barriers to meaningfully involving the FMH service user in risk assessment and management.

From what the researcher knows of routine practice, some of the following may represent examples of facilitators to FMH service user involvement in risk assessment and management: clinical interviews with service users conversing about their experience and plans for the future, the development of shared understanding of risk through psychological formulation, staff sharing risk reports with service users for feedback, or service users attending CPA meetings with their clinical team. As relationships are widely accepted as a core facet of recovery approaches (McKeown et al., 2016), and therapeutic rapport to elicit information sharing is deemed fundamental in effective risk assessment (Ollson & Schon, 2016), such practices are vital components of recovery. Without these practices, mistrust is generated in service users towards their risk management and recovery plans, and towards staff and the system (Shingler et al., 2020). Furthermore, Eidhammer et al. (2014) stated that

lack of adherence to core principles of the recovery approach can lead to inaccurate assessments of risk.

By contrast, effective service user involvement in risk assessment and management may not only contribute to the prevention of violence but towards achieving success across various domains: normal life, independent life, compliant life, healthy life, meaningful life, and progressing life (Livingston, 2018).

Rationale and Aim for the Current Review

A decade ago, Eidhammer et al. (2014) reviewed the research on FMH service user involvement in risk management interventions and observed that research on the topic was scarce. They concluded that there was a need for staff training on involving service users in risk management, and to develop risk management interventions focusing on service user involvement and self-management. Morgan and Levin (2019) more recently concluded that there continues to be a paucity of forensic literature by contrast to other disciplines, despite an increase in the number of services over the years.

Since Eidhammer and colleagues' (2014) review, the literature mainly represents professionals' experiences of violence risk assessment and management; a review of which was completed recently by O'Dowd, Cohen et al. (2022). Interestingly, results reiterated that service users continue to be excluded from their own risk assessment and management plans, and that they generally view the process negatively. O'Dowd and colleagues (2022) also noted collaboration as something that poses a continuous challenge within FMH, but something that may also serve to enhance therapeutic relationships and thus, the quality of risk assessment and management. Recommendations by O'Dowd, Cohen et al. (2022) echo that of Eidhammer et al. (2014) almost one decade later, in that staff training on the risk

assessment process should be increased, particularly regarding the communication of risk, to support staff understanding of why collaboration is important. Furthermore, they encouraged more exploration of FMH service users' experiences of risk assessment and management.

Therefore, the current review aims to synthesise and evaluate the quality of existing research on FMH service user involvement in risk assessment and management. A better understanding of how service users are involved and their perspective of this, could optimise engagement and increase recovery outcomes. Additionally, with enhanced understanding of the people whom they care for, and the barriers or facilitators to involving them in risk assessment and management, staff may be empowered to work collaboratively, as per recovery-oriented care.

The author was interested in studies that explored the evidence for, as well as perspectives and findings on, service user collaboration in risk assessment and management, from both service user and staff samples. To consolidate our understanding on the topic, including both service user and staff samples was deemed vital. A range of study methods were also included to optimise the quantity of appropriate research due to FMH traditionally being under-researched.

To the author's knowledge, there is currently no published systematic review on FMH service user involvement in risk assessment and management.

Review questions:

1. What is the evidence for service users participating in the development of their own risk assessment or management plans across FMH settings?
2. What are identified as barriers or facilitators to service user collaboration in risk assessment and management, according to staff and service users?

3. Do staff and service users regard collaboration in risk assessment and management plans as helpful to their recovery?

Methods

Registration

In accordance with Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA; 2020) guidelines, this systematic review protocol was registered with the International Prospective Register of Systematic Reviews (PROSPERO) on 5th June 2024 (CRD42024509262).

Search Strategy

Searches of four database search engines were completed on 14th April 2024 with no time range restrictions applied regarding date of publication. The databases identified included OVID Interface (MEDLINE and EMBASE) and EBSCO (CINAHL and PsychINFO). The SPIDER (Sample, Phenomenon of Interest, Design, Evaluation, Research Type) tool was used to guide the development of search terms as it supports the development of search strategies in qualitative and mixed methods studies (Cooke et al., 2012) .

The search strategy was amended as appropriate per database (see Appendix A, p. 71-74):

1. Key word searches related to main subject terms:

- **Forensic Mental Health:** Forensic Psychology OR Forensic Psychiatry OR Forensic Nursing OR Psychiatric Nursing OR Psychiatry OR forensic psych* OR forensic mental health OR forensic nurs* OR psychiatr* OR mental* OR mental health

- **User involvement:** Patient Participation OR Decision making, shared OR collab* OR involv* OR participat* OR service user* OR user involvement OR user participation OR shared decision making
- **Violence risk assessment and management:** (Violence AND Risk Assessment) OR (Violence AND Risk Management) OR violence risk* OR forensic risk*

2. The use of MeSH/Subject Headings to map articles to main subject terms.
3. The use of the OR Boolean Operator to combine search lines for each main subject.

Inclusion Criteria

- Adults over 18
- Samples from forensic community services, low, medium and high-security units
- Qualitative, quantitative or mixed-method design studies that involve either service user or staff samples
- Grey literature (unpublished, non-peer reviewed articles)
- Studies in the English language
- International studies

Exclusion Criteria

- General adult mental health samples
- Child and adolescent mental health samples
- Studies that do not report any new data, such as review papers

Method of Synthesis

A 'best fit' framework synthesis was employed (Carroll & Booth, 2011, 2013). The approach allowed for the deductive mapping of data from primary research studies onto a framework

constructed of pre-identified themes, concepts, theories or ideas, based on the principles of Framework Analysis. Thereafter, a phase of inductive theme generation began. Booth and Carroll (2015) argue that identifying patterns from the synthesis in this way, enables teams to formulate action planning for system-wide consideration. The method was further identified as suitable due to its increasing use in mixed-method reviews (Brunton et al., 2020).

The synthesis process adhered to the guidance of Carroll and Booth (2011, 2013):

1. The researcher became immersed in the data, gaining initial understanding of the range of views, experiences and evidence within the literature.
2. A suitable *a priori* framework was identified based on the above initial familiarisation stage.
3. Data for synthesis were extracted from the results of included studies; verbatim quotes and verbal summaries. No themes beyond the *a priori* framework were extracted from the data.
4. Extracted results were reviewed, coded line-by-line and compared with the *a priori* framework.
5. When extracted data differed from the *a priori* framework additional themes were created via secondary thematic analysis and the final framework updated.

O'Dowd, Laithwaite et al. (2022) resulting themes were identified as the *a priori* framework, explaining more than 50% of the data in this review (Carroll & Booth, 2011, 2013; see Table 3). This framework sought to explain service users' experiences of violence risk assessment and management in order to enhance meaningful service user collaboration, thus, aligning with the overall aim of the current review.

Screening

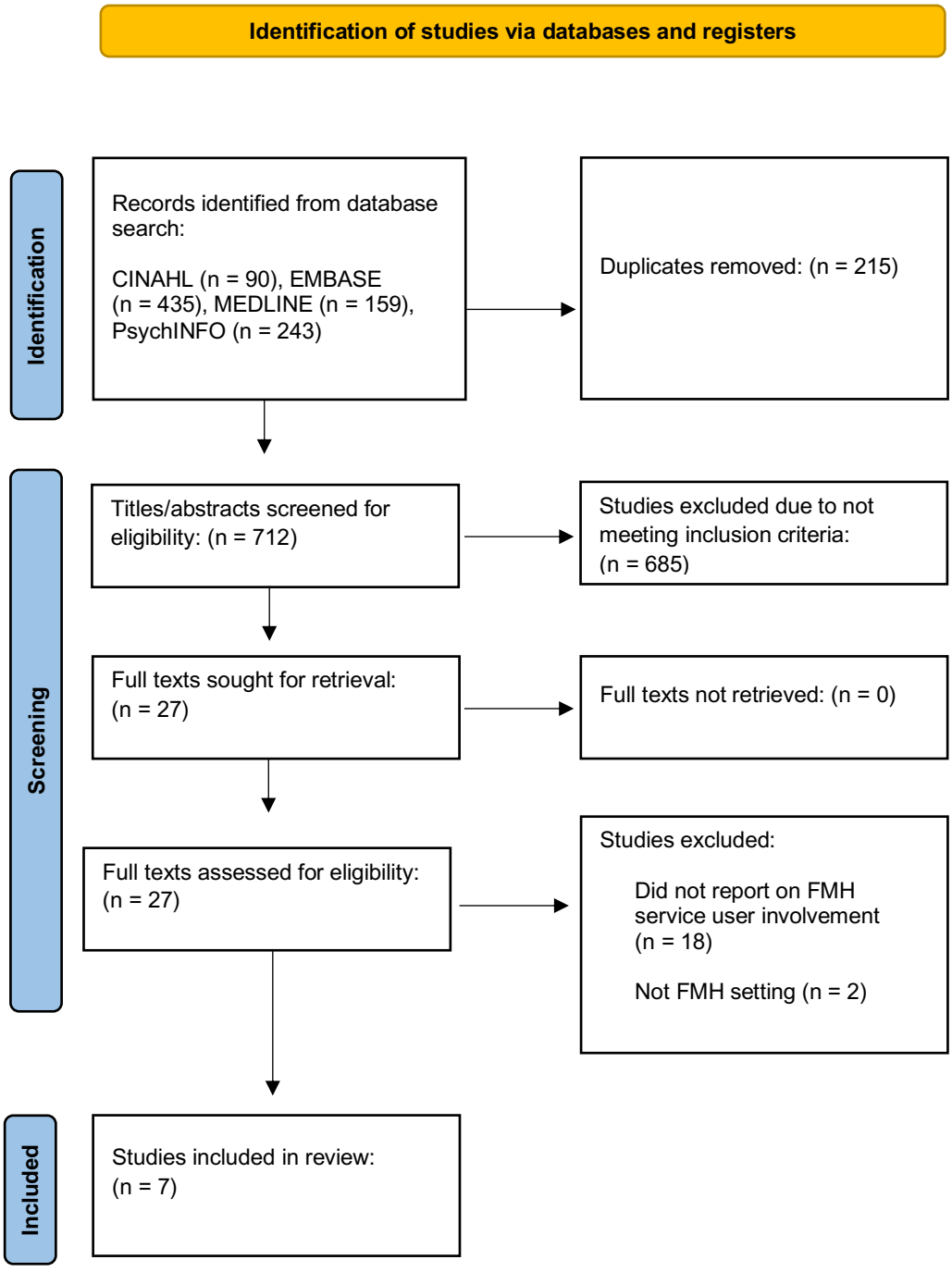
Following the collation of 927 articles from the databases, duplicates were removed and titles and abstracts screened for eligibility based on the inclusion criteria. Where titles were considered not to provide sufficient information, titles and abstracts were screened together. Thereafter, eligible studies were screened by full-text. See Figure 1 for PRISMA (2020) flow diagram.

A 20% (n = 140) screen of all study titles and abstracts was conducted by a second reviewer. 100% (n = 27) of full texts were screened by the first author and 20% (n = 5) were screened by the second reviewer. Where differences of opinion occurred at title and abstract stage, this was resolved by discussion between reviewers to reach 100% consensus. Differences specifically occurred regarding 'user involvement'. The concept was often not clearly defined in the research which led to studies requiring full text screen for eligibility.

Manual searches of reference lists of the included studies were conducted. A search of grey literature databases (OpenGrey, EThOS, Web of Science and Scopus) was also conducted. However, no additional studies were found.

Figure 1.

PRISMA (2020) Diagram - Process from Identification to Inclusion



Quality Appraisal

Quality appraisal was utilised to assess the strengths and limitations of included research. The Mixed Methods Appraisal Tool (MMAT) by Hong et al. (2018) was used to assess the quality of the included studies. This is a structured, critical appraisal tool designed for use in mixed-methods systematic reviews. MMAT permits to appraise the methodological quality of five categories of studies: qualitative, quantitative randomised controlled trials (RCT), quantitative non-randomised studies, quantitative descriptive, and mixed-methods. MMAT has been validated for its content and tested for reliability (Souto et al., 2015). The tool is divided into three categories (qualitative, quantitative and mixed-methods), with different methodological quality criteria used depending on study design and methods. Hong et al. (2018) do not recommend a scoring system, arguing that this is not an informative method of quality appraisal as it lacks detail regarding what aspect of the study is problematic. Nonetheless, they have provided scoring criteria to be used with in-depth quality appraisal review, whereby each item is rated as 'yes', 'no' or 'cannot tell'. Mixed methods studies are appraised using all three criterion, however, overall quality is reflective of the poorest scoring category.

The first author assessed 100% (n = 7) of included studies using the MMAT tool and the second reviewer assessed 30% (n = 2) of these independently, assessors then met to compare scores. Interrater concordance per item was 100% (10/10).

Results

Characteristics of Included Studies

Publication date for the seven included studies ranged from 2001 to 2022. Studies were from Sweden (n = 2), England (n = 2), the Netherlands (n = 1), Norway (n = 1), and Scotland (n =

1) and were conducted across FMH settings, including low (n = 1) and high (n = 2) security hospitals, and community services (n = 4). The majority of studies included service users (n = 5) compared to staff (n = 1) or mixed participant samples (n = 1). Of the six studies including service users, these included all male (n = 3) or mixed gender samples (n = 2). Study 7 did not report on gender. Staff samples included nursing and forensic psychiatry. Included studies were qualitative (n = 4), quantitative (n = 1), RCT (n = 1) and mixed-methods (n = 1). Qualitative methods included thematic analysis (n = 1), qualitative content analysis (n = 1), interpretative phenomenological analysis (n = 1) and interpretative content analysis (n = 1). Methods of data collection in the qualitative studies included interviews (n = 4) and the mixed-methods and quantitative studies included rating scales, observations and interviews. See Table 1 for summary of included study characteristics.

Table 1.

Study Characteristics

Author Year Location	***Relevant Study Aims***	***Setting, Participants, Sample Size***	***Relevant Methods & Analysis***	***Relevant Key Findings***
1. O'Dowd, Laithwaite et al. 2022) *Scotland, UK*	To explore service user experience of violence risk assessment and management.	Low secure inpatient wards, Male service users, N = 7	Qualitative: Interviews Interpretative Phenomenological Analysis	Themes: Who is this for?, Power, Misunderstood and Moving Forward.
2. Haggard et al.(2001) *Sweden*	To explore desistence and identify protective factors.	Community, Previous prisoners and FMH inpatients (male), N = 4	Qualitative: Interviews Qualitative Content Analysis	Impact of encounters with forensic mental health services: Mistrust, Disbelief, Not enough follow up and Thought-provoking.
3. Jacobs et al. (2010) *England, UK*	To explore service user views on a forensic personality disorder service.	Community, Male FMH patients, N = 12	Qualitative: Interviews Thematic Analysis	Themes: Relationship with care team, Insight and hope, Return to work and independence, Managing risk and coping strategies, and Areas of improvement and recommendations.
4. Olsson & Schon (2016) *Sweden*	To determine resources staff use to prevent violence, and explore how these practices resemble recovery-oriented care.	Maximum-security hospital, Key care workers, N = 13	Qualitative: Interviews Interpretative Content Analysis	Main category 1: Internal Knowledge; perceiving frames of mind, safeguarding and patient participation.

5.	Troquete et al. (2013) *Netherlands*	To test an intervention combining risk assessment and shared care-planning for effect on recidivism against treatment as usual (control).	Outpatient forensic psychiatric clinics, 58 case managers and 632 of their clients (male and female), N = 310 (intervention group)	Cluster Randomised Control Trial Logistic Multilevel Analyses	Findings showed a general treatment effect but no significant difference between the two treatment conditions. Recidivism was not reached through risk assessment embedded in shared decision-making.
6.	Urheim et al. (2020) *Norway*	To analyse what facets of care are associated with violent incidents.	High-security ward, Female and male patients with 3 month+ stay during study period, N = 55	Quantitative: SPSS and Mplus Analysis Descriptive Statistics, Correlations, Multilevel and single-level analysis	An increase in individualised, patient-oriented care strategies contribute to a low level of violence.
7.	Ward & Attwell (2014) *England, UK*	To explore service user perspective on the effectiveness of their involvement with forensic psychological services.	Community, (gender unspecified) service users, N = 10	Mixed-Methods: Interviews and rating scale Thematic Analysis and Descriptive Statistics	Themes: Practical support, Emotional support, Support around motivation to change and risk management, and support with/increased social integration and relationships.

Results of Quality Appraisal

The methodological quality of studies varied according to the MMAT criteria as can be seen in Table 2. Studies 1 to 4 (qualitative) were deemed to be of high quality, with three out of

four meeting all the MMAT criteria. MMAT criteria highlighted minor quality issues in study 2 regarding coherence between qualitative data sources, collection, analysis and interpretation as the links between these processes were not entirely clear. Study 6 (quantitative) also had minor quality issues regarding clarity of the sampling strategy used, however only a small amount of data was extracted from this study. Study 7 (mixed-methods) did not meet all the MMAT criteria, with issues noted regarding the integration of qualitative and quantitative results and their interpretation. Study 5 (RCT) also presented with quality issues due to outcome data was not being completed for all participants and outcome assessors were not blind to the provided intervention.

Table 2.

MMAT Quality Ratings

	Authors						
	O'Dowd, Laithwaite et al. (2022)	**Haggard et al. (2001)**	**Jacobs et al. (2010)**	**Olsson & Schon (2016)**	**Troquete et al. (2013)**	**Urheim et al. (2020)**	**Ward & Attwell (2014)**
Qualitative							
Qualitative approach appropriate?	Yes(Y)	Y	Y	Y			
Qualitative data collection method adequate?	Y	Y	Y	Y			
Findings adequately derived from data?	Y	Y	Y	Y			
Interpretation of results sufficiently substantiated by data?	Y	Y	Y	Y			
Coherence between qualitative data sources, collection, analysis and interpretation?	Y	No(N)	Y	Y			

Quantitative RCT		
Randomization appropriately performed?	Y	
Groups comparable at baseline?	Y	
Complete outcome data?	Y	
Outcome assessors blinded to intervention provided?	N	
Did participants adhere to assigned intervention?	N	
Quantitative		
Sampling strategy relevant to address research question?		Can't tell (CT)
Sample representative of target population?		Y

Measurements appropriate?	Y	
Risk of nonresponse bias low?	Y	
Statistical analysis appropriate to answer research question?	Y	
Mixed-Methods		
Mixed-Methods Criteria		
Adequate rationale for using mixed methods design to address research question?		Y
Different components of the study effectively integrated to answer research question?		N

Outputs of the integration of qualitative and quantitative components adequately interpreted?	N
Divergences and inconsistencies between quantitative and qualitative results adequately addressed?	Y
Adherence to quality criteria of each tradition of methods involved?	Y
Qualitative Criteria (as above)	Y, CT, Y, Y & N
Quantitative Criteria (as above)	Y, Y, Y, Y & Y

Framework Synthesis Results

The chosen *a priori* framework (see Table 3) allowed for organisation of findings from the included studies into an updated framework.

Table 3.

A Priori Framework (O'Dowd, Laithwaite et al., 2022)

Superordinate themes	**Subordinate themes**
Who is this for?	Whose risk assessment? Do I want to know?
Power	Mistrust Staff hold the power Playing along
Misunderstood	Am I a threat? They don't see me
Moving forward	Judged by my past Taking responsibility for myself Thinking about the future

The first theme in the *a priori* framework, '*Who is this for?',* and sub-theme '*Whose risk assessment?'* were somewhat substantiated by the other review studies. This described varied experiences of collaborating with staff and a general sense that risk assessment and management is something that is done "to" service users, rather than "with" them. However, O'Dowd, Laithwaite et al. (2022) described a portion of service users who actively

participated in their risk assessment. Notably, this was not reflected in the original framework. The sub-theme '*Do I want to know'* relating to the content of risk assessment, was not supported by other studies as a barrier to service user involvement, and was therefore removed from the updated framework.

The second theme, *'Power',* and subthemes, *"Mistrust', 'Staff hold the power' and 'Playing along',* appeared across other review studies. The *a priori* framework described issues with power, and disempowerment, as barriers to service user involvement in risk assessment and management processes.

The third theme in the *a priori* framework, '*Misunderstood'* had two subthemes which indicated service users perceiving staff to view them with excessive negativity as a further barrier. '*Am I a threat?*' which was removed due to not being substantiated by other studies, and *'They don't see me'*, which was renamed to '*They don't want to get to know me'* to better encapsulate the content of the theme in the updated framework.

The final theme in the *a priori* framework, '*Moving forward'*, and associated subthemes, were substantiated by all qualitative review studies and the mixed-methods study in the current review. This theme reported on varying degrees of control service users perceived to have over their future, indicating both barriers and facilitators to collaboration.

The most significant amendments to the *a priori* framework from the synthesis was the addition of two new themes (see Table 4). *'Becoming a team*' was derived from data in five of the included studies, arising from two subthemes, *'Engagement based on strengths'* and *'Good relationships*.' Mental health professionals and service users across these studies both discussed facilitators to collaboration in FMH practice which was often based on the person's interests and good therapeutic relationships. A second theme was added to the updated

framework, '*Joined approach to individualised care*' with subthemes, '*Shared care planning'* and '*Gaining understanding',* which were derived from data in six of the review studies including O'Dowd, Laithwaite et al. (2022). Mental health professionals and service users discussed ways in which service users participate in violence risk assessment and management, facilitators to this and how helpful this can be regarding recovery outcomes. Although these themes were not part of the *a priori* framework, all review studies identified at least one as a salient factor in their datasets. Therefore, they were introduced into the updated framework as recommended (Carroll & Booth, 2011, 2013).

Updated Framework

Six themes and twelve subthemes were identified following the framework synthesis and adapted into the updated framework (see Table 4).

Table 4.

Updated Framework.

Theme	Subtheme	Evidenced in
Who is this for? [sr]	Whose risk assessment?	O'Dowd, Laithwaite et al**.** (2022); Haggard et al. (2001)
Power [j]	Mistrust	O'Dowd, Laithwaite et al. (2022); Haggard et al. (2001); Jacobs et al**.** (2010); Olsson & Schon (2016); Ward & Attwell (2014)
	Staff hold the power	O'Dowd, Laithwaite et al. (2022); Haggard et al. (2001); Olsson & Schon (2016)
	Playing along	O'Dowd, Laithwaite et al. (2022); Olsson & Schon (2016)
Misunderstood [sr]	They don't want to get to know me[a]	O'Dowd, Laithwaite et al. (2022); Haggard et al. (2001); Jacobs et al**.** (2010); Ward & Attwell (2014)
Moving forward [j]	Judged by my past	O'Dowd, Laithwaite et al. (2022); Haggard et al. (2001); Jacobs et al**.** (2010); Ward & Attwell (2014)
	Taking responsibility for myself	O'Dowd, Laithwaite et al. (2022); Jacobs et al**.** (2010); Olsson & Schon (2016); Haggard et al. (2001)

	Thinking about the future	O'Dowd**,** Laithwaite et al. (2022); Haggard et al. (2001); Jacobs et al**.** (2010); Olsson & Schon (2016); Ward & Attwell (2014)
Becoming a team [b & j]	Engagement based on strengths[b]	Olsson & Schon (2016); Jacobs et al**.** (2010); Ward & Attwell (2014)
	Good relationships[b]	Haggard et al.(2001); Urheim et al**.** (2020); Olsson & Schon (2016); Jacobs et al**.** (2010); Ward & Attwell (2014)
Joined approach to individualised care [b & j]	Shared care planning[b]	Urheim et al**.** (2020); Troquete et al. (2013**);** Olsson & Schon (2016)
	Gaining understanding[b]	Haggard et al. (2001); Urheim et al**.** (2020); Jacobs et al**.** (2010); Ward & Attwell (2014); O'Dowd, Laithwaite et al. (2022)

Note. [a] indicates a reworded theme or subtheme; [b] indicates a new theme or subtheme, [j] indicates a joint theme representing both staff and service user, [sr] indicates a service user only theme

Who is this for? The first theme encompassed how some service users are involved in their risk assessment and how this can serve as both an opportunity and a barrier to further service user involvement. This theme does not account for staff perspectives.

Whose risk assessment? Service users mostly described feeling detached from these processes and risk assessment specifically was perceived as an inauthentic tool to serve the

professional, in which they have little involvement (O'Dowd, Laithwaite et al., 2022; Haggard et al., 2001).

> "… A lot of it is for show, there is nothing seriously being done." (O'Dowd, Laithwaite et al., 2022)

However, those who reported positive experiences of collaboration in their risk assessment, described being involved in the interview, or the initial stages of the process, as a personal learning opportunity, with some reporting to have countersigned their final assessment report (O'Dowd, Laithwaite et al., 2022).

> "I was able to think back on my life during the forensic psychiatric evaluation, and it was kind of thought provoking… That's something you can't do on your own…" (Haggard et al., 2001)

Despite these diverging accounts of collaboration and perceived partnership working with staff, those who were able to reflect on the presence of such involvement did report good outcomes regarding personal growth contributing to recovery. Thus, implying that some service users perceive collaboration to be helpful.

Power. This theme centred on the significance of the conditions under which FMH service users are detained and cared for within, and how this is embroiled in risk assessment and management. This theme described barriers and facilitators to collaboration, and reflects both staff and service user accounts.

Mistrust. Trust, and indeed mistrust, emerged in many of the studies as barriers and facilitators to FMH service user involvement. The complex nature of trust in FMH settings was highlighted in some of the discussions as trust is required to build therapeutic

relationships (Ward & Attwell, 2014) but this can be is a challenge to establish given that service users are "*cared for under duress and… free will is limited*" (Olsson & Schon, 2016).

> "[Therapist] knows me a lot more than I think he knows me... now I can tell him basically anything really. I think that has built up during the bonding we have had...it's good because it's the same person and it does make things a lot easier." (Jacobs, et al., 2010)

Jacobs et al. (2010) interestingly reported on trust according to community service users who likely had a significant amount of previous experiences building trust with staff within the tiers of FMH security. It is therefore possible that trust and mistrust is dependent on the amount of time spent in FMH settings and the associated stage of recovery journey, which could in turn be both a barrier and facilitator to collaboration in risk assessment and management.

O'Dowd, Laithwaite et al. (2022) reported on language used by service users that conveyed a perceived divide between themselves and staff, such as "they" and "them". This sample also alluded to the "opinions" of staff, implying that information recorded by staff was not based on fact or knowledge. This language was also noted by Jacobs et al. (2022). This sense of "us" and "them" likely maintains mistrust and could be further conceptualised as a barrier to FMH service user involvement.

Staff hold the power. FMH service users described involvement in risk assessment and management as mysterious and vague (Haggard et al., 2001), giving the impression that their participation is not at the forefront because staff hold the power. By contrast, staff discussed the recurring need to be reconciled with the service user (Olsson & Schon, 2016). These two

opposing descriptions of power and disempowerment in FMH settings highlights a clear barrier to authentic collaboration.

> "I have to ask for a bar of soap or shampoo, and you know toiletries, and I have to ask to get in and out and stuff like that, I think there's just no independence, you are totally dependent when you're in hospital." (O'Dowd, Laithwaite et al., 2022)

O'Dowd, Laithwaite et al. (2022) discussed disempowerment with regard to the lack of agency experienced by FMH service users in their day to day lives. Given the lack of control in meeting their own basic needs, it is not surprising that FMH service users feel they have limited power to influence complex decisions regarding their care and treatment by participation in risk assessment and management. Thus, further highlighting barriers to meaningful engagement in these processes.

Playing along. O'Dowd, Laithwaite et al. (2022) and Olsson and Schon (2016) described the subsequent challenge of acquiescence in FMH from the perspective of the service user and staff, respectively.

> "…you can't speak your mind because you know if you say some stuff then they take it serious." (O'Dowd, Laithwaite et al., 2022)

> "Many times we do not know if they agree on things because we say it, or because they want to.'' (Olsson & Schon, 2016)

Service users engaging in this way, being compliant and not disagreeing with staff, alludes to engagement in risk assessment and management. However, studies suggest that this is passive rather than meaningful engagement, which in turn could be viewed as a barrier, as

well as a facilitator, to collaboration in FMH. Although the outcome of this as a facilitator remains unanswered.

Misunderstood. This theme described further barriers to service user involvement due to service users feeling misunderstood as violent people and viewed negatively. These results were substantiated by service users.

They don't want to get to know me. The importance of service users having someone to "converse with" was reported. This may indicate that service users would benefit from initial rapport building to facilitate authentic collaboration in risk assessment and management thereafter.

> "Complete strangers were willing to give their time to me, and they knew my problems as an offender and were still willing to help, and I didn't think there were people this way, which modelled something which I want to replicate." (Ward & Attwell, 2014)

This describes service user perception of staff not knowing, or wanting to know, them beyond their offences. Service users also spoke about how the focus is on the "bad stuff" and that there is an assumed expectation to fail, leaving them feeling like there was no point trying to participate or be involved in risk assessment and management processes (O'Dowd, Laithwaite et al., 2022).

Moving forward. This theme encapsulates service users' varying accounts of moving forward and the level of control they feel they have over their futures. This accounts for barriers and facilitators to collaboration in risk assessment and management according to staff and service users, examples of involvement, and provides an indication as to whether service users deem it helpful to recovery.

Judged by my past. The use of the term "judged" and "judgmental" across studies was notable (O'Dowd, Laithwaite et al., 2022; Haggard et al., 2001; Jacobs et al., 2010; Ward & Attwell, 2014). O'Dowd, Laithwaite et al. (2022) reported that service users feel staff are overly critical of their characters, suggesting that they felt their risk assessments and management plans were not valid or justified. Tensions were also noted by service users regarding expected recovery journeys and frustration due to the weight placed on past offending (O'Dowd, Laithwaite et al., 2022; Haggard et al., 2001). Ultimately, these accounts are indicative of barriers to service user involvement in risk assessment and management.

By contrast, staff view discussions about the past as important in terms of gaining a shared understanding of what has influenced the person's behaviour until now and thus are imperative to inform decision making (Ollson & Schon, 2016) and to move forward. Nonetheless, service users view this as something that will hold them back, indicating lack of understanding of the process of recovery. This complex judgement made by staff regarding future offending, paired with reduced service user understanding, is likely a further barrier to collaboration.

Taking responsibility for myself. Some service users described an enhanced sense of responsibility, which appeared to have evolved from their involvement in risk assessment and management, and be linked to moving forward and achieving their goals. This sense of responsibility was specifically evoked in one service user by reading their risk assessment report:

> "… It was a bit funny at first but then I looked at it and said, no that can't be me, and then I realised, it was me." (O'Dowd, Laithwaite et al., 2022)

Haggard et al., (2001) also described this sense of responsibility as recognising the need, and showing up and engaging with the services on offer, which led to long-term outcomes in recidivism, in a ten year follow up study:

> "I was at the psychiatric hospital almost every day for the first few years. I saw a psychologist who kept me going. To get that extra push you need to succeed".

These accounts describe the need for service users to be involved in their risk assessment and management planning enough to gain awareness and understanding of their current circumstances so that they can then make informed choices about taking on increased responsibility, such as psychological intervention to better their mental health and risk of reoffending.

Thinking about the future. O'Dowd, Laithwaite et al. (2022) reported varied accounts of the future, with some service users' broad goals for the future being protective and meaningful to their personal recovery and others associating their future with the life that they could have had:

> "My life would have been totally different, it probably would have taken a hugely different direction, I probably would have had a family and stuff like that by now, it would have been a totally different life."

Ward and Attwell (2014) also reported on FMH service users feeling "*threatened"* by the prospect of their future. As such, the idea of planning for the future may be a barrier to collaborating with some service users, but a facilitator to others.

Jacobs et al. (2010) specifically reported service users' reflections on being able to make positive changes for their future as a result of engaging in risk management focused intervention:

> "For the first time since getting into trouble...I started to engage in the programme and therapy, and was able to make some positive connections as to where I had gone wrong and what help was available now, and how I could sort of change in the future… I have got a lot better understanding of what led me to commit the offences than I did and the impact that it has had on my victims and my family and myself."

Becoming a team. The concept of becoming a team recurred across studies, specifically with regard to facilitating service user involvement and associated recovery outcomes. Both staff and service users reported on this concept.

Engagement based on strengths. Staff highlighted the importance of timing and working collaboratively with service users in a way that is interesting to them:

> "... if one just waits and tries to build on the interests they have …'' (Ollson & Schon, 2016)

Ollson and Schon (2016) further identified that staff who held internal knowledge, such as individual skills or the ability to perceive frames of mind on the ward, could create a sense of safety for patients and encourage patient participation, which contributed to violence prevention.

Other studies highlighted service users accounts of engaging with services in a values-based way, and engaging with activities or interventions that mirror what is important to them (Ward & Attwell, 2014; Jacobs et al., 2010). These strength-based collaborations indicate

ways in which service users can participate in risk assessment and management or act as a facilitator to potential collaboration, as echoed by both staff and service users

Good relationships. Haggard et al., (2001) reported the importance of "a good relationship to at least one person" by a service user. Relationships were echoed in other studies as a vehicle towards recovery (Ward & Attwell, 2014).

Engagement with risk assessment and management in the form of building relationships with fellow service users or staff, was reported across studies. Ward and Attwell (2014) specifically discussed how building trusted relationships increased service user awareness of other people's points of view, and in some cases, had implications with regards to re-offending. Jacobs' et al. (2010) reported that the majority of service users described having a good therapeutic relationship with staff, all of whom identified an increased sense of hope and insight as a result of this.

Collaboration in risk assessment and management by means of building relationships highlights a more subtle form of service user involvement with a positive effect.

Joined approach to individualised care. This theme conceptualises more recent joined working practices according to both staff and service users, and how effective some of these are with regard to recovery.

Shared care planning. Troquete et al., (2013) tested whether risk assessment and subsequent shared care planning, in which staff and service user collaboratively translate identified risks and needs into a treatment plan, reduced offending behaviour. Findings showed a general treatment effect (22%) of clients with an incident at baseline versus 15% at follow-up, but no significant difference between the two treatment conditions. Although risk assessment is standard practice, recidivism was not reached through risk assessment embedded in shared decision-making. However, Urheim and colleagues (2020) found a substantial decline in offending behaviour associated with the implementation of new

treatment and care routines, one of which was joint staff and service user review following a violent incident, reflecting upon both staff and service users' perspectives.

These findings are suggestive of developing evidence for service user involvement in risk assessment and management for the purpose of recovery as measured by recidivism.

Gaining understanding. Various review studies described how working together contributes to a shared understanding between staff and service user of risk and how to manage this:

> "…It opened more doors in my head." (Ward & Attwell, 2014)

Jacobs et al. (2010) reported that gaining understanding about their risk also seems to contribute to service users' outlook on life and relationships, promotes adaptive coping strategies, develops insight and expresses empathy for themselves and others.

> "I have a problem with communication, so without all that therapy I wouldn't have known that and I wouldn't have known how to express it, so I don't only have a clearer understanding of what I am like but also of my limits." (Jacobs et al., 2010)

Discussion

This systematic review aimed to synthesise the literature on FMH service user involvement in risk assessment and management. Specific aims were to determine what the evidence is that service users are involved in risk assessment and management and in what way; what might act as barrier or facilitator to this in practice and, how helpful this may be to service user recovery. The analysis process led to a framework providing an overview of the literature to date, that could be used to understand FMH service user involvement from the perspective of the service user and staff, and inform ongoing clinical practice.

The results are particularly interesting considering the implementation of person-centred recovery approaches in FMH over the last twenty years, aligning with service user responsibility, shared decision making and self-determination (Barker, 2013). Importantly, this review indicates advancements in FMH service user involvement over the years in keeping with the evidence and legislation, as the majority of studies used service user samples and quantitative studies tested the effectiveness of recovery-oriented approaches.

The framework reports varied evidence that the participants in the included studies were involved in risk assessment and management, however some examples of this in practice were active engagement in risk assessment meetings and risk focused intervention, reading the final assessment report, signing it, reflecting on risk with staff post incident, engagement with strength-based approaches to risk assessment and management and shared care planning.

The framework includes various barriers to collaboration substantiated by both service users and staff such as, power imbalance within the FMH system and reduced control over the future. Service users also reported on their perception of being viewed with undue negativity by staff as a further barrier. However, the framework also encompasses facilitators to collaboration according to staff and service users such as, establishing good relationships within effective teams. 'Moving forward' was identified as both a barrier and facilitator to collaboration, indicative of the tensions between recovery and control; service users seek progression but do not have sole control of it. By contrast, staff appear to recognise the benefit of engagement but potentially disregard how challenging it is for service users.

A topic discussed across the studies by both staff and service users was trust, or mistrust. Although this manifested as a theme in itself, trust appeared throughout other themes within the framework too. Not only was mistrust described by service users during initial risk

assessments (O'Dowd, Laithwaite et al., 2022), but staff reported it being a barrier to general communication (Ollson & Schon, 2016). This highlights a common, but challenging problem to overcome and a barrier to collaboration. It is possible that collaboration could be promoted by increased trauma-informed practices, given the reoccurring concept of mistrust in FMH. However, with the scope of this review including varied FMH settings, overcoming mistrust was particularly apparent in follow up studies and community-based settings (Haggard et al., 2001; Jacobs et al., 2010; Ward & Attwell, 2014). This is indicative of timing and readiness to engage playing a monumental role in the development of trust to facilitate collaboration (Ollson & Schon, 2016).

Results are inconclusive regarding whether or not service users deem collaboration to be helpful to their recovery and something they want to participate in. Interestingly, the *a priori* framework included a subtheme '*Do I want to know?'*, and although this was not substantiated by other studies further exploration of this could strengthen the limited understanding. It is possible that service users would chose not to be involved in risk assessment and management processes given the presence of acquiescence widely reflected in FMH literature (Wagstaff, 2018), but also due to the fact that conversing about their previous violent behaviour may in fact be re-traumatising.

Recovery in the review studies was often measured by recidivism. This is not uncommon in FMH literature (Rotter et al., 2017), however made it challenging to decipher how helpful the presence of collaboration was in practice, according to staff or service users. It could be argued that recidivism is only a symptom of recovery, underpinned by gained understanding of self and others, likely enhanced through joined approaches to individualised care among other facets of FMH care. As such, 'outcomes' in the literature may not be indicative of authentic service user recovery given the restrictive nature of the system disabling violence

for the most part, as well as other factors that contribute to recidivism such as aging (Drennan & Alred 2013).

Strengths and Limitations

A strength of this review was the inclusion of studies employing a range of methodological approaches for review. Given that six of the seven included studies reported on service user perspectives, and two on staff perspective, this is also considered a key strength and a novel contribution to the existing reviews on forensic research. The inclusion of studies reporting on both staff and service user perspectives further expanded the range of information available when attempting to understand collaboration, and highlighted both differences and similarities in perspectives. Specifically, the two studies with staff samples contributed to better understanding service user perspective, rather than diluting service user data. Lastly, the 'best fit' framework synthesis approach enabled the development of an existing framework from a high-quality study, by putting data into the pre-defined themes, while also not being restricted, in order to establish an enhanced framework reflective of existing literature and review questions. This approach promoted a high-quality review in an area of nascent literature, resulting in a balanced and coherent review of FMH service user involvement to better inform healthcare practice, service development and future research. Lastly, this is the first known review to consider the evidence for FMH service user involvement in risk assessment and management.

Regarding limitations to this review, published literature may exist in other languages. Included studies were based in different countries with differing healthcare and criminal justice systems where care and legal restrictions may differ. Although not specifically noted in the studies, this may have had an impact on the results. Screening for systematic reviews is not an exact science and human error should be accounted for with regard to accidental

omission of relevant studies. Furthermore, accounting for novel and unknown possible search terms within a constantly developing discipline may mean that search terms were omitted. Specifically, 'user involvement' was conceptualised with variation throughout the literature and therefore may have resulted in uncaptured records. This disparity in language may also have an impact on research outcomes depending on how collaboration has been explained to service users. This was not clear within the included studies, but it is possible that there is a difference in how research and service users define involvement; an important facet for future research given the importance of power within this population. Results within FMH samples are not generalisable due to typically small samples, this should be considered when interpreting this review also. Finally, consideration should be given to FMH service users' perceptions that speaking about their care may impact on their recovery (Rusbridge et al., 2018).

Implications for Practice and Future Research

The framework highlights common perceptions held by both FMH service users and staff regarding trust and collaboration. Although service user accounts of their involvement in risk assessment and management varied across contexts, the framework may suggest therapeutic relationships that are built over time can contribute to enhanced involvement. Results from this review should be carefully considered alongside existing results from O'Dowd, Cohen et al. (2022) and Eidhammer et al. (2014) to holistically inform ongoing FMH provision. Specifically, future research should explore whether service users want to be involved in risk assessment and management given the complex dynamic between care and restriction, compounded by high levels of trauma reported by the FMH population, both likely exacerbating interpersonal mistrust (McKenna, Jackson & Browne, 2019). Growing the body of FMH research in this way could further enhance staff engagement skills and empower

service users to participate in risk assessment and management. Ultimately this could contribute to reduced risk and increased quality of life for service users (Livingston, 2018).

Declaration of Interest Statement

No potential conflict of interest was reported by the author(s).

Data Availability Statement

The participants of this study did not give written consent for their data to be shared publicly, so due to the sensitive nature of the research supporting data is not available.

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Chapter 2

A Qualitative Exploration of Service Users' Experiences of Strength-Based Approaches in Forensic Mental Health Settings:

An Interpretative Phenomenological Analysis

Prepared in accordance with the author requirements for Journal of Forensic Psychology Research and Practice

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Plain Language Summary

Title

Exploring Service Users' Experiences of Strength-Based Approaches in Forensic Mental Health Settings

Background

There has been a recent change in how forensic mental health services manage and assess risk of offending. Previously this part of care mainly focused on risk of violence and the person's mental health. Now, these services give more consideration to the person's strengths, what is important to them and their plans for the future. The term 'strength-based' describes these new approaches.

Strength-based approaches have been found to improve a person's quality of life and mental health symptoms, and reduce the risk of violence or acting in a way that is harmful (Cooney, 2020). However, there is little research on strength-based approaches and their use in forensic mental health (Wanamaker et al., 2018).

Until now, there has been no known research on forensic mental health service users' experiences of strength-based approaches. Asking these people about their experience of their strengths or things that are important to them being included in their treatment plans, may improve clinical care and patient recovery.

Aims

This study aimed to explore forensic mental health service users' experiences of strength-based approaches in their care and treatment.

Methods

Eight males in a medium-security forensic hospital in Scotland, took part in the study. Recruitment was aided by the clinical team on each target ward. Participants provided verbal and written consent after being given information in advance and time to consider their involvement. Participants were between the age of 25 and 61 years. The average amount of time spent in hospital was 14 years and each person hoped to move to a low-security hospital in the near future. Each participant met with the researcher for 1 hour approximately to discuss their experiences. An approach called Interpretive Phenomenological Analysis was used to make sense of these conversations.

Main Findings and Conclusions

Four main themes were identified: *The System, Recovery, Therapeutic Milieu,* and *A Chance.* These included several informant themes describing a range of further experiences.

The research highlighted that service users were somewhat familiar with their personal strengths, values and goals. Although, they were not as familiar with how they formed part of their care and treatment. It is possible that the inherent power imbalance between service users and the forensic mental health system is the primary barrier to this in practice.

Services should consider incorporating SBA earlier and more explicitly into care and treatment and increasing staff training on SBA and related principles.

Future research should explore the experiences of service users in forensic community services and low / high-security hospitals.

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Abstract

Forensic mental health (FMH) services have traditionally focused on eradicating factors associated with offending. Strength-Based Approaches (SBA) have recently shifted focus to individual strengths, values and goals to promote well-being. Extant research highlights positive outcomes from SBA in recovery, recidivism, mental health, risk and engagement. However, research on SBA applied to FMH is limited, much of which reflects staff rather than service user perspectives. Interpretive Phenomenological Analysis was therefore used to explore lived experience of SBA in FMH care and treatment. Eight males from medium-security rehabilitation wards in Scotland, were interviewed. Analysis generated four Group Experiential Themes; *The System, Recovery, Therapeutic Milieu,* and *A Chance.* Overall, service users demonstrated an awareness of SBA. However, awareness of this in their care and treatment was not apparent. The most striking barrier appeared to be service users' compliance with 'the system.'

Introduction

Risk Assessment and Management in Forensic Mental Health

Management of risk in people with mental health needs and risk of serious harm is a challenging and complex task. The process involves judgement and balancing the demand between care and control, and within the context of extensive legal and governmental requirements that are designed to optimise public protection. Forensic mental health (FMH) services aim to deliver recovery orientated healthcare in adherence with individual legal orders and restrictions, whilst maintaining public safety. The role of FMH professionals is therefore complex, and unique to the field. Mentally Disordered Offender is the legal term under the Mental Health Scotland Act (Scottish Government, 2015) for an individual using these services, with mental illness, personality disorder or intellectual disability and a history of offending behaviour and / or representing a significant risk to others (Matrix Evidence Tables: Forensic Services, 2014). As such, the dual aim in FMH is to improve service user mental health and prevent future offending. Furthermore, the service user is encouraged to make a dual recovery, by balancing risk management with a meaningful life (Drennan & Alfred, 2012).

FMH services are delivered across a range of specialist inpatient and community settings. Inpatient services are stratified by three tiers of security: high, medium and low. Each tier of security is representative of stage in the recovery pathway, with less restrictions applied to service users in low-security hospitals due to reduced risk. In order to transition through these tiers of security towards community discharge, service users must demonstrate risk reduction via engagement in risk focused interventions and improvement or stabilisation of mental health difficulties.

Established Processes to Assessing and Managing Risk

There is no one dominant explanatory model for risk of violence. However, within FMH, understanding and managing risk of harm has traditionally taken a deficit-focused or criminogenic approach (McKenna & Sweetman, 2021). This model seeks to reduce risk of offending alone, through interventions primarily focused on decreasing or eradicating the range of factors considered to have contributed to offence history, such as, substance use or mental ill health, typically via medication and risk focused psychological therapy.

Structured Professional Judgement (SPJ) approaches are the primary means of assessing and managing risk in FMH (Garrington & Boer, 2020). SPJ tools are analytical methods of understanding and mitigating risk of violence; discretionary in essence but relying on evidence-based guidelines (Guy et al., 2015). They involve assessment of a range of items associated with risk of offending, as informed by historical and dynamic risk factors, e.g. previous history of offending, traumatic experiences and violent attitudes. Rating these factors guides the development of an individualised, psychological risk formulation, which in turn informs a treatment and risk management plan that is updated routinely. The Historical Clinical Risk Management-20, Version 3 (HCR-20V3: Douglas et al., 2013) is considered the "gold standard" SPJ violence risk assessment protocol and is therefore most commonly used within FMH practice.

Strength-Based Approaches

More recently in FMH, and mental health more generally, there has been growing acknowledgement of person-centred, recovery orientated care encompassing restoration of the whole person beyond symptom reduction (Warner, 2009). 'Strength-based' approaches (SBA) are asset-based approaches that focus on individual strengths, abilities, goals and values to promote well-being, and are enabled via collaboration between service user and

professionals (Morgan & Ziglio, 2007). SBA align with the notion of recovery by focusing on a person's abilities and thus developing their confidence to embark on the journey of recovery (Xie, 2013). SBA specifically represent the shift from sole focus on factors that contribute to risk to a much wider consideration of the individual, particularly their strengths, values and goals for the future. In FMH practice, examples of SBA may be collaboration between staff and service user, goal setting in line with service users' strengths and values, or care plans that reflect what is important to the service user and their goals for the future.

According to Vandevelde et al. (2017), there has been a paradigm shift from deficit-focused approaches to SBA across various disciplines in multiple settings, such as, general mental health, forensic, criminal justice and education. Although, the evidence-base for this is limited and a meta-analysis by Ibrahim et al. (2014) did not find evidence to support the effectiveness of these approaches in improving functioning and quality of life in general mental health. However, SBA principles have long been embedded in the clinical psychology approach to assessment and intervention, underpinned by psychological formulation. This is an individualistic approach to understanding and managing need, including the identification of protective factors that help people deal more effectively with stress and mitigate future risk. Importantly, Vandevelde et al. (2017) also observed the term 'strength-based' to be used loosely when describing a variety of approaches. This likely contributes to inconsistencies in SBA in practice, thus compromising the integrity of otherwise evidence-based practice; which, in turn may result in reduced recovery and increased re-offending within FMH specifically.

Ward's (2002) Good Lives Model (GLM) of offender rehabilitation was at the forefront of the transition from deficit-focused to asset-based approaches in FMH, by incorporating individual's strengths, or protective attributes, into assessment and management. The GLM has been internationally embraced, although variation in the extent to which it informs

treatment was observed by Willis et al. (2013). Furthermore, Prescott et al. (2024) only recently developed a tool to monitor therapist fidelity to GLM. Nonetheless, evidence began to surface suggesting that identifying meaningful, prosocial goals with FMH service users could replace needs that had historically been met through offending behaviours. In fact, a recent systematic review by Cooney (2020) on SBA in FMH internationally, indicates that a focus on strengths can promote positive outcomes in a range of domains including quality of life, recovery from mental health symptoms, violence, risk, recidivism and engagement in treatment. However, there has been recognition that this way of approaching risk of harm may not preclude interventions informed by risk focused approaches (Wanamaker et al. 2018).

Acknowledging this, SPJ tools specifically evaluating the presence of factors that are protective to future risk have been developed. The Structured Assessment of Protective Factors for violence risk (SAPROF: De Vogel et al., 2011) was designed to be used alongside risk focused SPJs, such as the HCR-20V3 (Douglas et al., 2013). Furthermore, the recently updated HCR-20V3 now includes specifically individualised psychological formulation into the protocol to reflect strengths and protective factors. Incorporating formulation in this way aligns traditional risk assessment and management approaches with SBA, by eliciting an understanding of the person beyond diagnosis of risk and mental health difficulties. This has been framed as vital in informing good psychological care, risk management and care-plans (Logan, 2014).

Extant Literature on Risk Assessment and Management

A review of the literature for the purpose of this study, indicates that the majority of existing research explores FMH staff and service user experiences of violence risk assessment and management more generally, and the effectiveness of these processes in reducing violence.

However, Cooney (2020) specifically explored values and recovery in FMH and found this population shared similar values to that of non-offenders. Four categories of values emerged from this work: connecting with others, living a healthy life, being productive and contributing, and having agency and control. Cooney (2020) concluded that FMH service users face many barriers to living a values-based life such as, health, consequences of offending, relationships, environment and culture; making the journey to recovery all the more complex.

Staff have reported their experiences of positive risk taking within FMH as discouraging, due to pressures from society regarding public safety (O'Dowd, Cohen et al., 2022). This is collaborative identification and implementation of a 'positive' risk such as, reduced supervision, to enable growth and change; moving away from risk focused healthcare (Felton & Stacey, 2008). It is recognised by both service users and staff in the literature that the inclusion of collaboration and identification of protective factors in risk assessment and management, enhances the therapeutic relationship and service user acceptance and understanding of the process and the outcome (Nyman et al., 2020). Nonetheless, O'Dowd, Laithwaite et al. (2022) identified that exclusion of service users from this facet of their care continues. Wanamaker et al., (2018) made a wider observation that FMH services may continue to meet barriers integrating SBA with established approaches as a result.

Additionally, O'Dowd, Laithwaite at al. (2022) reported that FMH service users view risk assessment and management with suspicion and mistrust, and experience a lack of genuine collaboration with staff; findings that are consistent with existing research from community FMH and prisons (Dixon, 2012; Shingler et al., 2020). These findings imply non-individualised, risk focused approaches to patient care and the absence of focus on strengths and meaningful goals with service users. However, O'Dowd, Laithwaite et al. (2022) importantly also reported variance in these experiences and subsequent views, with some

service users reflecting positive experiences and attitudes, which the literature would benefit from understanding further.

These findings emphasise that further consideration to the FMH service user experience is required, specifically with regards to their experience of SBA. This is particularly pertinent as a need to improve mental health outcomes for those within the justice system has similarly been outlined in the Mental Health and Wellbeing Strategy (Scottish Government, 2023).

Rationale for the Current Study

Despite the shift represented in the literature towards a more holistic approach to risk assessment and management, research to date is limited on the impact of SBA, or psychological formulation, in predicting risk and recovery (Logan, 2014), and the literature that does exist is of poor quality (Cooney, 2020). This is likely associated with the relevant nascence of these developments but is further complicated by inconsistency in the available literature regarding how these approaches are conceptualised in practice. It therefore remains relatively unclear, the extent to which SBA have resulted in shifts in clinical practice, or are translated into formal care-plans, interventions and risk management plans. Moreover, the existing research on SBA neglects the experience of service users, meaning that current understandings are from mental health professionals' perspectives. In an effort to aid understanding of what SBA might mean in practice, capturing service user experience is vital.

Secure inpatient settings represent a critical stage in service user recovery. Particularly in rehabilitation wards where initial risk assessments and psychological formulations are developed to inform treatment, and are routinely shared with service users as per local policy. Additionally, these inpatients are subject to high levels of legal restrictions. In order to reduce these, motivation and engagement from the service user is required. This in itself can be a

barrier to meaningful engagement due to compliance (Markham, 2018). Given that the use of SBA is expanding and literature reflects that it is a vital component of informing risk (Logan, 2014), this study aims to explore medium-security inpatient experience of personal strengths, values and goals for the future in relation to day to day clinical care.

Qualitative methods have previously been found helpful in eliciting personal narratives with this population (O'Sullivan et al., 2013) and are particularly helpful in exploring novel or under researched topics. In this study, use of Interpretive Phenomenological Analysis (IPA) enabled the exploration of the so far, unheard voice of the FMH service user sharing and making sense of their lived experience regarding SBA. This method was specifically selected as they are more often than not excluded from the literature (Markham, 2018).

Gaining insight on SBA from this crucial and unique perspective may address an important gap in current understandings, and reflect a human contribution to the evidence-base rather than statistical accounts of outcomes and professional perspectives on the barriers to working with this population. This in turn may contribute to theory development in an under researched area and aligns with a specific aim from the Independent Forensic Mental Health Review (Scottish Government, 2021); the promotion of a holistic and person-centred approach to recovery in FMH services in Scotland.

Aims

The aim of the current study was to explore the experience and perspectives of FMH rehabilitation inpatients on strength-based approaches and related principles in their care and treatment.

Methods

Ethical Considerations

The study was approved by the West of Scotland Research Ethics Committee (Reference: 23/WS/0183) and NHS Greater Glasgow and Clyde Research & Development (Reference: UGN23MH374); (Appendix C and D, p. 77-82). Ethical approval was also obtained from the local research and audit committee of the host service (Appendix E, p.83). Informed consent was obtained from participants in verbal and written form (Appendix F, p.84), and all data were pseudo-anonymised.

Recruitment

Initial recruitment plans aimed to advertise the research via poster on each target ward, however it was highlighted during ethical approval processes that this may result in individuals wanting to participate but not meeting the research criteria, i.e. being too unwell too participate. This was part of the exclusion criteria to ensure participation did not negatively impact individual recovery. The poster phase of recruitment was therefore removed and recruitment was streamlined via staff for this reason. Individuals whom the researcher worked with clinically at the time of recruitment, or previously, were not approached to participate in order to mitigate risk of coercion regarding participation, or bias. See Table 1 for a summary of the inclusion and exclusion criteria applied to the recruitment process. Criteria were established and implemented in line with IPA principles, to obtain a homogenous sample.

Participants were recruited from four rehabilitation wards in a medium-security inpatient unit in Scotland, offering service to individuals presenting with mental health disorder and risk of violence. Participants were specifically recruited from rehabilitation wards as these

individuals are at an important stage in their recovery, preparing for discharge or referral to low-security, and therefore likely to be invested in plans that will support their recovery. The multidisciplinary clinical team on each ward supported judgements on whether participants met the recruitment criteria (see appendix for further information).

Females were not represented in this study as the host service rehabilitation wards accommodate male service users only, which is largely representative of gender in FMH across the UK (Denison et al., 2019).

Table 1.

Inclusion and Exclusion Criteria

Inclusion	Exclusion
Males resident on rehabilitation wards in a medium-security	Those unable to converse in the English language
Aged 18-65 years	Those not mentally or physically well enough to participate
Able to provide informed consent	
Able to converse about their experiences	

Procedures

The researcher attended the multidisciplinary clinical team meeting for each ward to explain the purpose and procedure of the research. The clinical team, including the Responsible Medical Officer (RMO), then discussed which patients met the criteria. Once agreed, the RMO gave verbal consent for a staff member to approach eligible participants with the Participant Information Sheet (PIS); (Appendix G, p.87). Interested participants were then identified to the researcher by a staff member, at which point a meeting was arranged with

the researcher for the participant to discuss the PIS in more depth and ask any further questions. During these meetings, explanations of SBA were further reiterated to ensure participant comprehension given the nascence of the approach and descriptive or conceptual inconsistencies reported in the literature. A verbal explanation of consent and confidentiality procedures was also reiterated during this contact. The researcher also re-clarified their role was not as a clinician but as a researcher. Participants were then given a week to consider participation and an interview was scheduled subsequent to receiving written consent. Participation being voluntary and having no impact on patient care or treatment was reiterated throughout the recruitment process to mitigate agreeability regarding consent.

Demographic Information

A total of 8 male service users were interviewed in this study. Given that participants were recruited from one of only three regional units in Scotland, demographic details were kept to a minimum to protect anonymity. Participants were between the age of 25 and 61 years. The average duration of time spent in FMH services was 14 years, ranging from 5 to 25 years. Interviews took place on site and lasted between 37 and 58 minutes, the average duration of completed interviews was 48 minutes.

Justification of Sample Size

Guidance for IPA studies indicate relatively small and homogenous samples. Smith et al. (2022) recommend a minimum of five and an optimum of ten participants for doctorate level research, in order to enhance depth of interpretation both at case level and across cases. 8 participants agreed to be interviewed, at which point recruitment ceased.

Data Collection

A semi-structured interview guide was developed by the researcher (Appendix H, p.88) in order to enable participants to flexibly reflect on their experiences and elicit meaning from them during the interview. Prompts were informed by further reiteration of SBA and initial exploration of service users' descriptions of their own strengths, values and goals. The interview was informed by Smith et al. (2022) guidance which states that questions should be open and expansive so that the participant can talk at length and in depth.

Analysis

The researcher adhered to the most recent IPA guidance by Smith et al. (2022) regarding terminology. For clarity, this study refers to the previously termed 'emergent theme', 'superordinate theme' and 'master theme' as an Experiential Statement, Personal Experiential Theme (PET), and Group Experiential Theme (GET), respectively.

According to Smith et al. (2022) IPA is described as 'double hermeneutic', acknowledging the influence of the researcher's beliefs and experiences while they attempt to understand participant views and sense-making. Therefore, the researcher maintained a reflective diary from data collection until analysis completion, enabling immersion within the data, while keeping track of their own thoughts and interpretation to maintain transparency and quality. As a FMH clinician, the researcher was aware of the inherent power imbalance and the prevalence of deficit-focused approaches in practice and considered the impact of this knowledge and direct experience may have on the research via this reflective diary.

Analysis began with each of the recorded interviews being transcribed verbatim by the researcher and went on to follow six steps indicated by Smith et al. (2022):

1. Read and re-read the transcripts to become immersed in each case
2. Noted significant case level content in an exploratory way, noticing the participant reflect on their own experience
3. Constructed experiential statements reflective of the case level analysis outlined in step 2
4. Identified connections across experiential statements within each case
5. Named these groups of connected experiential statements within cases as PETs
6. Searched for patterns of similarity and differences across PETs to generate GETs

Smith et al. (2022) indicate that the aim of this dynamic, analytic approach is to highlight the shared and unique features of experiences rather than presenting a group 'norm', which was held in mind and further informed the researchers analysis.

See Figure 1 for a sample from the analysis process.

Researcher Reflexivity

The researcher is a trainee clinical psychologist with prior experience working therapeutically with individuals that presented clinically within forensic populations, such as prisons, and specifically within FMH services. In addition, the researcher was working as a clinician within the host service at the time of recruitment and considered the impact this may have had on recruitment as well as on participant responses during interview. For example, participants not participating due to the aforementioned power imbalance between staff and service user, or not feeling comfortable sharing their honest experiences to a 'clinician.' However, the researcher was further aware that all positions of authority may elicit these challenging power dynamics in FMH, even the role of a researcher.

The researcher is aware of her own biases as a member of staff within FMH services such as, having a professional preference and investment in the value of psychological formulation to understand risk and mental health difficulties, and the incorporation of SBA into assessment, formulation, intervention and evaluation. Specifically, the researcher is invested in focusing on individual's values, skills and their goals for the future and aims to develop therapeutic rapport and promote meaningful engagement via collaboration with service users.

The researcher maintained awareness of these biases throughout the analysis process primarily via the reflective diary, however, generation of experiential statements and PETs in selected transcripts were also discussed in research supervision.

Results

The analysis elicited four GETs derived from several PETs, relating to participants' experiences and perspectives of their personal strengths, values and goals as part of their care and treatment (Table 3).

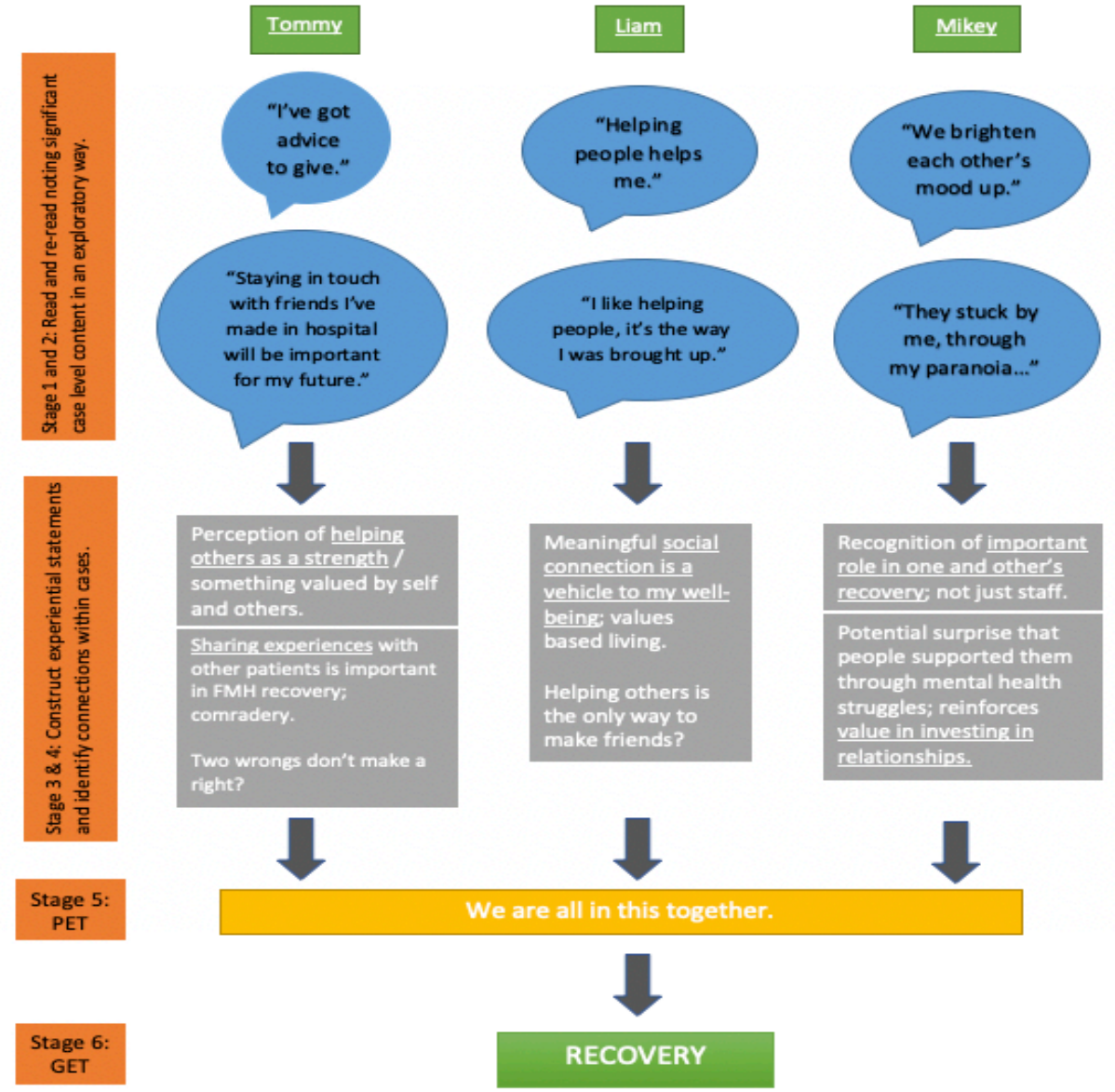
Table 3.

GETs and PETs.

GETs	PETs
1. The system	1. Playing the game 2. Time stands still 3. Suspicion
2. Recovery	1. A work in progress 2. Stage of the journey 3. We're all in this together
4. Therapeutic milieu	1. Got to have trust 2. Getting to know each other
5. A chance	1. Poverty of experience 2. Developing self-awareness

Figure 1.

Sample Analysis.



The System (GET 1)

The system was described by all eight participants. This was underpinned by feeling the need to play the game, frustration around the length of time spent in FMH services and perceived suspicion from staff towards service users regarding their personal motives. These themes imply that the system itself impacts on participants' awareness of their own strengths and appears to be a barrier to the implementation of SBA according to participants.

Playing the Game (PET 1)

An undeniable feature in some participant's descriptions of their care and treatment was a sense of being controlled by the system and having to meet the various requirements of their restriction orders and treatment plans in order to progress forward.

> "Yes sir, no sir, 3 bags full sir. It's just a big game now." (Tommy, p.10)

Tommy expressed his understanding of how to progress through the system which was indicative of playing along with what he feels is expected of him. He described "tick boxes" and that if one is "motivated", "a nice guy", that keeps themselves "clean and tidy", they will progress through the tiers of security more easily.

> "And hopefully the powers that be will release you one day." (Tommy, p.10)

Tommy's language suggests that he views his experience as superficial rather than an authentic journey of recovery harnessed by his own personal strengths and goals for the future.

In addition, participants communicated that there are often challenging situations faced within FMH that they must overcome in a way that is deemed appropriate by the professionals, and that if their response to these challenges is not favourable, it too can impact progression, or in other words, they might fail the "test".

> "People get tested in here too, and it can just be a test, like how are you going to react to it…" (Jamie, p.10)

Jamie went on to say that his "easy going" personality enables him to cope with such challenging situations in a way that is presumably deemed prosocial by professionals. This could be viewed as the use of a personal strength, perhaps encouraged through use of SBA, to progress through the system quickly. However, as described by Tommy, it could also indicate a lack of authenticity in other participant's personal growth and recovery, given that they are aware they are being observed, and how they should act or comply in order to progress. This could further imply that those more able to cope with overwhelming emotions may progress more easily, which may not be indicative of authentic recovery or reduced offending.

Time Stands Still (PET 2)

Participant's appeared to view the system as a place where time stands still. A place where the only option is to "take it day by day" in order to cope, according to Ronnie; a significant clash with the future focused and goal orientated underpinnings of SBA.

Chris recounted his earlier experiences in FMH. He described being young when he was first admitted to hospital and that he needed more support in the form of increased restrictions and guidance, than he received. He described the experience as "derailing" rather than promoting his recovery in mental health.

> "After 2 years they almost gave up on me. So, I internally gave up on them and on the process, and proceeded to spend another 6 years in that place. I was stuck and there was no way out." (Chris, p.11-12)

On further enquiry, Chris reflected that at this time his only strength was "hanging on" as he bided time. These experiences likely maintained a sense of being further punished within the

system rather than residing within an environment that observed and promoted his strengths, values and goals for the future.

Tommy also talked about his "bitterness" towards the length of time that some people, including himself, have been in the system for:

> "15 years is a life sentence, man. Then you have to go back out there and keep all the strengths you've got!" (Tommy, p.11)

Tommy went on to use highly pejorative language to express his disapproval with this aspect of the system, particularly with regards to rehabilitating individuals so that they can live a meaningful life in the future. He likened the FMH system to prison, but clarified that the certainty of prison is more attractive to him:

> "You know where you stand in prison. Now prison isn't a nice place, but if they said you can go back to prison, I would do it. If they were to send me back tomorrow with a liberation date and no more government orders, I'd go back. With a click of the finger." (Tommy, p.12-13)

This hypothetical comparison from Tommy emphasises the negative impact of uncertainty on recovery, likely perpetuated by reduced motivation and difficulty setting goals for the future; again, some of the underpinnings of strength-based approaches.

Mikey talked about being comfortable where he is but added that he should be in the next tier of security by now. However, due to the high volume of service users also waiting for beds, this has not yet been possible:

> "I've been here for a while and I know I shouldn't be here at the moment." (Mikey, p.12)

Suspicion (PET 3)

Feeling judged by the system and the staff within it was also reflected by participants. In particular when they described attempts to live a life in line with their own values and engaging in some of the things that are important to them:

> "I shouldn't be a coward about being helpful and nice, but that's the way I feel. Some people make me feel as if I'm up to something being nice…over doing it. That's the way I feel, some nurses make me feel that way. I'm being honest. 'You shouldn't be doing that.' 'I'm telling you what to do.' 'I'm the boss.' That type thing." (Liam, p.7)

Liam clearly feels condemned by staff for helping others on the ward. He implies that the reaction from staff is filled with suspicion. This highlights the power imbalance between service users and staff often experienced within FMH and the impact this could have on the incorporation of SBA into FMH care and treatment. It is possible that service users' previous violent behaviour may shape staff perspective which in turn may hinder the implementation or use of SBA in clinical practice, i.e. suspicion around someone with a violent past valuing helping others in the present.

However, Mark demonstrated contrasting perspective to why staff may be reluctant to take positive risk using SBA:

> "If I were released into the community and were to repeat something unspeakable, it could affect them." (Mark, p.9)

Interestingly, Mark, and others, reflected on how they had previously refrained from being honest with staff about their mental health difficulties which may maintain the suspicion perceived by service users. Nonetheless, this indicates a further barrier to SBA implementation.

Recovery (GET 2)

Recovery was an important component of all eight participant's goals for the future. There was a sense that participants view recovery as a work in progress and something to approach in a step like manner rather than an immediate outcome. They reflected on the differences in various stages of their recovery journey with regards to their strengths, as well as a shared sense of comradery, as something of value in their recovery and a facilitator to SBA in practice.

A Work in Progress (PET 1)

Participants used an array of progressive language to describe their ongoing recovery, such as, "gained", "learned", "build" and "developed".

> "I've got my confidence back. It dropped right down when I came in here. I didn't have any belief in myself, but now I've got strong belief in myself." (Rory, p.4)

Ronnie recounted a previous, longstanding and significant relationship. Through conversation, he seemed to recognise that his labelling of this relationship as unhelpful to him was in fact an important aspect of his recovery. He went on to describe that his engagement in psychological intervention empowered him to understand this:

> "So, I cut the relationship off because I was finally emotionally secure enough to do that. I wasn't before. I'm in the best place I've ever been. I'm looking forward to the future more now too." (Ronnie, p.6)

Similarly, Rory reflected on the benefits he acquired from psychological intervention. He went on to describe that although this has enabled him to better "understand" himself, he views this as an ongoing experience rather than something he did in the past that was time limited:

"I would like to carry it (psychology) on, it really benefits me." (Rory, p.7)

These accounts show that some service users approach recovery as a long-term goal facilitated by the development and recognition of personal strengths and values. Moreover, they view it as something that they have been supported by staff to achieve.

Stage of the Journey (PET 2)

The uniqueness of FMH recovery was further reflected on by some participants, particularly with regards to their stage in the journey. Many participants described difficulty in identifying and using their strengths to inform goals for the future, specifically when they were more unwell, or whilst in high-security. For example, Jamie described the contrast between his current experiences compared to being newly admitted high-security:

> "I hated my psychology meeting. The build-up to each appointment made me feel really uncomfortable. I was new to the system and I was unwell. I was having to speak about things and I didn't want to. I was kind of forced, not forced but pressured in. I didn't want to do any of the work, but now I actually enjoy it." (Jamie, p.3 & 4)

This account suggests that timing and readiness to engage are likely barriers or enablers to incorporating SBA specifically, into care and treatment.

Stage of the recovery journey was also significant with regards to restrictions in medium-security by comparison to that in low-security. Participants described limited access or ability to engage in activities that are in keeping with their personal strengths and values, "in a compound with big walls."

> "In a low secure environment, I can be myself, go off and do what I want to do." (Mikey, p.9)

This echoes some of the aforementioned experiences of recovery being a work in progress. It seems as though participants feel like this stage in their journey does not afford them the opportunity to achieve excellence in play, work or agency, in an explicit way that is recognisable to them.

We're all in this Together (PET 3)

All participants commented on the importance of community on the ward and the positive impact this can have on recovery. "Helping" other service users on the ward was described during multiple interviews but Liam reported his rational for this in more depth:

> "Because I've made so many mistakes…they listen to me. So hopefully I can help them not make their mistakes." (Liam, p.5)

Tommy also discussed his view on recovery in the context of what has been important for him. He reported using the knowledge and information he has acquired from experience, psychological intervention and from other service users, and transferring it onto others:

> "I'm not taking away from the staff when I say this, that's what they're there to do but some patients are patient on patient, you know what I mean? And I'd like to think that all the time I've spent in the mental health system, I've got advice to give too now. Whether they take it on or not." (Tommy, p.4)

Tommy went on to describe a time when he was experiencing increased stress due to interpersonal stressors regarding family in the community. He reported to have benefitted from the support of staff and other service users on the ward at this time, and valued it:

> "I've spoken to staff and some patients in here about it and it's released it." (Tommy, p.6)

These accounts demonstrate implicit recognition of individual strengths, values and goals for the future specifically in the context of recovery, and the importance of collaboration and shared experience as an enabler to SBA in care and treatment.

Therapeutic Milieu (GET 3)

All eight participants described the significance of being able to trust one another, and staff, and that this happens over time as they get to know each other; facilitating a strength-based ethos.

Got to have Trust (PET 1)

Most participants talked about their experience of trust between service user and staff and emphasised it's importance within FMH.

> "Some people have barriers. A lot of people have barriers. I ask my mates… The first thing you need is to have that trust and connection. Do you know what I'm talking about? When you're talking about your past, personal things, you need trust. "(Liam, p.8)

Liam seems to have experienced trusting therapeutic relationships during his time in FMH services despite his experience of this being understandably challenging as he divulged personal information. However, he reports good personal outcomes and appears to be advising others on the ward to work towards this too.

By contrast, Mark reflected on his experiences where staff trusted him to be open and honest with regards to his mental health and he "abused" that trust by withholding information about his deteriorating mental health.

Tommy also explained that trust is not always explicit in FMH, particularly when asked if he thinks staff are aware of his personal strengths and goals for the future:

> "I'm saying aye and to be honest, I don't know. I suppose they're looking… but I don't know what's going through their head. You can read some notes but there's some notes you can't read. I don't want to go as far as saying you can't trust… but you just don't know. It's the power in the pen the boys always say." (Tommy, p14)

Tommy's account in particular highlights a notable barrier to meaningfully incorporating SBA into FMH practice. His use of the word "looking" suggests a lack of collaboration and meaningful engagement between staff and service user. However, this disconnect may be further compounded by Tommy's own understanding of his personal strengths and goals for the future given his perspectives regarding the aforementioned complexities of the system.

Getting to Know each Other (PET 2)

Jamie described some of the challenges of getting to know others on the ward when in such a hostile and unpredictable environment.

> "It's years not weeks or months in here… with 12 guys in a wee room and someone thinks you're staring at them, it's a long time. I think to myself what can I look at today, the floor, the light or the telly." (Jamie, p. 10)

This account does not reflect therapeutic milieu on the wards which likely impacts the extent to which participants feel safe and secure to explore new skills or implement values.

However, Jamie described developing good relationships with staff over the years as being a positive and normalising experience for him:

> "It's not just patients, staff go through things as well. Psychologists have gone through things that I've gone through as well." (Jamie, p.4)

Jamie's account suggests that he feels contained and validated by these experiences with staff, thus enhancing therapeutic milieu on the ward; despite the challenges faced among service users.

In addition to Jamie's experiences, Mark describes that when people are first admitted to FMH services they are generally more unwell and interpersonal relationships are challenging to engage in and develop:

> "… people are usually quite unwell when they come in… there was people I had to do a double take on years later, they were so much improved." (Mark, p.10)

This reiterates the complexity of the FMH environment and the challenges faced by service users with regards to their mental health recovery in an environment that likely challenges their difficulties, whilst also being their "home". This highlights that therapeutic milieu and SBA each as an ethos, overlap, and one can serve as a barrier or facilitator to the other.

A Chance (GET 4)

Likening FMH to being given a chance, was discussed by seven of the eight participants, particularly with regards to poverty of prior prosocial experience, becoming more self-aware and using the experience as an opportunity to learn; a chance to live a life that they choose, in line with their strengths, values and goals.

Poverty of Prior Experience (PET 1)

Participants described difference of past experiences when discussing their personal strengths, with some having previous careers and others being in the FMH system their entire adult lives. Nonetheless, many participants described experiences that did not afford them a chance at a strengths-based life.

> *"*All I want out of life is to have a home, a garden, and do some voluntary work in the local food bank for the homeless. I've been homeless three times. Especially

nowadays, they buy these tents now. They can roll them up and move on if somebody moves them. Helps a wee bit. Some people want to be homeless..." (Liam, p.4)

It is possible that Liam views being homeless as a good enough life by comparison to being in hospital, based on his use of the word "want". This implies that Liam's experiences beyond hospital and being homeless are limited, which likely impacts his ability to independently reflect on the past and the present to inform goals for the future.

This account highlights how some service users' lives may not have afforded them with experience to highlight their personal strengths and values. Therefore, recognising them, comfortably expressing them and incorporating them into their plans for the future, is likely a challenge and may service as a barrier to implementing SBA in FMH.

Developing Self-Awareness (PET 2)

Other participants described their experience as a learning opportunity. Various participants reflected on the development of their self-awareness, particularly awareness of their own strengths, values and goals for the future.

"I'm good at helping people out on the ward, I'm ward rep. Just in preparation for getting their benefits and things. I tell them what to apply for and go through advocacy with them and feedback to advocacy." (Rory, p.1)

For others, the interview process itself appeared the be an opportunity to reflect and understand some of their own experiences in more depth, again indicative of the aforementioned paucity of prior experience:

"I suppose I'm doing more than I thought I was." (Ronnie, p.5)

Perhaps nobody ever asked Ronnie what his strengths are or, observed some of his strengths and communicated this to him. This may also be the case for Rory, despite his earlier account

of being ward rep, as he described a rehabilitation program available to service users at specific stages of their recovery:

> "It's just to get you structured so that you're learning a skill when you get out. Basically, like a college placement, you go once or twice a week. You can do cooking, photography..." (Rory, p.2)

Rory might assume that in order to live a good life, he and other service users require further skills that they do not currently possess. For many of the participants recognising their personal strengths was challenging:

> "Oh, I don't have many skills, been in institutions all my life so..." (Tommy, p.1)

> "I'm more aware of my weaknesses, I think." (Mark, p.1)

Tommy specifically indicates that he doesn't know what his strengths are, which he believes is because he has not had the chance to explore this much as a long-term inpatient. These accounts reflect a general unfamiliarity in service users discussing things they are good at, or that are important to them. Furthermore, the interview itself appeared to be a rare opportunity for reflection, for some, indicating a need for increased SBA led conversations.

Discussion

This study explored the lived experience of SBA as described by male service users in a medium-security FMH hospital. Four Group Experiential Themes (GETs) were identified from IPA analysis: *The System, Recovery, Therapeutic Milieu* and *A Chance.*

For the most part, service users had an understanding of SBA. Although, identifying this in their care and treatment was generally more challenging. It would appear that despite these service users recognising their strengths, values and goals, they potentially view compliance

as a more realistic approach to their recovery and progression; a vital consideration for FMH services as they support a population with an extremely high prevalence of trauma related difficulties (McKenna, Jackson & Browne, 2019).

Participant's articulated a sense of resentment toward the system they are cared for within. However, an awareness of the dual role held by the professionals was also highlighted in many conversations, i.e. service user recovery versus public safety, as well as the complexity of multiple systems (healthcare and the judicial system). It would appear that the system is deemed a necessary evil in many ways by the service user, but was often described as something that is done 'to' rather than 'with' them, perhaps leading to inauthentic collaboration. This was particularly notable as participant's commented on the length of time typically spent within FMH and the subsequent challenges associated with progression. This complex facet of FMH is ultimately linked to a process of acquiescence in care and treatment planning, as service users are left feeling powerless. Moreover, when considering the use of SBA within FMH and service users experiential understanding of their individual strengths, skills and values, the system appears to be a barrier. According to service users, staff are suspicious of them, which in itself is not indicative of a strength-based culture, nor trauma-informed practice for that matter. These findings are broadly consistent with previous research which indicated that FMH service users experience staff as holding all the power with regards to violence risk assessment and management, and ultimately progression (O'Dowd, Laithwaite et al., 2022). Despite the present study exploring a contrasting narrative by addressing SBA, the outcome has a resounding similarity to the existing research. Overall, the coercion and restriction that is part of the system does not appear to foster a strength-based ethos.

In the literature, recovery is described as an active process with a focus on personal resources and supportive contexts (Andvig & Biong, 2014). According to the participants, the journey to recovery in FMH is a complicated one. They described the difference of experience across the tiers of security, specifically with regards to the implementation of SBA and how it is reflected in their care and treatment. For example, many reflected on the conditions applied to medium-security, specifically the restrictions and the availability of recreation. The general consensus was that medium-security offers more opportunity than high-security to meaningfully engage with services offered, such as psychology. Many participants described increased levels of trust within medium-security, which they associated with recovery and developed insight to their mental health and risk. It would appear that those in medium-security, particularly those who have previously spent time in high-security, perceive themselves to be further along in their recovery journey. This stage of recovery may be indicative of increased desire and ability to reflect on ones values, strengths and goals for the future. Furthermore, and by contrast to high-security, service users are exposed to different aspects of recovery in medium-security, such as leaving hospital and managing public transport under supervision. This is important for services to consider and indicates the need for foundations in SBA to be laid down as soon as an individual is introduced to FMH so that they are socialised to the ethos and empowered regarding their personal attributes and goals throughout the recovery journey. This could be addressed via routine use of The Structured Assessment of Protective Factors for violence risk (SAPROF: De Vogel et al., 2011) in risk assessment, so that service users are familiar with strength-based narratives from the earliest possible stage, and enhanced trauma-informed practice, the 6 principles of which are: safety, choice, trustworthiness, collaboration, empowerment and cultural consideration (Office for Health Improvement & Disparities, 2022). The purpose of trauma-informed practice is not to treat trauma-related difficulties, but to address barriers people affected by trauma can

experience when accessing health and care services, such as reluctance to engage due to mistrust based on prior experiences. These adaptations, would not only benefit the service user experience, but could in turn enhance staff experience of positive risk taking by enabling closer monitoring of strengths, values and goals via better relations, alongside individual recovery.

While the milieu of an inpatient facility is considered a treatment modality in itself, literature has predominantly focused on the role of staff in creating the milieu rather than the patient's perception of it (Thomas et al., 2002). However, therapeutic milieu was interestingly alluded to by the participants of this study while discussing their experiences of SBA in their care and treatment. Participants reflected on the importance of a therapeutic community, and that this was not only informed by themselves and staff, but also by fellow peers. Therefore, the facilitation of SBA into clinical practice is likely impacted by the therapeutic milieu and further important for FMH services to consider in conjunction. The conversations highlighted the complexity of the FMH setting and it could be surmised that therapeutic milieu may foster SBA in practice, or indeed the opposite.

There was an overwhelming sense that service users establish a multitude of first-time experiences while in FMH, such as, building relationships, acquiring a skill or managing distress without substances. Participants described enhanced introspection as a FMH service user; indicative of developed awareness and awareness of one's own strengths in particular. Although many participants struggled to identify personal strengths and values, things that are important to them, and goals for the future initially, this became somewhat easier as the conversations progressed. This in itself implies that FMH service users require appropriate support and encouragement to understand their personal strengths and goals in order to

meaningfully engage with SBA in their care and treatment and be empowered to collaborate as part of their recovery.

Implications for Services

By attempting to understand service users' perspectives of their experience, these findings may inform further policy development and clinical approaches to promoting the application of SBA in FMH. Findings may also promote professional awareness while contributing to theory development in an under-researched area. Undeniably, the nature of FMH settings remains challenging for both service user and staff. However, by attuning to the factors that could support engagement and recovery in FMH, such as, incorporating SBA early and explicitly into care and treatment, educating service users via a strength-based ethos and focusing on therapeutic milieu, some of these challenges may be limited. For example, incorporating SBA into assessment or Care Planning Approach documentation and integrating SBA into existing training packages for FMH staff.

Implications for Future Research

Given that this research developed in medium-security settings, similar studies in community FMH or high and low-security hospitals, would be beneficial in generating a holistic understanding of SBA across the tiers of security. This would further align with important observations from the Independent Forensic Mental Health Review (Scottish Government, 2021), specifically the need for promotion of a holistic approach to violence risk assessment and recovery in FMH. Future studies could also gain the perspective of FMH service users who are female or those with intellectual disabilities. Furthermore, service users should be empowered to speak about their experiences and contribute to the literature in this way via the introduction of a FMH Patient and Public Involvement group. This collaborative staff and

service user experience may address some of the aforementioned power and marginalisation issues within FMH.

Strengths and Limitations

The aim of IPA is not to provide generalisable results but to offer idiographic insight into a particular perspective of the phenomena under study; the sample represent a perspective rather than a population (Smith et al., 2022). As these findings reflect the lived experience of eight male service users from a medium-security hospital in Scotland; this could be viewed as both a strength and a limitation. A strength of the study being the in-depth exploration of their specific individual experiences, but a limitation due to the need for subsequent studies to gradually add to the claims made, as the sample of 8 males is not representative of all service-users in medium secure hospitals and not generalisable to wider mixed-gender FMH population experience.

The researcher acknowledges that their positionality may have influenced this study to some extent being a trainee clinical psychologist with previous FMH experience. This prior understanding of the challenges faced by service users as well as the challenges experienced by staff in balancing recovery with restriction, may have impacted interpretation. In particular, as participants struggled to elicit their personal strengths and values in conversation or were cautious or inconspicuous while reflecting on some of their experience. As a novel IPA user, the researcher's positionality was further challenged by ensuring adherence to interview guidance while simultaneously noting personal reflections. However, in an attempt to avoid bias, notes were taken regarding preconceptions that arose in order to bracket existing assumptions. Furthermore, there can be multiple, potential interpretations of the data and Smith et al. (2022) indicate that study readers should also consider their positionality when doing so.

A further limitation of this study is the absence of respondent validation to assure that their voices have been accurately represented. However, given the innate power imbalance historically reported on in FMH, this could introduce challenges in ensuring the process is valid.

Given that the researcher was working clinically in the service at the time of recruitment it is possible that participants may not have been as open as they may have been with an external researcher. Effort was made to reduce this potential by ensuring participants were not clinically involved with the researcher before inviting them to the study, however, this potentially remains a limitation.

Consideration should also be given to the potential limitation of volunteer bias, whereby service users who participated may have been motivated to do so as a result of extremely positive or indeed negative experiences in FMH. Participation may also be an indication of participants observing a rare opportunity to be heard, particularly as they were aware of the interview topic and that their words would be anonymous.

Conclusion

These findings illustrate the complex reality of FMH and general unfamiliarity of service users regarding personal strengths and resources as part of their care and treatment. This highlights a specific responsibility for professionals to foster increased, shared awareness of service users' strengths, values and goals as an important part of their recovery. In addition, the findings also highlight various barriers within this particular sample to the implementation of SBA such as, feelings of powerlessness regarding the future compounded by suspicion from professionals regarding their strengths and intentions. Some potential facilitators to the implementation of SBA were also identified: progression often enabling

autonomy, choice and increased self-awareness as well as therapeutic milieu on the wards. Specifically, participants demonstrated little awareness of the extent to which their personal strengths, values or goals are reflected in their care and treatment; which in itself may answer this question.

Declaration of Interest Statement

No potential conflict of interest was reported by the author(s).

Data Availability Statement

The participants of this study did not give written consent for their data to be shared publicly, so due to the sensitive nature of the research supporting data is not available.

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Appendices

Appendix A. Full Search Strategy

Supplementary Table 1a. Full Search Strategy (OVID: Medline)

Database	Limiter	MeSH Headings	Search Terms
Medline	Forensic Mental Health	**S1.** exp Forensic Psychiatry OR exp Forensic Psychology OR exp Forensic Nursing OR exp Psychiatry OR exp Mental Health OR exp Psychiatric Nursing	**S2**. forensic mental health OR forensic psych* OR forensic nurs* OR psychiatr* OR mental*
	User Involvement	**S3.** exp Patient Participation OR exp Decision Making, Shared	**S4.** participat* OR involve* OR user involvement OR user participation OR collab* OR service user* OR shared decision making
	Violence Risk Assessment and Management	**S5.** (exp Violence/ and exp Risk Assessment) OR (exp Violence / and exp Risk Management)	**S6.** violence risk* OR forensic risk*
Final coding Strategy	**(S1 OR S2) AND (S3 OR S4) AND (S5 OR S6)**		

Appendix A. Full Search Strategy

Supplementary Table 1b. Full Search Strategy (OVID: Embase)

Database	Limiter	MeSH Headings	Search Terms
EMBASE	Forensic Mental Health	**S1.** exp forensic psychology OR exp forensic psychiatry OR exp Forensic Nursing OR exp Psychiatry OR exp Mental Health OR exp Psychiatric Nursing	**S2**. forensic mental health OR forensic psych* OR forensic nurs* OR psychiatr* OR mental*
	User Involvement	**S3.** exp patient participation OR exp shared decision making OR exp cooperation OR decision making	**S4.** participat* OR involve* OR user involvement OR user participation OR collab* OR service user* OR shared decision making
	Violence Risk Assessment and Management	**S5.** (exp risk assessment/ and exp violence) OR (exp risk management/ and exp violence)	**S6.** violence risk* OR forensic risk*
Final coding Strategy	**(S1 OR S2) AND (S3 OR S4) AND (S5 OR S6)**		

Appendix A. Full Search Strategy

Supplementary Table 1c. Full Search Strategy (EBSCO: PsychINFO)

Database	Limiter	MeSH Headings	Search Terms
PsychINFO	Forensic Mental Health	**S1.** exp Forensic Psychiatry OR exp Forensic Psychology OR exp Psychiatry OR exp Mental Health OR exp Psychiatric Nurses	**S2**. forensic mental health OR forensic psych* OR forensic nurs* OR psychiatr* OR mental*
	User Involvement	**S3.** exp Participation OR exp Collaboration OR exp Involvement OR exp Cooperation OR exp Client Participation OR exp Decision Making	**S4.** participat* OR involve* OR user involvement OR user participation OR collab* OR service user* OR shared decision making
	Violence Risk Assessment and Management	**S5.** (exp Violence/ and exp Risk Assessment) OR (exp Violence / and exp Risk Management) OR exp Forensic Assessment	**S6.** violence risk* OR forensic risk*
Final coding Strategy	**(S1 OR S2) AND (S3 OR S4) AND (S5 OR S6)**		

Appendix A. Full Search Strategy

Supplementary Table 1d. Full Search Strategy (EBSCO: CINAHL)

Database	Limiter	MeSH Headings	Search Terms
CINAHL	Forensic Mental Health	**S1.** Forensic Psychiatry+ OR Forensic Psychology OR Forensic Nursing OR Psychiatry+ OR Mental Health OR Psychiatric Nursing+ OR Forensic Nurses+ OR Psychiatric Nursing+	**S2**. forensic mental health OR forensic psych* OR forensic nurs* OR psychiatr* OR mental*
	User Involvement	**S3.** Patient Participation+ OR Decision Making, Shared OR Joint Practice OR Collaboration OR Decision Making+	**S4.** participat* OR involve* OR user involvement OR user participation OR collab* OR service user* OR shared decision making
	Violence Risk Assessment and Management	**S5.** (Violence+/ and Risk Assessment+) OR (Violence+ / and Risk Management+) OR Violence Risk+ OR Risk for Violence, Self-directed or Directed at Others	**S6.** violence risk* OR forensic risk*
Final coding Strategy	**(S1 OR S2) AND (S3 OR S4) AND (S5 OR S6)**		

Appendix B. PRISMA 2020 Checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	9
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	10
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	13
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	13-14
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	15
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	14-15
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	71-74
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	16-17
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	16-17
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	N/A
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	N/A
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	17-18
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	N/A
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	N/A
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	21-22
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	15-16
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	N/A
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	N/A
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	N/A

Section and Topic	Item #	Checklist item	Location where item is reported
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	15
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	N/A
Study characteristics	17	Cite each included study and present its characteristics.	19-20
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	21-22
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	19-20
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	21-22
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g. confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	N/A
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	22-31
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N/A
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	N/A
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	22-31
	23b	Discuss any limitations of the evidence included in the review.	33-34
	23c	Discuss any limitations of the review processes used.	33-34
	23d	Discuss implications of the results for practice, policy, and future research.	34
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	14
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	14
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	N/A
Competing interests	26	Declare any competing interests of review authors.	34
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	N/A

Appendix C. NHS Ethical Approval

NHS Ethical Approval form (pages 102-105) removed due to confidentiality issues

NHS Ethical Approval form (pages 102-105) removed due to confidentiality issues

NHS Ethical Approval form (pages 102-105) removed due to confidentiality issues

NHS Ethical Approval form (pages 102-105) removed due to confidentiality issues

Appendix D. NHS R&D Approval

NHS R&D Approval (pages 106-107) removed due to confidentiality issues

NHS R&D Approval (pages 106-107) removed due to confidentiality issues

Appendix E. Forensic Research and Audit Committee Approval (Email)

From: O'brien, Darryl

To: Bradley, Megan

Cc: Meade, James; Slavin, Kirsteen

Mon 04/09/2023 15:23

MRP-P FINAL.DOC

Hello Megan,

As you are aware your project "A Qualitative Exploration of Service Users' Experiences of Strength-Based Approaches in Forensic Mental Health Settings: An Interpretative Phenomenological Analysis" has been approved at a recent research and audit committee meeting on behalf of GG+C Forensic Directorate.

I hope the project goes well and would be grateful if you could consider presenting your work at one of our R+A meetings in the future.

Regards,

Darryl.

Appendix F. Participant Consent Form

Title of Project: Exploring Service Users' Experiences of Strength-Based Approaches in Forensic Mental Health

Name of Researcher: Megan Bradley

CONSENT FORM

Please initial box

I confirm that I have read and understood the Participant Information Sheet Version X DATE. ☐

I have had enough time to think about the information and ask questions. I understand the answers I have been given. ☐

I understand that it is up to me whether I take part. I can stop taking part at any time, without giving any reason. This will not affect my legal rights or the care I receive. ☐

I agree to my interview being recorded on a password-protected recording device. ☐

I understand that the findings will be stored for up to 10 years by University of Glasgow and this consent forms will be stored by NHS GG&C for 3 years, in line with Data Protection policies and regulations. ☐

I understand that, although unlikely, there is a possibility that topics discussed during the interview could cause distress. I can request a break, reschedule or a debrief with the researcher/clinical team who are trained in distress management.

I understand that all information I provide will be kept private and seen only by the study researcher. ☐

NHS GG&C may check the study to make sure it is being managed properly. If this happens, I understand that these representatives will have access to my information while checking the study. ☐

I understand that the things I say in interview might be quoted in the report, but my name or anything else that could tell people who I am will not be revealed. ☐

I know that my RMO is aware of my participation in this study. ☐

I agree that the researcher will inform a member of the clinical team should concerns regarding my mental or physical health arise during my participation in the study. Or, if tell the researcher that I or someone else is at risk. ☐

I understand that if I tell the researcher about a criminal offence that I have not spoken about before they will have to tell my clinical team, social worker, and/or the police. ☐

I agree to take part in the above study. ☐

_____ _____ _____

Name of participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

(1 copy for participant; 1 copy for researcher; 1 copy in health records)

Appendix G. Participant Information Sheet

https://osf.io/6h84v?view_only=93275f0dc6bd43ea9ebc28a4b1620e2b

Appendix H. Interview Guide

https://osf.io/zc2bp?view_only=93275f0dc6bd43ea9ebc28a4b1620e2b

Appendix I. COREQ (COnsolidated criteria for REporting qualitative research) Checklist

No. Item	Guide questions/description	Reported on Page #
Domain 1: Research team and reflexivity		
Personal Characteristics		
1. Inter viewer/facilitator	Which author/s conducted the interview or focus group?	50
2. Credentials	What were the researcher's credentials? E.g. PhD, MD	51
3. Occupation	What was their occupation at the time of the study?	51
4. Gender	Was the researcher male or female?	52
5. Experience and training	What experience or training did the researcher have?	51
Relationship with participants		
6. Relationship established	Was a relationship established prior to study commencement?	50
7. Participant knowledge of the interviewer	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	87

8. Interviewer characteristics	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	51
Domain 2: study design		
Theoretical framework		
9. Methodological orientation and Theory	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	51
Participant selection		
10. Sampling	How were participants selected? e.g. purposive, convenience, consecutive, snowball	50
11. Method of approach	How were participants approached? e.g. face-to-face, telephone, mail, email	50
12. Sample size	How many participants were in the study?	50
13. Non-participation	How many people refused to participate or dropped out? Reasons?	50
Setting		

14. Setting of data collection	Where was the data collected? e.g. home, clinic, workplace	50
15. Presence of non-participants	Was anyone else present besides the participants and researchers?	n/a
16. Description of sample	What are the important characteristics of the sample? e.g. demographic data, date	50
Data collection		
17. Interview guide	Were questions, prompts, guides provided by the authors? Was it pilot tested?	50-51 + 88
18. Repeat interviews	Were repeat inter views carried out? If yes, how many?	n/a
19. Audio/visual recording	Did the research use audio or visual recording to collect the data?	51
20. Field notes	Were field notes made during and/or after the interview or focus group?	51
21. Duration	What was the duration of the inter views or focus group?	50
22. Data saturation	Was data saturation discussed?	n/a
23. Transcripts returned	Were transcripts returned to participants for comment and/or correction?	66

Domain 3: analysis and findings		
Data analysis		
24. Number of data coders	How many data coders coded the data?	51-52
25. Description of the coding tree	Did authors provide a description of the coding tree?	53
26. Derivation of themes	Were themes identified in advance or derived from the data?	51
27. Software	What software, if applicable, was used to manage the data?	n/a
28. Participant checking	Did participants provide feedback on the findings?	66
Reporting		
29. Quotations presented	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	53-63

30. Data and findings consistent	Was there consistency between the data presented and the findings?	53-63
31. Clarity of major themes	Were major themes clearly presented in the findings?	52
32. Clarity of minor themes	Is there a description of diverse cases or discussion of minor themes?	53-63

Appendix J – Final Approved Major Research Proposal

https://osf.io/8vs35?view_only=93275f0dc6bd43ea9ebc28a4b1620e2b