PATIENTS' EXPERIENCES OF HIGH SECURE HOSPITAL READMISSION FOLLOWING UNSUCCESSFUL TRIAL LEAVE

Research Project Portfolio Volume 1

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Thesis abstract

Introduction

Discharge from high to medium secure hospital is preceded by 'trial leave' in which patients transfer to medium secure hospital but remain under their high secure hospital responsible clinician's care for a period. This allows readmission without referral if problems arise. Patients often encounter difficulties during trial leave and many are readmitted to high secure hospital (Tetley, Evershed & Krishnan, 2010; Blattner & Dolan, 2009). The financial cost of unsuccessful trial leave is high and patients experience psychological distress and disrupted recovery. Few studies explore patients' difficulties on trial leave and why it fails so frequently. Investigations into patients' experiences of trial leave failure and high secure hospital readmission are scarce. Thus, patients' lived experiences of trial leave failure and readmission are unclear as are their needs following readmission.

Objective

This thesis aimed to explore patients' experiences of high secure hospital readmission following unsuccessful trial leave to a medium secure hospital.

Method

Following ethical approval, semi-structured interviews were conducted with five male patients who had been readmitted to high secure hospital following unsuccessful trial leave within the previous five years. The interviews explored their retrospective experiences of unsuccessful trial leave, before, during and after readmission. The interviews were audio-recorded and transcribed before applying Interpretative Phenomenological Analysis.

Results

Four superordinate themes emerged during data analysis, each with two or three subordinate themes: (1) I lost my safe attachments; (2) my trial leave experience was like my previous traumatic experiences; (3) the needs of the trial leave system overrode my needs; and (4) I was stigmatised because I came from high secure hospital and had a personality disorder diagnosis.

Discussion

This study yielded a rich understanding of patients' expressed experiences of unsuccessful trial leave and high secure hospital readmission, adding to theoretical and empirical understanding. Identified themes are discussed in the context of previous research and psychological theory. Participants experienced distress when they abruptly lost safe high secure hospital attachments. They struggled to build new attachments in medium secure hospital, perceiving them as less safe. Participants felt mistreated on trial leave, relating elements of their care to previous traumatic experiences. Participants felt their needs were not met as they were overridden by requirements of the trial leave system. They felt coerced into taking responsibility for their trial leave failure, despite attributing some responsibility to aspects of the trial leave system. They noted this coercion affected their self-concept. Participants felt that medium secure hospital staff stigmatised them for their high secure hospital history and their personality disorder diagnosis. They believed staff over-perceived their risk, overlooked their vulnerabilities, and failed to meet their needs, which were different to their medium secure hospital peers. These findings build on the limited existing research, providing a detailed and patient-focused account of the experience of unsuccessful trial leave and readmission. Clinical implications and ways to improve the transition process are also identified. Limitations of the study and further research recommendations are reported.

Statement of contribution

1. **Systematic review:** Alice Conlin (supervised by Louise Braham).

2. **Research project design:** Alice Conlin (supervised by Louise Braham).

3. **Applying for ethical approval:** Alice Conlin (supervised by Mark Gresswell and Thomas Schröder).

4. **Writing the thesis literature review:** Alice Conlin (supervised by Mark Gresswell and Thomas Schröder).

5. **Recruiting participants:** Phil Willmot and Alice Conlin.

6. **Data collection:** Alice Conlin (supervised by Phil Willmot, Mark Gresswell and Thomas Schröder).

7. **Transcription:** Administration staff at the high secure hospital.

8. **Data analysis:** Alice Conlin (supervised by Danielle De Boos).

9. **Write up:** Alice Conlin (supervised by Mark Gresswell, Thomas Schröder and Danielle De Boos).

JOURNAL PAPER

Patients' experiences of high secure hospital readmission following unsuccessful trial leave

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Patients' experiences of high secure hospital readmission following unsuccessful trial leave

In the UK, before high secure hospital discharge, patients undergo a period of trial leave during which they transfer to medium secure hospital while remaining under high secure hospital care. This is a costly process with a high failure rate. This study explored patients' experiences of high secure hospital readmission after unsuccessful trial leave. Five male patients with personality disorders (PD) were interviewed. Their accounts were analysed using IPA. Four superordinate themes emerged, each with two or three subordinate themes: (1) I lost my safe attachments; (2) my trial leave experience was like my previous traumatic experiences; (3) the needs of the trial leave system overrode my needs; and (4) I was stigmatised because I came from high secure hospital and had a PD. The researchers concluded that patients' trial leave and readmission experiences could be improved by training staff in trauma and attachment dynamics, improving communication between high and medium secure hospitals, and improving patients' psychological preparation for trial leave.

Keywords: transitions; medium secure hospital; high secure hospital; personality disorder; patient experience; Interpretative Phenomenological Analysis (IPA).

Introduction

Many mentally disordered offenders receive treatment in secure psychiatric hospitals. These hospitals comprise a network offering different levels of security (low, medium and high) taking patients with different levels of risk and allowing them to progress to less restrictive hospitals as they recover (Department of Health, 2007). Discharge from high to medium secure hospital is preceded by a period of trial leave, during which patients move to medium secure hospital but their high secure hospital clinicians retain legal responsibility for their care (Department of Health, 2015). Trial leave allows readmission without formal referral to high secure hospital. (See Extended Introduction for more information on mental disorders, high secure hospital treatment and outcomes, trial leave and secure hospital pathways).

Problems with the trial leave process are well documented (Durcan, Hoare & Cumming, 2011) and the failure rate is high (20-46%; Blattner & Dolan, 2009; Tetley, Evershed & Krishnan, 2010). Little research has explored why failure occurs so frequently. Most studies, reviewing reasons given by medium secure hospitals, suggest patients deteriorate in manageability, mental health and/or risk (Blattner & Dolan, 2009; Tavernor, Swinton, Collins, Brook & Beadle, 1998; Tetley, Evershed & Krishnan, 2010). This research is helpful but does not explore underlying factors that cause deterioration.

Adshead (2002) attributed patients' mental health and/or behavioural deterioration on trial leave to losing secure attachments. Goodwin (2003) emphasised the importance of providing patients with secure attachments and observed that services may actively hinder recovery if they re-enacted insecure attachment histories. Thus, she proposed that service design should be attachment-informed. However, as with most services, little work has evaluated how well forensic services meet patients' attachment needs (Bucci,

Roberts, Danquah & Berry, 2015). Thus, it is unclear whether trial leave difficulties stem from attachment loss or whether underlying factors may contribute.

Only two studies have explored patients' trial leave experiences. Skelly (1994) interviewed fourteen patients with personality disorder (PD) or mental health diagnoses, who failed trial leave. Skelly associated five factors with trial leave failure. Patients were given insufficient information before trial leave so developed unrealistic expectations. They were demotivated, perceiving their transfer as a backwards step as the medium secure hospitals offered fewer privileges and more restrictions. They believed they had to 'play the game' rather than undertaking meaningful activity. Skelly noted patients' frustration at transfer delays which were attributed to medium secure hospital staff. Finally, Skelly reported that the threat of readmission triggered disengagement or challenging behaviour. Another study supported three similar themes: limited preparatory information; readmission fear; and perceived lack of gains (Tetley, Evershed & Krishnan, 2011). This paper described two further problematic themes experienced by trial leave patients: boredom and difficulties adjusting to the new culture. These researchers interviewed sixteen patients with PD about their trial leave difficulties. However, most participants succeeded on trial leave so likely had different experiences to patients who fail.

No research has explored patients' experiences of high secure hospital readmission from trial leave. However, Tavernor and colleagues (1998) suggest problems encountered during trial leave might continue following readmission, interfering with patients' re-settling.

Failed trial leave has high costs for services and negative impacts on patients psychologically and on their recovery. Clinicians acknowledge the high failure rate and the stressful nature of transitions (Skelly, 1994) which can lead to increased risk (Joint

Commissioning Panel for Mental Health, 2013). The limited understanding of patients' difficulties with trial leave makes it difficult to intervene (Thomas Peter, 2002; Wallace, 2012).

This study aimed to investigate patients' experiences of unsuccessful trial leave and readmission, exploring experiences before, during and after readmission. The research question addressed was: what are patients' experiences of high secure hospital readmission following unsuccessful trial leave? The findings provide a richer understanding of the difficulties experienced and highlight ways to improve the trial leave process and support patients on readmission. (See Extended Introduction for the researchers' expected findings based on theoretical underpinnings of findings from previous research).

Method

Participants.

After obtaining a Regional Ethics Committee's approval (See Appendices 6-9), psychologists in Mental Health and PD Services in one English high secure hospital were asked to give a study information sheet (See Appendix 1) to male patients who had been readmitted within the previous five years following unsuccessful trial leave. After providing informed consent to participate (See Appendix 2), five patients were recruited from the PD Service. No patients from the Mental Health Service met the inclusion criteria.

Participants' demographic information was collected (See Appendix 3). They were between 24 and 53 years old. All had at least one PD diagnosis and two had comorbid mental health diagnoses. Before trial leave, participants resided in high secure hospital for between 16 and 101 months (average 57.2 months). No participants had previously

experienced trial leave. Participants had been readmitted for between 9 and 59 months (average 36 months). (See Extended Method for additional information on ethical approval, obtaining consent, participant selection procedures, demographic information and inclusion and exclusion criteria).

Procedure.

The primary researcher conducted semi-structured interviews, lasting approximately two hours, with an independent staff member present. Interviews followed an interview schedule (See Appendix 4) comprising six questions, with additional prompts. These aimed to explore perceptions, experiences and interpretations (Pietkiewicz & Smith, 2012) of the entire process, trial leave preparation, their transition, problems encountered, their readmission and the future. Interviews were audio-recorded and transcribed. Identifiable information was removed and pseudonyms were assigned to maintain confidentiality. (See Extended Method for a more detailed description of study design and procedure).

Analysis.

Interviews were analysed using Interpretative Phenomenological Analysis (IPA; Smith, Flowers & Larkin, 2009). (See Extended Introduction for a rationale for the use of qualitative methodology, particularly IPA in comparison to other methods). IPA provides in-depth interpretations of participants' experiences and reflections of complex phenomena (Smith & Osborne, 2008). Following IPA analysis guidelines (Smith, Flowers & Larkin, 2009), transcripts were re-read several times for immersion in the narrative, then objects and descriptors were noted in one margin to structure the data. Preliminary interpretations of participants' experiences were noted in the opposite

margin. Each transcript was re-read to generate initial themes. Themes were amended as subsequent transcripts were analysed and integrated into superordinate and subordinate themes.

The researchers took a critical realist position (Willig, 2015), assuming participants experienced events in a unique way, mediated through previous experiences. IPA involves a 'double hermeneutic' as researchers interpret the meaning of participants' expressed experiences (Smith, Flowers & Larkin, 2009). As researchers' own experiences can influence findings, adherence to IPA guidelines was important to maximise analysis quality. Quality assurance processes included bracketing (setting aside researchers' perspectives) and discussions between authors on emerging themes during analysis. A reflective diary aided awareness of how theoretical and personal preconceptions influenced interpretations. (See Extended Method for a more detailed description of the data collection and analysis, quality assurance measures and the researchers' epistemological position).

Results

Themes (Table 1) are described here. (See Extended Results for elaboration of these themes).

Table 1: Superordinate and subordinate themes.

Superordinate themes	Subordinate themes
I lost my safe attachments.	- My strong high secure hospital attachments ended abruptly. - Medium secure hospital offered me unsafe alternative attachments.
My trial leave experience was like my previous traumatic experiences.	- My trial leave process was abusive. - The abusive experience felt familiar to me.
The needs of the trial leave system overrode my needs.	- My needs weren't met. - I had to take responsibility for my trial leave failure. - Prioritising the system's needs affected my self-concept.
I was stigmatised because I came from high secure hospital and had a PD.	- I was misperceived as risky and treated as high risk. - I had different needs to medium secure hospital patients. - My vulnerabilities were overlooked.

1. I lost my safe attachments.

Participants described strong attachments to the high secure hospital's environment, routines, rules and staff, which ended on moving to medium secure hospital.

One subordinate theme expressed the quality of participants' attachments within high secure hospital and their abrupt severing. They noted the importance of trust and predictability in promoting a sense of safety, so they could disclose vulnerabilities and

difficulties. They described high secure hospital staff as reliable and having their best interests at heart.

> I knew how things worked in [high secure hospital], I was comfortable with the regime…I felt safe with the staff, I didn't feel they'd ever do anything to hurt me. (Robert).

Participants described feeling shocked and abandoned on suddenly losing these safe attachments, at a time when they most needed reassurance and encouragement. These feelings were exacerbated by the differentness of the new environment and the abrupt realisation that their relationships were no longer predictable.

> I said 'where's [high secure staff]?', [medium secure staff] went 'oh they've gone…they went straight away'…You shouldn't do that because these are the people you respect who got you there…Saying 'well done, you can do this'…you need to hear those words. (Jason).

Another subordinate theme related to the replacement of these attachments in medium secure hospital with replacements they perceived as less safe. Participants described their new wards as chaotic, with unsettled patients and fewer staff, compared to high secure hospital wards. They reported struggling to adapt and perceived negative consequences for querying rules.

> My perception of how it was going to be there was…chilled out…settled…it was like Beirut…loads of lads really unwell, really unsettled. (Chris).

Participants described forming negative first impressions, noting inadequate preparation for their arrival and changes to agreed trial leave plans. They reported feeling unsafe, with little confidence in their new hospital, and fearing readmission. Participants

described feeling unwelcome and unsupported. perceiving staff as unavailable and disinterested, thus struggling to build relationships with them.

Participants described responding to feeling unsafe with a fluctuating pattern of engagement, ranging between hostility and approval-seeking. Some resorted to maladaptive coping strategies which likely caused medium secure hospital staff to deem them risky and unsuitable for medium secure hospital.

> 'They don't care why should I talk', so eventually I stopped talking completely and I ended up going back to old behaviours and dealing with things which was self-harm, the aggression, because…aggression keeps everybody at arm's length. (Robert).

2. My trial leave experience was like my previous traumatic experiences.

Participants described feeling unjustly mistreated by medium secure hospital staff and let down by their trial leave experience. They perceived this as abusive and likened it to previous traumatic experiences.

> I've been used and abused and let down...doctors in [another medium secure hospital] went 'this man has been totally let down by the system'. (Jason).

One subordinate theme outlined how participants experienced trial leave as abusive. They reported receiving little support or compassion and feeling their physical and emotional needs were neglected, so they felt isolated and rejected, particularly as they believed other patients received better treatment.

> I couldn't even get to the dentist…I was that much in pain…if you start fucking carrying on you get recalled back…that's not fair…that's setting you up to fail. (Jason).

Participants described feeling tricked when staff changed agreed trial leave plans and excluded them from care planning. They reported confusion about perceived inconsistent and changeable staff feedback, which escalated into questioning staff intentions, believing they were dishonest and sabotaging them or looking for reasons to readmit them. They described feeling vulnerable and anxious about readmission.

> They were looking for the first opportunity for you to be returned back to high secure...they were looking for me to say the wrong thing. (Chris).

Participants believed medium secure hospital staff were punitive, failing to reward good behaviour and misperceiving behaviour as manipulative, so threatening readmission, which they felt was an abuse of power.

> Whenever I questioned something…it was seen that I was trying to push boundaries or resist against something…I'd tell them what worked with me…they went 'no, we'll do it our way'...was almost seen as I was trying to push boundaries…or manipulate. (Robert).

Another subordinate theme reflected how the abusive trial leave experience reminded participants of previous experiences of betrayal or abuse.

> …people that abused me growing up, were people in authority…how they worked basically just tapped into those core things, those core kind of problems. (Robert).

Participants acknowledged they may have been hypervigilant to abuse and noted they responded to perceived threat with maladaptive coping strategies because of previous

trauma, which staff likely perceived as increased risk. On readmission, participants described feeling shame and anger when others blamed them.

> When a situation's coming up that's really emotional yeah you can become really hyper-sensitive so you pick up on these things more and more and we have a tendency to misread them. (Chris).

3. The needs of the trial leave system overrode my needs.

Participants perceived instances in which the needs of the trial leave system were prioritised over their needs.

One subordinate theme describes how participants believed that aspects of the trial leave process itself interfered with their needs being met. Delays and rushes in the timing of trial leave processes impeded preparation.

> It all happened in a rush…there wasn't a lot of transition work…I was flying blind…Work should have been done on…how I was going to handle it, the different things I could encounter…I was winging it. (Steven).

Additional factors included poor liaison between medium secure hospital staff and high secure hospital staff who knew them, and little flexibility in the choice of medium secure hospital, resulting in admissions to wards that could not meet participants' needs.

> …everyone is unanimous that [medium secure hospital] is the worst, so I really didn't want to go…but I had no choice of where I wanted to go. (Danny).

Another subordinate theme reflected how participants were expected to accept full responsibility for trial leave failure and address the reasons it failed through treatment.

Participants accepted their behaviour contributed to readmission but believed they were not fully to blame.

> I shouldn't have self-harmed…shouldn't have assaulted a member of staff and I fully accept that. However, there were things they shouldn't have done but…all the blame…is on me. (Robert).

They described feeling coerced into unnecessary treatment. They believed their feelings of loss and injustice were dismissed, causing them difficulties re-settling following readmission.

> Things I've had to do to meet criteria to go back I don't think are ethical…made us do a test…to prove I didn't have problem with women…if you refuse it it looks like you've got something to hide…it took us a long time to let go because for quite a while it was the injustice of it all. (Steven).

The final subordinate theme described how participants felt the prioritisation of the system's needs over theirs affected their self-concept. Participants saw trial leave failure as loss of their future life and described grieving for their lost opportunity. They reported confusion about the readmission reasons, acknowledging their challenging behaviour but believing the failure was not entirely their fault.

> I've been given a few different answers. When I counteract one, they come with another one…it takes two to tango and yes if I'm arguing with someone, I'm arguing with somebody but that doesn't mean it was all my fault. I didn't threaten anybody, I wasn't abusive. (Danny).

Participants reported feeling ashamed and unjustly blamed for the failure, and hopeless about their future, which hindered high secure hospital re-settlement.

Eventually, they reported having no alternative but to accept the loss and work towards another attempt. However, their reported powerlessness and vulnerability experienced during trial leave reduced their confidence in the mental health system and their own self-efficacy. Thus, they described fluctuations between feeling relief to be in a familiar environment and hopeful for the future, and experiencing a traumatic loss, including a loss of self-worth.

> My belief and faith in the systems to help people move on, I don't have as much faith in…it's been an eye opener…things can go wrong…I have a lot more apprehension and anxiety about moving on. (Robert).

4. I was stigmatised because I came from high secure hospital and had a PD.

Participants believed their high secure hospital history and PD led to stigmatisation by medium secure hospital staff. Three subordinate themes described how this stigmatisation manifested.

Firstly, participants felt misperceived as risky by medium secure hospital staff, who overperceived their risk and misinterpreted innocent behaviour as challenging. Consequently, staff set higher standards for them and supervised them more closely, which demotivated them, increased their anxiety about readmission and hindered their ability to build relationships with staff.

> I was getting room searches and drug tests every week…[patients] coming in after me weren't getting that special attention…'you come from [high secure hospital] so things are a bit different'...they've got a massive stigma…high secure patients…we are treated differently. (Danny).

Secondly, participants believed their needs, which were different to their peers', were not met by the medium secure hospital, partially as they felt staff had limited experience of high secure hospital patients with PD. Staff were perceived as seeing participants' differentness as creating additional work and indicative of their unsuitability for medium secure hospital.

> They thought I was a bit of a hindrance because they had to get off their arse and go and do something, whereas normally they'd just be sat in the office, give out medication...they just weren't pragmatic with someone that wanted to do stuff, they were so used to not having to do stuff. (Chris).

Finally, participants described themselves as vulnerable and felt staff overlooked these vulnerabilities, sometimes perceiving them as increased risk. Consequently, participants stopped seeking help and instead resorted to maladaptive coping strategies which were seen as increased risk.

> Something little like me asking for medication turned into like a big thing, I had to go to my ward round and talk about was I stressed, who was I going to attack, is that why I wanted my medication. (Chris).

Discussion

Patients' experiences of failed trial leave and high secure hospital readmission were explored. Superordinate themes, based on interpretations of participants' expressed experiences, are described in relation to psychological models and literature. (See Extended Discussion for a more detailed discussion of the themes in relation to theory and previous literature, as well as additional implications for clinical practice and further recommendations for future research).

1. I lost my safe attachments.

Participants described feeling vulnerable on losing their relationships with high secure staff and their predictable environment, and difficulties they experienced in forming safe alternatives. The researchers interpreted this as relating to attachment theory. Insecure adult attachment styles are prevalent among high secure hospital patients (Fonagy & Levinson, 2004). Participants' expressed comfort in the high secure hospital environment and their apparent trusting relationships with high secure hospital staff are reflective of secure adult attachments (Mann, Matias & Allen, 2014), and a sign of emerging recovery (Willmot & McMurran, 2016). Attachment theory suggests losing secure attachments results in feelings of insecurity and loss (Bowlby, 1988), much like grief. Participants reported limited opportunities to prepare psychologically for this loss, so described experiencing them as abrupt, noting that the lack of practical preparation before trial leave impaired their ability to adapt to a new "secure base".

Participants' reported reactions to losing these attachments paralleled those of distressed adults with insecure attachment styles. They described expressing high levels of emotion and concern about their relationships and/or avoiding attachment opportunities (Barber, Short, Clarke-Moore, Lougher, Huckle & Amos, 2006; Main & Goldwyn, 1989). Diener and Monroe (2011) suggested that mental health staff misunderstanding patients' responses to attachment loss can adversely affect building new attachments and impede progress.

2. My trial leave experience was like previous traumatic experiences.

Participants reported feeling mistreated during trial leave and felt it mirrored previous abusive experiences. They believed medium secure hospital staff lacked

compassion and treated them more punitively than their peers. Consistent with previous research, participants reported feeling under threat of readmission if they did not comply with required behavioural standards, but feeling confused about what was required of them and unable to ever receive positive feedback. These perceptions were interpreted as consistent with definitions of abuse (Thompson & Kaplan, 1996).

Participants recognised they may have overperceived the potential threat to themselves in the medium secure hospital. Hypervigilance to threat is common among people with traumatic histories (Buckley, Blanchard & Neill, 2000) and the majority of high secure hospital patients have traumatic histories, particularly multi-type abuse or 'complex trauma' (Willmot & Evershed, 2018), which has been associated with poor emotion regulation, self-awareness and interpersonal relatedness (Suveg, Morelen, Brewer & Thomassin, 2010). Modern theories of PD (e.g. Schema Therapy) consider these difficulties and associated behaviours as maladaptive strategies developed to keep the individual safe (Young, Klosko & Weishaar, 2003). Attachment disruptions, alongside exposure to trauma triggers, can lead to destabilisation and extreme behaviour (Wayland, 2008), which likely contributed to participants' readmissions.

3. The needs of the trial leave system overrode my needs.

Participants believed aspects of trial leave prevented their needs being met and this affected their self-efficacy, faith in the trial leave system and their ability to resettle following readmission. The researchers interpreted this in context of NHS initiatives to make services more person-centred (NHS England, 2014), as a perception that the trial leave system's needs overrode patients' needs. Participants believed the limited choice of medium secure hospital resulted in their admission to wards not designed to meet their needs. Supporting past research (Tetley, Evershed & Krishnan, 2011), participants

also described timing issues in the transition process compromising their preparation. The time-consuming admission process, limited bed availability and the imperative to maintain high bed occupancy all contribute to timing issues (Durcan, Hoare & Cumming, 2011; Harty et al, 2004). Thus, high secure hospital clinicians may delay trial leave preparatory work until a bed has been secured. If transfer occurs quickly after acceptance, this may impede adequate preparation.

Previous research highlighted that patients can experience trial leave as a 'backwards step' (Skelly, 1994; Tetley, Evershed & Krishnan, 2011). Participants described placement on admissions wards which they experienced as unsettled and chaotic. Most medium secure hospital admissions come from prisons and low secure hospitals following acute mental health problems and risky behaviour (Durcan, Hoare & Cumming, 2011). Consequently, participants reported feeling unsafe and encountering more restrictions than expected.

Participants reported little liaison between current and previous clinical teams. Poor 'joined-up working' is known to negatively affect patients' progression (Duggan, 2007; Durcan, Hoare & Cumming, 2011).

Participants reported that they were expected to accept full responsibility for trial leave failure. They accepted their behaviour contributed to readmission but also blamed other situational factors. This external attributional style (Jones & Nisbett, 1971) was likely reinforced by feeling powerless to influence their trial leave care and shame about their failure. Participants' reported their clinical teams attributed the failure to participants' themselves (internal factors), despite research suggesting that external attribution can be a protective factor against distress arising from failure (Johnson, Panagioti, Bass, Ramsey & Harrison, 2017).

Participants described readmission as a loss of their future life, similar to the experience of bereavement (Kubler-Ross, 1969). They reported that high secure hospital care overlooked these feelings on readmission, hindering their ability to re-engage.

4. I was stigmatised because I came from high secure hospital and had a PD.

Participants described feeling stigmatised by medium secure hospital staff for their high secure hospital history and PD. They believed they were perceived and treated more negatively than other patients, in line with definitions of stigma (Link & Phelan, 2001). Much evidence demonstrates that patients with PD are perceived more negatively by staff, as harder to manage, less deserving of care, with poorer treatment outcomes. Efforts have been made to improve staff attitudes but Beryl and Völlm (2018) suggest this has been unsuccessful. Other studies have suggested high secure hospital patients are perceived as more dangerous and harder to treat (Murie, 2010). This may be valid given their admission criteria, but patients are sometimes labelled as 'dangerous' without undertaking risk assessments (Lammie, Harrison, Macmahon & Knifton, 2010). This stereotype may explain participants' perceptions of being supervised more closely and of their behaviour being negatively misinterpreted. Participants' belief that a lack of experience contributed to medium secure hospital staff's negative perceptions is corroborated by Beryl and Völlm's (2018) finding that, despite initiatives to train staff to address stigmatisation, 44% of staff had no formal training in working with patients with PD. These researchers noted that staff's low confidence in their ability to work with people with PD can result in helplessness, therapeutic pessimism, efforts to maintain social distance, and stigmatisation.

Strengths and limitations

Consistent with IPA methodology, only five participants were interviewed, limiting the representativeness of our results. Readers should be cautious of applying these findings to other high secure hospital patients. Secondly, only patients with PD participated. The findings, particularly regarding stigmatisation, may be biased towards this group. Additionally, participants were interviewed some time after readmission; it is unclear whether their interpretations of the experience had changed due to memory deterioration or reflection. Finally, only participants who failed trial leave were interviewed, whose experiences may be different to those who succeed. Again, caution should be applied when generalising these findings to other groups.

Notwithstanding these limitations, this study is important as little research has explored patients' experiences of trial leave, and none has investigated experiences of high secure hospital readmission. Participants' articulate and reflective accounts enhance our understanding. (See Extended Discussion for further critique of the methodology).

Clinical implications

This study identifies suggestions for improving trial leave and readmission experiences. Firstly, taking an attachment theory perspective, work preparing patients for the psychological effects of transition and attachment losses has shown success in reducing trial leave failure (Adshead et al, 2017). This could be offered alongside practical information and ward visits, from when patients begin the trial leave assessment process, to increase predictability of the new environment and begin to build new attachments. Secondly, on readmission, patients could be assisted to re-engage more quickly if they undertook bereavement work to address issues of loss (McMurran & Ward, 2010; Stroebe & Schutt, 1999). Since external attribution can protect against

distress, acknowledgement of situational factors involved in trial leave failure may also help them resettle (Johnson, Panagioti, Bass, Ramsey & Harrison, 2017; Neimeyer & Sands, 2011). Thirdly, this and other studies indicate the value of staff awareness training, particularly in trauma- and attachment-informed models of PD, to help staff support patients during transitions (Adshead, 2018; Willmot & Evershed, 2018). Fourthly, timing and inter-service communication issues surrounding trial leave are well documented. A collaborative, dynamic and timetabled trial leave pathway could allow patients to prepare practically and psychologically. Team formulation involving both staff teams could improve patient care. Lastly, high secure hospital attachment-informed 'transition teams', similar to those in adolescent services, could be considered to improve liaison between teams and better co-ordinate transitions.

Future research

Using IPA means findings are based on participants' reported experiences. Given their confusion about their readmission reasons, exploring how their experiences compare to clinicians' views would be helpful. Additionally, only patients who failed trial leave were interviewed. To investigate the critical factors in successful trial leave, comparing these findings to successful patients' experiences would be helpful. Furthermore, patients with PD may have different experiences to other high secure hospital patients, thus exploring their experiences would be useful.

Conclusion

Trial leave fails frequently (Blattner & Dolan, 2009; Tetley, Evershed & Krishnan, 2010) and little is known about how patients experience failure and high secure hospital readmission. This study corroborates previous findings that patients find transitions

including trial leave difficult, and offers possible reasons. Participants said losing secure attachments and experiencing the process as traumatic exacerbated existing difficulties. Participants perceived the process as overriding, rather than meeting, their needs, and felt stigmatised for their high secure hospital history and PD. The findings indicate patients do not always feel supported by the trial leave process and support previous recommendations for improvements.

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EXTENDED PAPER

The extended paper expands upon, and should be read alongside, the information in the journal paper. Further detail on all sections of the journal paper (the introduction, methodology, results and discussion sections) is provided here.

Journal choice rationale

The primary researcher decided to write the journal paper for submission to the Journal of Forensic Psychiatry and Psychology. This journal was chosen because it has previously published research focusing on secure mental health services including qualitative research. This study adds to the existing literature, and publishing in the same journal would make it easily accessible to readers interested in the topic. A proportion of the literature exploring patients' transitions between high and medium secure hospital has been published here. While the current study may be of interest to teams working with patients transitioning between other services, the primary focus is on the transition between secure psychiatric hospitals, particularly high to medium secure hospitals. Thus, the researchers wanted to target clinicians and other researchers working in secure hospitals in England, and this journal was felt to be the most appropriate choice for the intended audience. The journal's instructions for authors can be found at: https://www.tandfonline.com/action/authorSubmission?journalCode=rjfp20&page=instructions

Introduction

Overview

The following section is an extension of the introduction in the journal paper. It provides additional information about the existing research relevant to the current study and outlines the rationale for the study.

Mentally disordered offenders

A significant proportion of people who commit crimes are mentally disordered (Department of Health, 2009), and many mentally disordered offenders will receive treatment in a psychiatric hospital. Mental disorder comprises many different diagnoses. The most frequently reported mental disorder diagnoses in forensic populations relate to personality disorder and mental illness (Glover & Olson, 2012). Personality disorders and mental illnesses, and their relationship to crime, are explored below.

Personality disorder

There is a great deal of controversy surrounding the diagnostic category of personality disorder. Traditionally, the clinical description of personality disorder has rested on the existence of a set of problematic, pervasive and persistent ways of thinking, feeling and behaving that deviate from the norm. Within this definition, a number of specific types of disorder have been described (such as antisocial/dissocial, borderline/emotionally unstable, avoidant) comprising different symptom clusters which are used as diagnostic criteria. Unfortunately, the criteria for the different types of personality disorder frequently overlap. One example of this is that ‘hostility’ and ‘impulsivity’ are noted as criteria for both antisocial personality disorder and borderline personality disorder diagnoses. Furthermore, people with very different constellations of symptoms can be diagnosed as having the same type of personality disorder. Thus, somebody can be diagnosed with an avoidant personality disorder if, alongside a presentation of detachment and negative affect, they have either low self-esteem, feelings of inferiority and a reluctance to engage in intimate relationships, or poor self-direction and a preoccupation with criticism. Tyrer, Reed and Crawford (2015) note that there is poor validation for the existence of

the different types of personality disorder. As a result, there have been recent attempts to improve the way in which personality disorder is diagnosed, with a view to changing the criteria within diagnostic and statistical manuals. A move from the current categorical system, which had been decided by panel consensus, to a dimensional (or hybrid) system, using trait-based personality theory, were discussed (Livesley, 2010) but rejected. Thus, the diagnosis of personality disorder remains a controversial topic.

An additional problem is that minority ethnic groups are known to be under-represented amongst patients with personality disorder. Consequently, it has been argued that personality disorder may have a cultural bias, centred on Western concepts of personality functioning (McGilloway, Hall, Lee & Kamaldeep, 2010).

For many clinicians, this controversy has fuelled an argument that personality disorder is a meaningless term, and that the problems presented by patients might be better described using a more functional approach which can more effectively determine treatment strategies (e.g. the use of attachment models). Other clinicians have also noted the stigma attached to the diagnosis of personality disorder, and that this can prevent patients from accessing services because they are deemed untreatable (Department of Health, 2003). Warren and Dolan (1996) also describe therapeutic pessimism associated with personality disorder among clinicians and argued that the diagnosis of personality disorder represented a label as a “service abuser” rather than a service user.

However, Tyrer, Reed and Crawford (2015) argue that the confusion surrounds the specific characteristics of personality disorder rather than its core components. They note that many people presenting with a combination of problematic, pervasive and persistent traits continue to be diagnosed with personality disorder. Service commissioners and providers continue to use the diagnostic criteria for personality disorder to determine treatment pathways. Outcome studies pertaining to these services and their treatments also consider personality disorder as a diagnostic entity, often highlighting less successful outcomes for people diagnosed with personality disorder (Tyrer, 2009).

Diagnostic criteria

DSM-V (American Psychiatric Association; APA, 2013) defines personality disorder as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture". The pattern usually begins in adolescence or early adulthood and it is notably stable and persistent. Personality disorders are seen to influence several domains of personal and social behaviour (work, relationships, and leisure) and are manifested in more than one area: cognitive (influencing the perception of self, events and others); emotional (affecting the emotional lability, intensity and appropriateness); impulse control; and interpersonal functioning. DSM-V describes 10 different subcategories of personality disorder, grouped into three clusters: paranoid, schizoid, schizotypal (the odd/eccentric cluster); antisocial, borderline, histrionic, narcissistic (the dramatic/erratic cluster); and avoidant, dependent and obsessive-compulsive (the anxious/fearful cluster) (APA, 2013). Thus, patients with a diagnosis of personality disorder comprise a heterogeneous group, often with different presenting problems and treatment needs. Many people meet the diagnostic criteria for more than one of the personality disorder subcategories and comorbidity with other mental disorders is common. As a result, people diagnosed with a personality disorder tend to be seen as clinically complex as their clinical formulations frequently suggest a broad, multi-faceted spectrum of interlinked affective, behavioural and cognitive pathologies, which are inflexible and pervasive. The ego-syntonic, rigid and pervasive nature of the disorder means that it is difficult to manage and treat sufferers effectively.

Prevalence

Lenzenweger, Lane, Loranger and Kessler (2007) suggested that in the US and the UK, approximately 11% of adults overall have at least one personality disorder. However, prevalence within prison and forensic mental health settings is much higher (Joseph & Benefield, 2010). In a UK community setting, prevalence is estimated at about 4% of the population (Coid, Yang, Tyrer, Roberts & Ullrich, 2006) but this rises to between 66% and 90% of the population in high secure settings (Blackburn, Logan, Donnelley & Renwick, 2003; Ranger, Methuen & Rutter, 2004).

Aetiology

As with other complex disorders, there is very little evidence to support the notion of a single-factor aetiology in the development of personality disorder (Livesley, 2003). The diagnostic criteria for the different types of personality disorders consist of different clusters of behavioural, affective and cognitive patterns (APA, 2013), suggesting a degree of heterogeneity. Additionally, most clinicians agree that a combination of biological, psychological and environmental factors lead to the development of these difficulties (Alwin, Blackburn, Davidson, Hilton, Logan & Shine, 2006; Livesley, 2003). Modern theorists have included biological factors in the development of personality and personality difficulties (Livesley, 2003). This is based on evidence from twin and adoption studies (Paris, 1996), which have highlighted that genetics and the later underlying temperament of a child affect personality development (Paris, 1996; Rothbart & Ahadi, 1994). However, Linehan (1993) and Young (1990) suggest that negative environmental influences impact on personality development. Livesley (2010) argues that biological influences alone do not account for the onset of personality disorder. Experiences of trauma, including neglect and childhood abuse, attachment difficulties and an "invalidating environment" have been linked with the development of personality disorder (Johnson, Cohen, Brown, Smailes & Bernstein, 1999; Linehan, 1993; Perry, 2002). The notion of a trans-biopsychosocial model of personality disorder development is now accepted by most theorists and clinicians (Bateman & Fonagy, 2004; Linehan, 1993; Livesley, 2003).

A model is described as biopsychosocial if it attributes the causality of a problem to the interaction of different types of variable including biological factors (e.g. genetic, biochemical), psychological factors (e.g. cognitions, affect, behaviour), and social factors (e.g. cultural, familial, socioeconomic, traumatic). It is important to note that the different factors do not act independently but interact with and affect each other to bring about the difficulty. Thus, an adverse situation regarding one factor is likely to impact adversely on others. Biopsychosocial models are particularly usefully applied to complex phenomena since they allow a more holistic perspective.

Prognosis

Personality and personality traits are understood to be relatively enduring across the lifespan and as a result, personality disorder is perceived to be a lifelong phenomenon (Biskin, 2015), however, most clinicians acknowledge that there is a reduction in symptoms as people age. Zanarini, Frankenburg, Reich and Fitzmaurice (2012) demonstrated that symptoms typically improve from age 30 onwards, although functional recovery (in terms of the ability to work, maintain relationships and abstain from substance use) is more elusive. In turn, Tyrer, Reed and Crawford (2015) suggested that the high suicide and premature mortality rates in this population might be associated with this poor functional recovery.

Treatment

Over the last fifteen to twenty years, several new therapeutic models have been designed to address personality disorder and there is a growing body of evidence suggesting that patients can benefit from these newer therapeutic frameworks. However, the different models have differing theoretical approaches to the understanding of personality disorder and they promote a differing set of processes and targets within therapeutic approaches (Moore, Evershed, Kilcoyne & Jones, 2014). Most of these newer models are long-term so the research base is in its infancy and as a result, there is an acknowledgement that the evidence base for the effective treatment of personality disorder is insufficient. Existing research conclusions are limited by small sample sizes and most of the existing evidence relates only to the treatment of borderline personality disorder (Bateman, Gunderson & Mulder, 2015). There is a paucity of high-quality randomised controlled trials looking at the differential effectiveness of these different treatments and as a result patients can be offered an array of interventions.

Nevertheless, in 2006 the British Psychological Society noted that a variety of approaches including Dialectical Behaviour Therapy, Mentalisation Treatment, Cognitive Behaviour Therapy for personality disorders, Schema Therapy and Therapeutic communities might all have benefits (Alwin, Blackburn, Davidson, Hilton, Logan & Shine, 2006). It concluded that the most efficacious treatments for personality disorder, regardless of the specific treatment approach, are structured, systematic, theoretically coherent and well-

integrated with other services. There is a general agreement among clinicians that personality disorder can be understood as a 'socioemotional disability' which presents as difficulties in a range of areas including arousal, affect, cognition, behaviour, relationships and self-identity. Thus, effective treatment needs to target all these areas and is therefore likely to be intensive and long term (Adshead & Sarkar, 2012).

Given that people with personality disorders have different treatment and responsivity needs to other patient groups, requiring structure, coherence and consistency, it may be that their outcomes on trial leave will also be different. Tyrer (2009) noted that patients with a personality disorder struggle to manage transitions and cope outside a high secure environment in the longer-term. Thus, it is possible that the experience of trial leave and the ability to cope with it and its failure may be different for patients with a personality disorder compared to those with a mental illness.

Mental illness

The diagnosis of "psychotic" illnesses has also been a controversial issue for many years (Szasz, 1960). Diagnosis rests on a medical model which assumes that mental illnesses "exist" and "are real" in the same way as physical health illnesses (Division of Clinical Psychology, 2017). There is no discrete dividing line between psychotic experiences and those considered "normal", rather mental health is seen as a continuum (Campbell, O'Rourke & Slater, 2011). Stressful events (e.g. trauma) and extreme circumstances (e.g. sleep deprivation) can lead to the development of unusual cognitive phenomena including paranoid thoughts and hallucinations (Hemsley, 1993). While only one in fifty people within the general population of the UK experience these phenomena at a diagnosable level (van Os, Linscott, Myin-Germeys, Delespaul & Krabbendam, 2009), ten percent of the population experience some unusual cognitive phenomena (Johns et al, 2014). In western countries these unusual phenomena tend to be pathologized (Fernando, 2000), whilst other cultures may be more accepting, seeing them as religious or spiritual (Romme & Escher, 1993).

Further controversy lies with the failure of mental health diagnostic labels to describe consistent symptom patterns (Division of Clinical Psychology, 2017).

Those diagnosed with mental illnesses often experience them differently (Hemsley, 1993) and the medical model, on which the diagnostic symptoms are based, does not reliably link symptoms to underlying biological causes (APA, 2013). As a result, people are often diagnosed differently and clinicians often do not agree on diagnoses (Aboraya, Rankin, France, El-Missiry & John, 2006).

Diagnostic criteria

The term mental illness covers a multitude of different presentations. Most commonly, the term is used to describe the diagnostic categories of schizophrenia and bipolar disorder (Division of Clinical Psychology, 2017) and this is particularly the case in secure forensic services. This is mirrored in the prevalence rates for psychiatric diagnosis in mentally disordered offenders (McElroy et al, 1999).

Schizophrenia is recognised as a chronic and severe mental disorder that affects people's cognitions, emotions and behaviours (Bentall, 2003), often developing in late teenage years to early adulthood (Division of Clinical Psychology, 2017). In order to be diagnosed with schizophrenia, DSM-V (APA, 2013) requires that two out of five positive symptom types are present. Positive symptoms include delusions, hallucinations, disorganised speech, grossly disorganised or catatonic behaviour; and negative symptoms. Negative symptoms can include reduced affect, apathy and social withdrawal. The symptoms must cause social or occupational dysfunction and must have been present for at least six months. Since only two of the five symptom types need to be present for a diagnosis, patients comprise a heterogenous group with differing needs.

Bipolar disorder is characterised by the experience of alternating manic and depressive episodes. During depressive episodes, the sufferer experiences low mood, low self-esteem and reduced energy. Manic episodes can involve hyperactivity, distractibility and grandiosity (Eaves, Tien & Wilson, 2000). Bipolar disorder has two forms; to be diagnosed using DSM-V, both forms require the presence of depressive episodes, but bipolar I disorder also requires manic episodes lasting at least seven days. For people suffering less intense manic episodes (hypomania), lasting for between four and seven days, bipolar II disorder would be diagnosed (APA, 2013).

Prevalence

Experiences of mental illness appear to be relatively common, with around 10% of people experiencing some symptoms during their lifetime. However, only about 1% of people are formally diagnosed with schizophrenia and 1% are diagnosed with bipolar disorder (bipolar I or II disorder) (Division of Clinical Psychology, 2017). In forensic settings, the prevalence of diagnosed schizophrenia is approximately ten times higher than the general population (Department of Health, 2009). The prevalence of bipolar disorder among people in the criminal justice system is between 2-7% (Fovet, Geoffroy, Vaiva, Adins, Thomas & Amad, 2015).

Aetiology

Schizophrenia is recognised to be a complicated disorder with many causative factors, both environmental and biological, linked to it. Traditionally, schizophrenia was assumed to have a biological cause but no specific biological mechanism has been identified yet and as a result the purely biological view has been challenged. Nevertheless, many clinicians believe there is a strong genetic component due to findings from twin studies (Gejman, Sanders & Duan, 2010). A number of environmental risk factors have also been suggested, including pre- and peri-natal difficulties and infections, childhood trauma and substance misuse. Whilst the relative contribution of these different factors has not been established, many clinicians now agree that there are likely to be many factors playing a role in the onset and maintenance of schizophrenia, and that its presentation and causes can vary from person to person (Bentall, 2003). Therefore, schizophrenia is perhaps best viewed as a syndrome, rather than a single disorder, with a cluster of symptoms, all of which may have different causes: a biopsychosocial disorder. Genetic factors may be a necessary mechanism for the onset of the disorder but additional environmental and lifestyle stressors are necessary for the disorder to develop (van Os & McGuffin, 2003).

The aetiology of bipolar disorder is similarly unclear: twin and adoption studies have indicated an increased likelihood of development if family members are sufferers (Goodwin & Jamison, 2007). However, environmental

and lifestyle factors also appear to be important in the development of the disorder, such that symptoms often only appear as a result of stressful events (Padmos et al, 2009). Initial episodes often coincide with stressful events, substance abuse, lack of routine (including sleep), and physical illness (Suppes & Dennehy, 2012). Most clinicians agree that there does not appear to be a single cause for bipolar disorder but it may be that biological factors, with additional environmental stressors, are required for its onset (Division of Clinical Psychology, 2010).

Prognosis

Around 50% of patients diagnosed with schizophrenia experience single episodes from which they recover completely, and only a minority of the remainder experience further serious problems (Slade, Amering & Oades, 2008). In addition to medication, five factors appear to be helpful in recovery: connections (e.g. supportive relationships); hope; a positive identity; having a purpose or meaning in life; and empowerment (Leamy, Bird, Le Boutillier, Williams & Slade, 2011). This suggests recovery is aided by improving patients' ability to cope with the environmental factors linked to the onset of schizophrenia, alongside medication which helps to manage the biological factors. Research has shown that recovery rates are better when patients are employed, when they have control over their lives, when they are not stigmatised or discriminated against, and when they have supported relationships (Division of Clinical Psychology, 2017). Many of these factors are unachievable for patients living in secure hospitals.

Approximately 60% of people who have been diagnosed with bipolar disorder do not relapse after recovery (Coryell et al, 1998). However, bipolar disorder can vary in its course and severity and for some people it is a lifelong condition. As a relapse-remitting condition, mood episodes recur occasionally, but individuals recover between episodes and can return to their normal lifestyle. Episodes are exacerbated by stress but can occur unprovoked (Basco & Rush, 2007), causing impaired psychosocial functioning (Zaretsky, Rizvi & Parikh, 2007). On average, mood episodes occur bi-annually, although rapid cycling can cause more frequent relapse.

Treatment

Best practice guidelines for the treatment and management of schizophrenia recommend a combination of medication and psychological therapy (NICE, 2014). In terms of psychological interventions, CBT for psychosis (CBTp) is particularly advocated for, as well as family interventions if the patient resides with family members (NICE, 2014). CBTp and family interventions have a robust evidence base highlighting their efficacy (van der Gaag, Valmaggia & Smit, 2014; Wykes, Steel, Everitt & Tarrier, 2008; Kuipers, 2011). However, other psychological interventions also show promise, such as cognitive remediation (McGurk, Twamley, Sitzer, McHugo & Mueser, 2007), trauma-focussed therapy (Boon, Steele & van der Hart, 2011), ACT (Morris, Johns & Oliver, 2013), and narrative therapy (Rhodes & Jacques, 2009).

Almost everyone entering mental health services with schizophrenia will be offered anti-psychotic medication, which many find helpful, particularly those who experience distress as a result of their symptoms (Morrison, Hutton, Shiers & Turkington, 2012). Until recently medication was seen as the treatment of choice (Morrison, Renton, French & Bentall, 2007) but there is a growing belief that the efficacy of medication has been over-estimated (Freeman & Garety, 2012). A recent meta-analysis found that only 20% of patients with schizophrenia improved following stand-alone medication (Morrison, Haddock & Tarrier, 1995). Medication also usually incurs side-effects which can range from muscle spasms to tremors (Parkinsonism) (van der Gaag, Valmaggia & Smit, 2014).

The key aim for the treatment of bipolar disorder is to reduce the likelihood of future episodes. Research indicates psychological therapies, alongside pharmacology, can improve bipolar disorder outcomes, including symptoms, and longer-term psychosocial functioning (Miklowitz, 2008; Reinares, Sanchez-Moreno & Fountoulakis, 2014).

Whilst NICE guidelines recommend that best practice treatment includes medication and CBT (NICE, 2006), a range of other psychological therapies have also been found to have good outcomes, particularly Interpersonal and Social Rhythm Therapy (IPSRT; Frank et al, 2005) and family-focussed therapy (FFT; Miklowitz et al, 2007). Meta-analyses have found CBT reduced manic and depressive symptoms, and likelihood of relapse (Benyon, Soares-Weiser,

Woolacott, Duffy & Geddes, 2008; Gregory, 2010a, b). IPSRT has been shown to reduce relapses and suicide risk (Rucci et al, 2002; Frank, 2007), whilst FFT can decrease risk of relapses and hospitalisation (Miklowitz, 2007). RCT studies have found no significant difference in efficacy between IPSRT, FFT and CBT (Frank et al, 2005; Scott & Gutierrez, 2004; Scott, 2006). In addition, all of these interventions include an element of psychoeducation which is seen as fundamental (Colom et al, 2009; SIGN, 2005).

Medication in the form of mood stabilisers, anti-depressants and anti-psychotics, is nearly always offered as part of the treatment for bipolar disorder. Similarly to medication for schizophrenia, there are lots of common side-effects, including weight gain and thyroid and liver damage (Division of Clinical Psychology, 2010).

High secure psychiatric hospitals

In the UK, there is a network of psychiatric hospitals which are specifically designed to meet the needs of mentally disordered offenders. This network comprises hospitals offering different levels of security, for patients who present with different levels of risk to the public.

Low secure hospitals house patients who require “a combination of physical, relational and procedural security to remain safe”. At any time, around 3700 patients live in such services, placed there according to the degree of their risk-related mental disorder, their level of risk, and the care and supervision they require (NHS England, 2013). Patients whose needs cannot be met in low secure hospital will be considered for a medium secure hospital admission. Medium secure hospitals treat over 3000 patients at any time. Patients represent a heterogenous group with a range of needs, but all present a “serious but not grave and immediate danger to others” (Department of Health, 2006); most will have a history of violent behaviour and many pose a risk of absconsion.

There are three high secure psychiatric hospitals in England and Wales, housing approximately 900 patients suffering from a mental disorder, as recognised by the Mental Health Act (Department of Health, 2007), deemed to pose a grave risk to the public (NHS England, 2013). A key purpose of the high secure hospitals is to protect the public, therefore there is an emphasis on safe

containment and management of the patients' risk to themselves and others. However, their key stated aims are to reduce patients' risk of harm, treat mental disorder and facilitate patients' recovery (NHS England, 2013).

In some of the hospitals patients are housed separately according to their primary diagnosis and access specialist treatment pathways, adapted to address their diagnosis-related needs. For example, at one of the hospitals a separate national service exists solely for patients with a learning disability. In other hospitals, patients are integrated. Nevertheless, all of the treatment pathways available within the hospitals reflect the aims to reduce mental disorder, decrease risk of harm and facilitate recovery.

Treatment

The high secure hospitals are based on a rehabilitation model (Killaspy, Harden, Holloway & King, 2005), offering a whole-systems approach to promote adaptive functioning after discharge to lower security mental health services, prison or the community (Tapp, Warren, Fife-Schaw, Perkins & Moore, 2013).

The biopsychosocial model underpins the treatment and treatment pathways provided for patients within these hospitals (Tapp, Warren, Fife-Schaw, Perkins & Moore, 2013) with interventions based on treating biological, psychological and social deficits (Ghaemi, 2009).

Patients admitted to high secure hospitals often present with many different needs, both in terms of their clinical presentation and manageability. There is often confusion about these patients' diagnoses, with many patients having multiple diagnoses for comorbid disorders, and many whose primary diagnosis has changed over time (Moore, Evershed, Kilcoyne & Jones, 2014). As a result, these patients tend to have a complex constellation of clinical needs. Many of the patients have traumatic histories, histories of substance misuse and/or self-harm, and some are criminally versatile or have unusual offending patterns. Most clinicians working with high secure hospital patients would agree that they are unlikely to benefit from standard, uni-focused psychological treatments. Effective psychological treatment pathways for this group need to be responsive to all of their needs for substantive change to occur as the different needs impact on each other (Moore, Evershed, Kilcoyne & Jones, 2014).

Typically, the psychological treatment pathways will include elements to address motivation and engagement, mental disorder symptomatology, and offending risk (Moore, Evershed, Kilcoyne & Jones, 2014). Since many of high secure hospital patients' disorders are ego-syntonic in nature, they do not always see the need for change, and thus present with more motivation-based difficulties (McMurran, 2009). Thus, a range of treatment approaches, based on the Stages of Change Model (Prochaska & DiClemente, 1984) are implemented. The next phase of the treatment pathway aims to reduce symptoms of mental disorder and develop coping skills to manage these. Therapies promoting interpersonal effectiveness, emotional control, social problem-solving and specific symptom management, such as hearing voices, are included (Moore, Evershed, Kilcoyne & Jones, 2014). The psychological interventions provided to reduce the risk of reoffending draw on the Good Lives Model (Evershed, 2010), which promotes the notion of living "good lives" pro-socially (Ward & Brown, 2004).

There is very little evidence of the efficacy of each component of the treatment pathway within a high secure setting. However, the treatment components have often been developed from interventions designed for other patient groups and adapted to better meet the needs of high secure patients. There is evidence for the efficacy of the treatment components with other populations, for example, offence-focussed interventions usually produce effect sizes of approximately 15% between treated and untreated groups, which is small but significant (Moore, Evershed, Kilcoyne & Jones, 2014).

While limited, there is some evidence of treatment efficacy with high secure hospital patients from some small scale or pilot studies; most conclude that the various treatments show promise. In 2008, a pilot study into the efficacy of a Violent Offender Treatment Programme found promising results among its fourteen patients, including a reduction in violent behaviour and risk, and an increase in coping skills (Braham, Jones & Hollin, 2008). Additionally, reductions in the frequency and intensity of 'anger incidents' were noted in eight patients following their completion of a programme to address problematic anger (Jones & Hollin, 2004). Another pilot study of eight patients found reductions in the seriousness of their violent incidents and suppressed anger, compared to a comparison group, following completion of an adapted

Dialectical Behavioural Therapy programme (Evershed, Tennant, Boomer, Rees, Barkham & Watson, 2006). However, one small study into the efficacy of Schema Modal Therapy, with 29 patients, found no significant difference in risk, personality style or schemata, compared to a control group (Tarrier, Dolan, Doyle, Dunn, Shaw & Blackburn, 2010). It should be noted that this trial has been criticised for the quality of the therapy delivery (Bernstein, De Vos, Jonkers, de Jonge & Arntz, 2012). A further difficulty regarding the evidence from all of these studies is that they only measure the effect on patients while still in the high secure environment. There is no evidence into the longer-term effects, outside of the high secure environment, as patients move towards living in the community. Some authors have suggested that high risk patients, particularly those diagnosed with a personality disorder, may not be able to sustain adaptive change outside a controlled environment. It has been proposed that treatment effects may be determined more by changes in the environment which minimise the impact of the mental disorder on the individual, rather than changes in the individual themselves (Tyrer, 2009).

Outcomes of high secure hospitals

Some studies have explored the efficacy of the high secure hospitals by examining outcomes for patients following discharge. They have tended to focus on mortality, reconviction and readmission rates as the negative outcomes.

Two large-scale studies, with approximately 200 patients each, looked at discharges from the three high secure hospitals, following patients up for over ten years. They found that the mortality rate for patients discharged from high secure hospitals is significantly higher than the mortality rate of the general population and can be up to twice as high (Jamieson & Taylor, 2002; Steels, Roney, Larkin, Jones, Croudace & Duggan, 1998).

The most frequently examined outcome has been reconviction rate. Twelve key studies have been conducted which measured reconviction rates for patients, regardless of diagnosis, who were discharged from any of the high secure hospitals in England and Scotland. These studies found differing reconviction rates, ranging between 19% (Thomson, Davidson, Brett, Steele & Darjee, 2008) and 55% (Tennent & Way, 1984). These variations can partially

be explained by the differences in the way the studies collected data. The studies had different follow-up periods, ranging between 0.5 years and 14 years. Clearly, shorter follow-up periods offer less opportunity for reconviction to occur. However, a number of authors have suggested that reconviction is most likely to occur in the first few years following discharge (e.g. Black, 1982), and this pattern is reflected in the research. For example, Tennent and Way (1984) found the highest reconviction rate (55%), whilst Thompson, Davidson, Brett, Steele and Darjee (2008) found the lowest reconviction rate (19%), and these studies had very similar follow-up periods of an average of 8.7 years and 8.8 years. More importantly, the proportion of patients discharged directly into the community, rather than to other secure hospitals or prisons, varied across the studies. The authors believed that this had a major influence on reconviction rates, with higher rates among those discharged directly to the community (Buchanan, 1998). It should be noted that much of this research was conducted over 30 years ago. Since this time, the management, treatment and post-discharge supervision of forensic patients has changed dramatically. Thus, this research's relevance to current day practice is questionable. This improvement in post-discharge supervision is observable within the studies examined, as the reconviction rates demonstrated in the earlier studies tended to be much higher (between 27% and 55%; Home Office and Department of Health and Social Security, 1973; Acres,1975; Black, 1982; Norris, 1984; Tennent and Way, 1984; Bailey & Macculloch, 1992) than those demonstrated in the studies conducted since 1995 (19% to 38%; Reiss, Grubin & Meux, 1996; Buchanan, 1998; Buchanan, Taylor & Gunn, 2004; Jamieson & Taylor 2004; 2005; Thomson, Davidson, Brett, Steele & Darjee, 2008). Research has also focussed more specifically on the reconviction rates for 'serious' offences (usually defined as violent or sexual crimes against the person). Looking at the most recent data (since 1995), the reported reconviction rates for serious offences committed post-discharge from a high secure hospital mostly vary between 4.6% (Buchanan, Taylor & Gunn, 2004) and 14% (Jamieson & Taylor, 2005). Jamieson and Taylor's earlier research (2004), which studied an earlier cohort, reported a rate of 25% but it is unclear why this rate was so much higher.

Rates of readmission to psychiatric hospital following discharge from a high secure hospital have also been studied. Two early studies found readmission

rates of 13% (Acres, 1975) and 28% (Black, 1982). More recent research, with longer follow-up periods, has indicated more consistent readmission rates of between 19% (Jamieson & Taylor, 2002) and 20% (Thomson, Davidson, Brett, Steele & Darjee, 2008).

The above research suggests that when released from high secure hospital, approximately 40-60% of patients will die, be reconvicted or readmitted in the years immediately following their discharge. However, this proportion is likely an overestimate since some of the patients in these studies might have been counted twice, if they experienced more than one of these outcomes.

Pathways out of high secure hospital

High secure hospitals form part of an overall forensic mental health pathway, designed to treat people who have committed a serious offence or whose risk to others is deemed unmanageable elsewhere, as a result of a mental disorder. They are a low volume, high cost service, costing £273,000 per person annually in 2008/9 (Durcan, Hoare & Cumming, 2011) with only approximately 700 beds (Duke, Furtado, Guo & Völlm, 2017). Furthermore, clinicians are required to detain patients in the least restrictive environment possible (Department of Health, 2007). Therefore, there are economic, legal and humanitarian reasons patients should be progressed from high secure hospitals as soon as possible.

Patients within these hospitals have been detained under a section of the Mental Health Act (Department of Health, 2007). With very few exceptions, most patients are admitted to high secure hospitals through one of two routes. Some patients will be admitted directly from a criminal court having been given a Hospital Order. Other patients will have been sentenced by a criminal court to a period of imprisonment and later transferred to high secure hospital for assessment or treatment. There is also a proportion of patients who have been transferred to high secure hospitals from hospitals with lower security, having previously been given either a Hospital Order or been transferred from prison.

Most patients in high secure hospitals will have additional restrictions placed upon them by the Secretary of State for Justice if they are deemed to present a higher level of risk. This means that the Secretary of State for Justice makes the final decision about applications for their community leave, transfer and discharge.

For patients without additional restrictions, the decision to discharge rests with their responsible clinician, or a First-Tier Tribunal (Mental Health Review Tribunal). All patients have access to regular tribunals, depending on the Section of the Mental Health Act under which they are detained. High secure hospital patients are usually eligible for tribunals six months after admission and then annually thereafter. Tribunals review the patient's case with a view to determining whether their mental disorder symptomology is of a level and degree that warrants detention. The tribunal panel consists of an independent medical professional, legal professional and layperson with knowledge of the mental health system. Tribunals are quasi-legal hearings to which reports are submitted and witnesses, including the patient, their solicitor, and their responsible clinician and other members of their clinical team will provide evidence. The remit of the tribunal is solely to determine whether or not the statutory criteria for discharge have been met. If the criteria are met, patients detained without restriction will be discharged into the community, absolutely (without conditions) or conditionally. Patients transferred from prison cannot be discharged into the community if they have time left to serve of their custodial sentence, so are returned to prison to complete this. However, patients detained with restrictions cannot be discharged, even with approval from a tribunal, until the Secretary of State for Justice has agreed to this.

Regardless of the specific pathway to discharge, all decision-making panels will be informed by risk assessments completed by the current and/or prospective clinical team (NHS England, 2013). In this context, a risk assessment is a systematic process of identifying the nature, likelihood, severity and imminence of risk of offending posed by an individual. Best practice risk assessments will consider knowledge from research evidence, the individual's history and current presentation, and the clinicians' clinical judgment (Department of Health, 2009). A risk assessment should inform the level or care and security required to ensure their and the public's safety by informing decisions about placement, transition and discharge. Therefore, the risk assessments used should be dynamic documents, which require regular updating to best assess a patient's current risk. There are a wide range of risk assessment tools available, each with a different evidence base. Perhaps the most widely used tool is the HCR-20 (Douglas, Hart, Webster & Belfrage,

2013), which has a strong international evidence base suggesting a correlation between HCR-20 outcome and subsequent violence (Douglas, Hart, Webster, Belfrage, Guy & Wilson, 2014). However, the evidence is not as strong regarding the use of the HCR-20 or similar risk assessments for demonstrating change in risk over time. Authors suggest this may be because patients tend to only show gradual changes in risk over long periods of time, so the effect size is small (O'Shea & Dickens, 2015). As a result, a panel's decision to discharge or transfer is more likely to be more influenced by the clinical judgment of the patient's team than the standardised and systematic process of risk assessment, so the potential for error is higher.

For most high secure hospital patients, the next step in their treatment pathway entails transferring to a medium secure psychiatric hospital. However, this is not the end of their difficulties in their pathway through secure care. A number of studies have found adverse outcomes in terms of reconvictions, readmissions and mortality following discharge into the community from medium secure hospitals (Conlin & Braham, 2017).

Trial leave

The process of transferring to a medium secure hospital involves a period of 'trial leave', in which patients are transferred to the medium secure hospital (usually six months). During this time, patients remain formally under the care of their high secure responsible clinician, but the medium secure hospital clinical team make day-to-day decisions about their care (Department of Health, 2015). If problems arise, patients can be readmitted to the high secure hospital without referral. Otherwise, the patient's progress is formally reviewed following their trial leave, and if deemed successful, patients are discharged into the medium secure hospital provider's care.

There are inherent difficulties in this transition process between hospitals. Limitations on medium secure hospital bed availability can cause significant delays in the transfer process (Durcan, Hoare & Cumming, 2011) so that many high secure patients are refused admission altogether (Tetley, Evershed & Krishnan, 2010).

Success rate of trial leave

Even when patients do transfer, many encounter difficulties during their trial leave. Blattner and Dolan (2009), reviewing 77 patients who transferred to medium secure hospitals between 1986 and 2007, found that 46% were returned to high secure hospital. A later study looking at 80 patients found that 20% of patients discharged to low and medium secure hospitals were returned to high secure hospitals (Tetley, Evershed & Krishnan, 2010). In both studies, some of the patients had experienced an unsuccessful trial leave previously.

Why does trial leave fail?

Tetley, Evershed and Krishnan (2010) found that the most common reasons given for trial leave 'failures' were that patients had disengaged from treatment or were deemed to be unmanageable due to exhibiting a range of 'challenging behaviours'. Similarly, Blatter and Dolan (2009) reported reasons including 'threatening and volatile presentations', committing another offence and absconsion.

Research is sparse regarding the reasons why so many patients do not successfully complete their trial leave. Where research does exist, most studies have looked at the reasons given by returning medium secure hospitals. The most common reasons identified included: aggression; boundary violations; absconsion; failure to progress or engage; and deterioration in mental health or risk (Tavernor, Swinton, Collins, Brook & Beadle, 1998). This research is helpful but does not highlight or explain the underlying factors behind patients' presenting behaviours, nor does it describe the lived experience of patients undergoing this process.

There is a recognition that the transition process between services is stressful for patients (Skelly, 1994). However, Wallace (2012) noted that services' ability to address transition problems was hindered by poor understanding of patients' experience of the process. Although Wallace's argument pertained to female patients, who arguably have different difficulties, other clinicians have reported a similar lack of understanding of male patients' experiences (Thomas Peter, 2002). While research is limited, there are several hypotheses for why patients might find the transition difficult and some of these are listed below.

Change anxiety

Patients on trial leave are likely to experience anxiety in adapting to their new environment's regime, unfamiliar rules and social dynamics. For trial leave, patients are often transferred to wards focussing on new admissions and assessment. Other patients on these wards usually have less experience of psychiatric care and are nearer the start of their treatment pathway, which can result in more challenging behaviour as their mental disorder symptoms have not yet stabilised. This environment may be more chaotic than high secure wards, which may further exacerbate existing anxieties for transferred patients. Additionally, living on an admission ward could elicit feelings that they are 'starting again': having to re-earn privileges and retell their story while undergoing the process of assessment again, rather than continuing their progress in therapy (Tetley, Evershed & Krishnan, 2010).

Adjustment difficulties

Adjusting to the new ward's culture may cause further difficulties for patients on trial leave. For example, there may be easier access to potentially risky situations (e.g. illicit substances), reduced access to staff support and structured activity, and more emphasis on self-direction (Tetley, Evershed & Krishnan, 2011). It could be argued that psychosocial interventions offered in high secure hospital are less able to prepare patients to generalise and apply their learning in such potentially risky situations, partly because security restrictions limit what can be done and partly because staff have limited understanding of medium secure hospital culture.

Attachment

Attachment theory is a psychological model that aims to describe the dynamics of interpersonal relationships. Attachment is defined as a "deep and enduring emotional bond" that connects a care-seeker and a care-giver (Bowlby, 1969). In adults, a secure attachment acts as an "internal representation of security" and provides a secure and safe emotional base from which to explore the world (Holmes, 2001). Securely attached adults tend to be more likely to seek support when distressed and more able to alleviate insecurity (Simpson, Rholes & Phillips, 1996). Secure attachments are often

deemed to be a protective factor against vulnerability to mental disorder (Bowlby, 1988). However, the termination of a secure attachment is likely to result in feelings of loss. Adshead (1998) theorised that psychiatric services staff frequently become attachment figures for patients and separation from them can be distressing. The benefits to recovery of providing patients with secure attachments have been noted (Goodwin, 2003). However, on transition during trial leave, patients are unable to seek support from their established networks and attachment figures. Additionally, Mikulincer and Shaver (2007) found that people with mental disorders were more likely to have insecure attachment styles, so that secure attachments formed in high secure hospital may represent a patient's first secure attachments. Goodwin (2003) noted that repeating patients' patterns of insecure attachment and attachment loss is likely to be detrimental in the longer term. Barber, Short, Clarke-Moore, Lougher, Huckle and Amos (2006) noted a tendency for patients, on losing secure attachments, to disengage, and they noted that care staff often attributed this to treatment resistance. Goodwin (2003) recommended that service development be informed by attachment theory, but Bucci, Roberts, Danquah and Berry (2015) observed that little evaluation had been undertaken to assess how well mental health services, including forensic services, meet patients' attachment needs. .

Fear of failure and the diathesis-stress model

The diathesis-stress model describes how stressful life events can trigger an individual's vulnerability or predisposition to psychological disorder. For those with existing mental disorders, symptoms can be exacerbated by stress (Ingram & Luxton, 2005). Within this model, stress is seen as a life event or experience that disturbs the balance of a person's life; stressors can be discrete events or longer-lasting (Monroe & Simons, 1991). Transitioning to a medium secure hospital could be deemed a stressor according to the model as it represents forced significant change to the routine of daily life, disruption to social networks and it may include high levels of uncertainty in regard to the continued threat of failure and return to a high secure hospital. The process of trial leave is therefore likely to negatively impact upon patients' ability to manage their existing mental health problems, thus increasing the burden of managing the

transition. The model also suggests that stressors are more potent when fewer support networks are in place, as would occur when a patient is transferred to another hospital (Albrecht & Goldsmith, 2003).

Opportunities to engage in behaviours linked to risk

Policies across different institutions vary widely in their management of risky and challenging behaviour. However, overall, medium secure hospitals tend to be less restrictive than high secure hospitals (Bartlett, Mantovani, Cratsley, Dillon & Eastman, 2010). In addition, medium secure hospitals offer more access to the community, either directly through community leave, or indirectly through other patients' leave and their family. While increasing patient freedom and choice, this also represents a potential hazard in terms of offering more opportunities to relapse.

Among forensic patients in the UK, there is a high rate of historic substance misuse (Derry, 2008). Many of the patients transitioning from high secure to medium secure hospital are likely to have a history of substance misuse and this may be linked to their offending behaviour. The use of illegal substances within medium secure hospitals has been highlighted as problematic (Durand, Lelliott & Coyle, 2006). This suggests that patients moving from high secure hospital may find that illegal substances become more readily available than they have been used to, increasing the opportunities to relapse.

Similarly, when transitioning to a medium secure hospital, patients' access to the internet and other media would become less restricted, offering increased opportunities to access material concerning their offence-related interests, such as pornography (Jones, 2010).

Staff expectations

Patients may also be perceived as treatment resistant and harder to manage due to the stigma around being a 'high secure patient' (Williams, Moore, Adshead, McDowell & Tapp, 2011). This can result in staff and other patients focusing on negative behaviours and discounting their strengths, which can elicit negative responses from staff and patients.

Research into patient experience

One study investigated patients' experiences of transferring to medium secure hospitals. The patients identified five key difficulties they experienced during their transition: limited preparatory information before transferring; adjustment to the new culture; fear of high secure readmission; boredom; perceived lack of or limited gains (Tetley, Evershed & Krishnan, 2011).

Unfortunately, this study included all patients who had transferred to a medium secure hospital for trial leave, whether or not this was successful. Of the sixteen participants, only two were readmitted following unsuccessful trial leave. It seems likely that these patients had qualitatively different experiences of the process of trial leave than patients whose trial leave was successful, but the study did not discriminate between the groups.

Additionally, the study focused only on difficulties experienced by patients with a personality disorder diagnosis. The authors recognised that some elements of personality disorder might cause particular problems for patients coping with a transition to a medium secure hospital. They noted that such patients are perceived as harder to treat and manage, perhaps impacting upon clinicians' motivation to help them manage the transition. Conlin and Braham (2017) demonstrated that the outcomes following discharge from medium secure hospital care were different for patients with a personality disorder than patients with a mental illness. Patients with a personality disorder tended to have higher reconviction rates, while those with a mental illness had higher readmission and mortality rates. Therefore, it is highly likely that patients' experiences of transitions (discharge and trial leave) will differ according to their diagnosis.

Impact of unsuccessful trial leave

There is very limited research evidence about the experience of transitions between secure hospitals, but most authors agree that this is frequently experienced as difficult by patients and it is characterised by an increase in risk to self and others (Joint Commissioning Panel for Mental Health, 2013). For example, researchers from the University of Manchester (2016) found that the suicide rate for mental health patients almost doubled within their first three months following discharge from hospital.

Of the research on transitions, almost all of the studies relate to the experience of progressive transitions; moving to lower security hospital. There is even less research focussing on the experience of unsuccessful transitions or readmissions. In Machado, Leonidas, Santos and Souza's (2012) literature review regarding psychiatric readmission, they noted that patients' perspectives were "largely unexplored" in the research they reviewed.

Tetley, Evershed and Krishnan (2011) also gave little guidance regarding the needs of patients who were readmitted to high secure hospital and their experience of this. Often, many of the difficulties faced during trial leave continue after readmission to high secure hospital (Tavernor, Swinton, Collins, Brook & Beadle, 1998) such as change anxiety, adjustment difficulties, attachment and reattachment problems, coming to terms with failure and negative staff expectations. These difficulties are likely to be exacerbated by the way in which patients perceive their return to high secure hospital.

Expectations

There are a number of ways in which a patient might perceive an unsuccessful trial leave and readmission to high secure hospital. The nature of the experience of these events will depend on how they perceived them. The researchers' expectations of the way in which patients experienced such events was based on their clinical experience of working with patients in medium and high secure hospitals, and their knowledge of the psychological literature on theories of grief and loss, and the experience of failure and resilience. Acknowledging these expectations, bracketing, set the context for the researchers' interpretations and allowed researchers to track potential biases during data analysis.

Grief and loss

A failure of trial leave might be seen as a loss or bereavement if it is experienced as a "deprivation of something valuable" (Kubler-Ross, 1969). Most authors agree that grieving in response to a bereavement is a process that allows the bereaved person to adjust to their loss. Most bereavement theorists describe this as a phased process although they posit that people will move back and forth between some or all of the phases during their grief (Stroebe &

Schutt, 1999). Thus, the researchers in this study expect patients to describe struggling to accept the reality of the loss and that they might oscillate between 'acceptance' and non-acceptance. They expect patients might be 'searching' for the reasons for the loss or 'bargaining' regarding the responsibility for the loss (e.g. minimisation and denial) or its subsequent implications for them. The researchers in this study also anticipate patients will describe fluctuations in their emotional response to the loss, including numbness, hope, depression/pessimism and anger, before they 'restore' or 'reorganise' their lives (Bowlby, 1980; Kubler-Ross, 1969; Klass, Silverman & Nickman, 1996; Stroebe & Schutt, 1999; Worden, 1991).

Failure and resilience

The researchers in the current study anticipate that patients will experience unsuccessful trial leave as a personal failure. Research indicates that the experience of failure can result in significant psychological consequences and emotional distress, including low mood, guilt, shame, frustration, anxiety (Jones & Sheffield, 2007), and deterioration in cognitive functioning (Johnson, Tarrier & Gooding, 2008). On this basis, the researchers expect the patients will describe experiencing a range of negative emotions. However, a recent systematic review of resilience factors demonstrated that three psychological constructs could protect against emotional distress arising from the experience of failure: high self-esteem, external attributional style and low perfectionism (Johnson, Panagioti, Bass, Ramsey & Harrison, 2017). Therefore, the researchers in this study expect that patients will attempt to alleviate emotional distress resulting from the experience by using an external attributional style and seek opportunities to improve their self-esteem.

Rationale for the current study

The number of patients failing trial leave is high (20%; Tetley, Evershed & Krishnan, 2010). Trial leave failure may be due to inadequate assessment of patients' readiness to transition to medium secure hospital. However, research suggests that even successful patients experience difficulties during this process, and there is a recognition that the trial leave process itself may contribute to its failure.

The cost of failed trial leave is high, in terms of the impact of resulting challenging behaviour on staff and other patients, the psychological impact on the individual, and the financial cost. During trial leave high secure hospitals must keep a bed available in case of readmission. Trial leave usually lasts for six months. Based on 2008/9 figures, the cost to keep their high secure hospital bed available for this period is approximately £134,000. This is in addition to the cost of their bed in the medium secure hospital, which is £87,500 for six months (Durcan, Hoare & Cumming, 2011). The average stay of a patient in high secure hospital, following a 'failed' trial leave, is unclear. Thus, it is impossible to determine the additional costs that a 'failed' trial leave incurs.

There is a dearth of literature investigating the underlying difficulties faced by patients on trial leave from high secure hospital. Additionally, no research has focussed on the experience of patients who have failed trial leave. Similarly, there is little research outlining patients' experiences following unsuccessful trial leave and readmission to high secure hospital. Given the high cost of high secure hospitals, it is important to maximise the efficiency of preparing patients to move on again. During this preparation, clinicians must help patients make sense of their unsuccessful experience and address their outstanding needs so they can more quickly restart their rehabilitative journey. Additionally, understanding the impact of a 'failed' transition in this context, may shed light on patients' experiences of other unsuccessful transitions in other contexts.

Research is required into patients' experience of readmission to high secure hospitals, following trial leave in a medium secure hospital. From a service standpoint this is a failed trial leave, but from patients' perspectives it also represents a disruption to their recovery. For a richer understanding of patients' experiences of the breakdown of trial leave, it is necessary to explore patients' thoughts, feelings, perceptions and interpretations of the process and its consequences. This implies the need for qualitative methodology, as perceptions of an experience cannot be measured quantitatively. Qualitative methodology is designed to understand and represent people's experiences as they encounter real situations (Smith & Osborn, 2008). Interpretative Phenomenological Analysis (IPA) is one such methodology, which is particularly useful in developing understanding within poorly researched areas, where there are few or no existing hypotheses to test. IPA emphasises the importance of

each participants' interpretation of their experience in detail, and in context to their particular situation (Smith, Flowers & Larkin, 2009).

This study has taken an IPA approach. Five patients were interviewed, using a semi-structured interview, to investigate their experiences of their unsuccessful trial leave process, exploring their experiences before, during and after readmission.

The themes that emerged from the interviews add to the theoretical and empirical understanding of how patients experience trial leave failure. The themes also help to improve understanding of the factors underlying trial leave failure, and thus help to identify ways to improve the transition process and better support the patients and staff involved. The findings shed light on patients' continuing presentation, some aspects of which stem from the trial leave failure or from the readmission itself.

Method

Overview

The following section is an extension of the method section in the journal paper. It describes the methodology used to carry out the study. It outlines the rationale for the research methods used, and explains how the participants were recruited, the way in which the information was collected, and the process undertaken to analyse the information.

This study aimed to increase understanding of the experiences of patients who have been readmitted to a high secure hospital following unsuccessful trial leave to a medium secure hospital. The focus was on patients' experiences of readmission to high secure hospital and what implications they felt this would have on their future. It also explored patients' experiences of the lead-up to trial leave, their transition between hospitals and the benefits and problems they encountered during trial leave. The research question addressed was: what are patients' experiences of high secure hospital readmission following unsuccessful trial leave? In conducting this research, it was expected that the study would also improve understanding of why trial leave can sometimes be unsuccessful, and highlight patients' needs before and during trial leave, and following readmission to high secure hospital.

Qualitative and quantitative research

The relative value of qualitative and quantitative methods continues to be debated within social and medical research arenas. A key reason for the debate regarding the value of the two approaches, is that the methodologies and the thinking that underpins them have developed in contrasting ways. It is beyond the remit of this study to give a full historical description of the development of qualitative and quantitative methods. However, a brief summary is given here, outlining the philosophical underpinnings of the two approaches. A study's chosen mode of enquiry will depend on the nature of the research question and the ontological and epistemological position of the researchers.

Ontology and epistemology

Ontology outlines the researcher's perspective on the nature of reality. Epistemology focuses on what the researcher believes can be known. Quantitative methods are founded on the ideals of realism, empiricism and positivism and the notion that there is an external social reality, independent of the researcher, knowledge of which can only be acquired through direct observation. Information is gathered and coded in numerical form in order to verify or falsify pre-determined hypotheses (Guba & Lincoln, 1994). Data can then be subjected to statistical analysis, reducing its complexity so that findings can be generalised and replicated. Objectivity and hard evidence are valued and researchers are encouraged to avoid influences that might corrupt their analytical capacity (Bryman, 1988). Qualitative research methods have been criticised from this position. Their focus on non-numeric data means that findings are individualised or seated within the research context, and their interpretive nature contravenes ideals of objectivity (Pidgeon & Henwood, 1997).

By contrast, qualitative methods derive from idealist, interpretivist and naturalistic ideals and the view that knowledge of the social world is based on the interpretation of experience and the meaning ascribed to events rather than from basic empirical enquiry. Information collection focuses on participants' interpretations and experiences of the social world as well as the significance of the researchers own interpretations of the phenomenon under study. Self-determination is seen as a key element in guiding action so that participants' 'lived experiences' rather than simple objective facts, are explored to seek holistic explanations and connections between different aspects of their lives. Proponents of qualitative methodologies argue that the rigid adherence to objective quantifiable facts ignores human consciousness and the reality of human experience (Denzin & Lincoln, 2011).

Strengths and weaknesses of qualitative research

Elliott (1995) proposed the key purpose of qualitative research is to contribute to a process of revision and enrichment of understanding, rather than to confirm previous findings or theories. Qualitative research methods aim to capture and analyse people's expressions of their experiences, interpretations, beliefs, values, feelings, motivations and actions as they engage in, and

encounter natural situations (Elliott, Fischer & Rennie, 1999). They work to provide rich descriptions of complex phenomena by elaborating and interpreting the meaning that participants bring to events in a way that quantitative methods cannot (Sofaer, 1999). They are particularly concerned with learning directly from participants what is important to them, with giving voice to those whose views are rarely heard, and in moving towards explanations of events (Taylor, Bogdan & DeVault, 2016).

Qualitative research methodologies were developed to address some of the perceived limitations of traditional quantitative approaches: to “reach the parts other methods cannot reach” (Pope & Mays, 1995). At the same time, qualitative methods are distrusted by many because they often do not provide an easily generalisable foundation for policies (Jones, 1995). Some of this debate has been fuelled by the perception of the two approaches as mutually exclusive and in opposition to each other. However, more recent thinking has ascribed value to both approaches, with both methodologies offering potential contributions depending upon the nature of the specific research question, and has viewed them as complimentary (Seale, 1999).

The use of qualitative methods in mental healthcare settings has increased dramatically over the last decade. Perhaps noting that “complex questions require complex methodologies”, research councils now recognise the contribution of qualitative methods to the efficiency and effectiveness of service and intervention development (Peters, 2010). For example, qualitative research provides the vehicle for exploring how general research findings are best applied to individuals or specific contexts, or in understanding individual factors in wider systemic phenomena (Palinkas, 2014).

However, because qualitative research is open to criticisms in terms of reliability, validity and generalisability, the best qualitative research is systematic and rigorous in seeking to address bias and error (Sofaer, 1999). Many specific systematic methods of analysis are available to the qualitative researcher. Best practice suggests that the choice of methodology should be determined by the research question and type of data collected but is also based on the philosophical approach underlying the study.

Rationale for using a qualitative methodology

The literature on the discharge process between secure hospitals that is outlined above provides a breadth of understanding relating to the efficacy of the process, its challenges and patient suitability to transfer. However, much of the research has employed quantitative methodology which fails to elaborate the patients' lived experiences of their transition (Wallace, 2012). Non-completion of trial leave has been investigated focusing on the reasons given by returning medium secure hospitals (Tavernor, Swinton, Collins, Brook & Beadle, 1998). The research highlighted the external factors linked to readmission, but was unable to explain the underlying factors behind patients' presenting behaviours, nor did it describe the lived experience of patients undergoing this process. One thematic analysis study did investigate patients' experiences of transfer (Tetley, Evershed & Krishnan, 2011) but the study was limited to patients with a personality disorder diagnosis and did not distinguish between the experiences of patients who successfully completed trial leave, and those who were unsuccessful, who may have had qualitatively different experiences of the process.

To gain a greater understanding of patients' subjective experience of unsuccessful trial leave, a methodology that would capture the depth of participants' experience and of the meaning attributed to the process was required. Quantitative methodology would not have provided the opportunity for patients to explain what was important and meaningful to them. A qualitative framework was deemed more appropriate for this objective.

Types of qualitative research

There are a number of different qualitative research methodologies, each informed by different, but sometimes overlapping, epistemological positions. Miles and Huberman (1994) outline three basic approaches to qualitative methodology. Collaborative social research is used by action researchers in partnerships comprising different and sometimes opposing, organisations, which was not relevant to this research. Social anthropological approaches seek regular patterns from detailed information, looking to refine these patterns into categories so that underlying theories can be tested. If researchers aim to present a holistic view of the data rather than seeking to categorise it,

interpretive approaches, which are phenomenological in nature, tend to be used.

One example of a social anthropological approach is grounded theory (GT), developed by Glaser and Strauss (1967). GT explores participants' personal experiences as a means to construct theory (Charmaz, 2008). It is founded on positivist and interpretative theories, and is systematic in its approach. The current research aim was to increase understanding of the unique lived experiences of patients who have been unsuccessful in completing trial leave, rather than to develop a theory around why this occurs. Thus, GT was not seen as an appropriate methodology for this research.

Four interpretative approaches are commonly used: discourse; narrative; thematic and interpretative phenomenological analyses. Discourse Analysis (DA) is based on a relativist ontology and allows multiple constructed realities. DA's methodology has evolved into several different subtypes, all of which examine the language used by participants. There is an underlying assumption that language is used by individuals, in a given context, to construct a version of their social world, rather than to simply reflect their understanding of it (Willig, 2015). As a result, DA was not seen to fit the objective of the research, which was to explore how participants made sense of their experiences of unsuccessful trial leave and the meaning they ascribed to it, rather than the language they used to elaborate this.

Narrative Analysis (NA) works to understand how individuals develop and use stories to make sense of the world (Lawler, 2002). The analysis is concerned with how people link events, sequentially or otherwise, to construct meaning and bring order to their world (Riessman, 2005). However, NA works best with finite events, which once ended can be constructed into a narrative. Whilst "failing" trial leave might be seen as a finite event, the causes, impact and implications are considered to be an ongoing process, so that the individual's story is not complete. As a result, NA was not deemed to be the most useful approach for this research.

Thematic Analysis (TA) works by identifying patterns and themes within collected data, usually using a coding scheme (Braun & Clarke, 2006). Smith (2015) argues that TA does not stem from a particular philosophical standpoint, and as such it can be used within research which takes a realist, critical realist

or relativist ontological position. Researchers can use TA methodology flexibly. A deductive approach can be used to test theories or hypotheses, while an inductive approach offers a more exploratory investigation. Semantic TA focuses on the form and meaning of the data, using verbatim accounts, whereas a latent TA approach requires the researcher to interpret ideas and meanings underpinning explicit statements. Descriptive TA aims to describe and summarise themes within the data, whilst interpretative TA goes deeper than this to elaborate meaning and ascribe importance (Clarke, Braun & Hayfield, 2015). While a range of approaches are available within TA, unlike IPA none of these acknowledge the explicit impact of the researcher's interpretations on the analysis of the data, nor the impact the researcher might have on the participants' responses. Since so little is known about patients' experiences of trial leave and unsuccessful trial leave, it was particularly important to minimise, or at least acknowledge, the impact of the researchers' biases and beliefs on the data gathered. Thus, TA was not deemed to be the most appropriate methodology for this research.

Researchers' ontological and epistemological position

From an ontological perspective, the researchers took a social constructionist stance. Individuals were not seen as passive perceivers of an objective reality, but as beings who interpret and understand their world by constructing meaning from events. There may be stable and enduring features that make up their underlying reality, but the researchers acknowledge that there might be many different meanings associated with this reality (Fade, 2004).

Epistemologically, the researchers took a critical realist position, which assumes that individuals perceive events in a unique way, mediated by thoughts, expectations and beliefs, shaped from previous experiences (Willig, 2015). The researchers also accept that their own previous experience will influence their interpretations of collected data and impact on the research findings.

Interpretative Phenomenological Analysis

The study employed Interpretative Phenomenological Analysis (IPA) as a research methodology. IPA, developed by Smith (1996a), aims to offer insights into how a participant, from a particular perspective, in a given context, experiences a given phenomenon. It requires participants to reflect subjectively on their "lived experience" of the phenomenon, and involves researchers in interpreting these reflections.

IPA is grounded in phenomenology (the detailed study of conscious experience) and hermeneutics (the study of interpretation) and it takes an idiographic perspective (Smith, 2015). From a phenomenological standpoint, IPA is concerned with participants' subjective reports rather than the search for an "objective truth" (Flowers, Hart & Marriott 1999). Participants' expressed perceptions are seen as a function of their relationship with the world: constructed by their culture, history and the context in which they live their lives. Understanding this is perceived to be fundamental to understanding the meaning of their expressed perceptions. Thus, any attempt to research and interpret participants' experiences must be approached in a flexible and open-minded way.

IPA is based in social constructionism, in that it assumes that all participants have an equally valid view of reality (a valid personalised experience) which the process attempts to interpret and represent. It also acknowledges that different researchers might interpret different meanings from the findings, and accepts that these differing views are all valid.

A key issue within IPA is the "double hermeneutic" which describes how the final identified themes result from researchers' interpretations of participants' expressed experiences. IPA acknowledges that accessing and interpreting participants' "personal world" depends on and is influenced by the researcher's own conceptions. Researchers must be aware of their own conceptions and consider how these influence data collection and interpretation. However, IPA accepts it is impossible for researchers to fully put aside their own perspectives. It assumes that by remaining aware of their values and conceptions, and how these might influence data collection and interpretation, researchers can understand and represent participants' experiences more accurately than otherwise possible. It is accepted that the final analytic account produced is

based on the joint reflections of both participant and researcher (Osborn & Smith, 1998).

Rationale for using IPA

IPA has been seen as having particular utility within the arena of health and mental health (Smith, 2015) and most published studies using IPA have been within this field. This may reflect a rejection of simple biological models of disorder which assume that symptoms or psychological reactions map onto the experience of events in a predictable and uniform way. Within psychology there is a long tradition of seeking to understand how people construe the world and how these personal constructions are used to make sense of new phenomena (Claxton, 1996). Over the last few years there has been a growing recognition that research methods need to reflect the clinical understanding that symptom patterns, and psychological responses in particular, are constructed in their nature and based on the meanings that individuals ascribe to them. Thus, the importance of using methods to explore participants' perceptions and interpretations of their experiences has begun to be recognised (Johnson, Burrows & Williamson, 2004).

However, it is also understood that these theories may not be known or directly accessible to the individual: that they are implicit. This presents a challenge for the research method as if these theories exist at an implicit level they have to be discovered or made visible before they can be scrutinised (Sternberg 1990). Research methods need to be able to reveal the participants thinking, but also need to be able to make inferences and extract meaning from participants' constructions.

It can be argued that IPA, a method that focuses on exploring in detail how participants make sense of their world through interpretation of their accounts (Smith & Osborn, 2008) is well suited to exploring these subjective experiences, and works to describe and understand the participants' "lived experiences" of their difficulties. IPA's use of subjective and reflective processes of interpretation can lead to rich and detailed accounts. This makes it especially useful when exploring the meaning of complex and new or uncommon phenomena that are hard to explain (Smith, 2015)

Readmission to high secure hospital following unsuccessful trial leave to a medium secure hospital is a complex and relatively rare process which involves short term changes and potentially longer-term implications. Patients' responses to the process can be variable, and likely depends on their interpretations of the lead-up to and experience of trial leave, and their understanding of the implications of their return. IPA methodology offered the opportunity to explore their lived experience of the process and their subjective reflections on the process as a means of developing our understanding of the phenomenon.

Critique of IPA

Despite IPA being chosen for the research as the most appropriate methodology, there remain some limitations in using IPA. Smith (2004) noted that researchers new to qualitative methods frequently shy away from in-depth interpretative analyses, tending to limit their accounts of the findings to descriptive social comparisons. This may be in part because researchers more used to positivist, empirically-grounded research designs are wary of stepping away from hard evidence and objectivity (Biggerstaff & Thompson, 2008). To a degree, this difficulty can be overcome by novice researchers accessing supervision and guidance from supervisors experienced in using IPA, particularly during analysis.

The depth of the findings is also likely to be limited by the extent to which the participants are willing and able to access their thoughts, expectations and beliefs about events, and the degree to which researchers are able to facilitate verbalisation of these. However, the use of semi-structured interviewing within IPA allows for the use of prompts and questioning. This flexibility offers the opportunity for the researchers to probe participants' accounts in more depth, and should enable more access to underlying meaning.

The impact of the researchers' own beliefs and preconceptions, and the participants' perceptions of the researchers, will inevitably impact upon the accuracy of participants' original accounts (Smith, 1996b). IPA methodology accepts, but requires transparency about, the contribution of the researchers' experience to the interpretation of meaning, and promotes the notion of trustworthiness (Koch & Harrington, 1998). It is also clear that any meanings

and interpretations of these must be directly linked to participants' verbatim accounts. To promote scientific rigour within the research, along with the use of patterns and themes inferred from participants' responses, IPA promotes the use of participants' direct quotations to substantiate these interpretations.

Participants' accounts need to be understood within the context of the research process. The impact of a mental health professional as interviewer may also influence accounts. Especially within this particular research context, the participants, who are detained, may make assumptions about the researchers' role and influence over their clinical team. The researchers acknowledge that there is an increased likelihood of positive impression management, as a means for participants to progress more quickly along their care pathway. However, fundamentally IPA researchers accept participants' accounts as reliable and valid, within the context of the research.

Generalisation of IPA research findings is limited by its idiographic nature. Findings tend to be "subjective, intuitive and impressionistic", making it hard to determine the relevance and importance of the different themes (Malim, Birch & Wadeley, 1992). However, proponents of IPA have recommended that themes that are consistent and common across accounts are likely to hold more relevance and importance, and have wider implications (Reid, Flowers & Larkin, 2005). IPA researchers are encouraged to focus on theoretical instead of statistical generalisation of their findings (Johnson, 1997). IPA researchers aim for the themes derived from their studies in one particular context to offer insights and prove useful in similar contexts, but not be replicated. Another advantage of using IPA methodology is that it requires in-depth exploration of experience within the interviews, which allows for the discovery of richer and deeper meaning.

Although IPA has weaknesses, it's relative strengths lead it to being chosen as the most appropriate methodology to answer this study's research question. The research question aimed to explore the lived experience and meaning attributed to unsuccessful trial leave. A phenomenological approach, such as IPA, offered the most appropriate methodology to examine this.

Procedure for selecting participants

Participants were recruited from one of the high secure psychiatric hospitals in England. Based on research into the pathways in and out of this hospital, including discharge and readmission rates, it was estimated that approximately twenty patients would meet the study's inclusion criteria (Nicoll, 2012). Similar research has attained a 45% participation rate (Tetley, Evershed & Krishnan, 2011), thus a similar rate of consent was anticipated among people who met the inclusion criteria, which would yield a sample of nine potential participants.

Smith, Flowers and Larkin (2009) recommend doctoral studies using IPA should interview between four and ten participants, emphasising that "less is more", and recommending that the subject sample is homogenous. Thus, the lead author interviewed five patients.

Inclusion criteria

For inclusion in the study, patients must have been detained at the chosen high secure psychiatric hospital and transferred to a medium secure hospital on trial leave, but readmitted to the high secure hospital when this trial leave was unsuccessful. The readmission must have occurred within the last five years; an arbitrary cut-off determined for two reasons. Firstly, a short period was necessary to maximise the accuracy of patients' recollections of their experiences. Secondly, given the relatively small number of patients readmitted to high secure hospital, a five-year cut-off provided a viable number of potential participants.

In addition, eligible participants would be:

- Male.
- Able to speak English fluently.
- Able to provide informed consent to participate (determined by their psychologist).
- Able to reflect on their experiences in terms of cognitive ability, memory of the experience and mental lucidity.
- Unlikely to suffer undue harm as a result of the interview (determined by their psychologist).

This hospital admits male and female patients aged between 18 and 80, who have a mental disorder, and are deemed to pose a grave danger to the

public. Therefore, all participants were within this age bracket. For this study, only male patients were recruited due to the differences in the pathway for female patients, for example, the number, location and types of secure hospitals available. These differences were deemed likely to impact differently on their experiences and therefore different themes may have emerged from their interviews.

Participants were recruited by asking all psychologists at the hospital to identify suitable patients under their care, based on the above inclusion criteria.

Exclusion criteria

People were excluded from participating in the study if they had not been readmitted to this high secure psychiatric hospital, within the last five years, following unsuccessful trial leave at a medium secure hospital. Due to the hospital only admitting patients between 18 and 80 years old, participants were not younger than 18 years old or older than 80 years old. As explained above, females were excluded from this study. Patients were excluded from this study if they were:

- Female.
- Unable to speak English fluently.
- Unable to provide informed consent to participate (determined by their psychologist)
- Unable to reflect on their experiences in terms of cognitive ability, memory of the experience and mental lucidity.
- Likely to suffer undue harm as a result of the interview (determined by their psychologist).

Due to data protection and confidentiality, the researchers were not allowed access to the names of any patients at the hospital, until the patients consented to this. For this reason, participants were recruited by asking all of the hospital's psychologists to identify suitable patients from their caseload, based on the inclusion criteria. The ability to provide informed consent to participate was one inclusion criterion, thus the psychologists decided this. The psychologists were asked to give each of the identified patients an information sheet about the

study (Appendix 1) and a consent form (Appendix 2). If patients wished to consent to participate in the study, they were asked to return their consent form to their psychologist. The psychologist witnessed them signing the consent form. The researchers collected completed consent forms from the psychologists. This process of gaining consent is common practice when conducting research within secure hospitals.

The psychologist informed the potential participants of all aspects pertaining to participation in the study. It was explained that entry into the study was entirely voluntary and that their treatment and care would not be affected by their decision. The psychologists ensured that all of the potential participants had sufficient time to consider participating or not. The psychologists also gave the researchers' contact details to the potential participants so that they could answer any questions concerning study participation.

Data collection procedure

Once the researchers had received potential participants' consent forms, demographic information was collected for all potential participants, from their clinical records, and recorded on a proforma (Appendix 3). This information included: age, mental disorder diagnosis, index offence, admission date to high secure hospital, date of trial leave, trial leave location, and readmission date to high secure hospital. It was planned that this information would be used to generate descriptive statistics and inform participant selection, so that participants to be interviewed would be chosen on the basis of homogeneity.

The researchers received only five completed consent forms, all from patients within the personality disorder directorate. The psychologist informed the researchers that only one patient from the mental health directorate met the inclusion criteria for the study, but he did not wish to participate. Thus, all five patients who consented to participate were selected for interview.

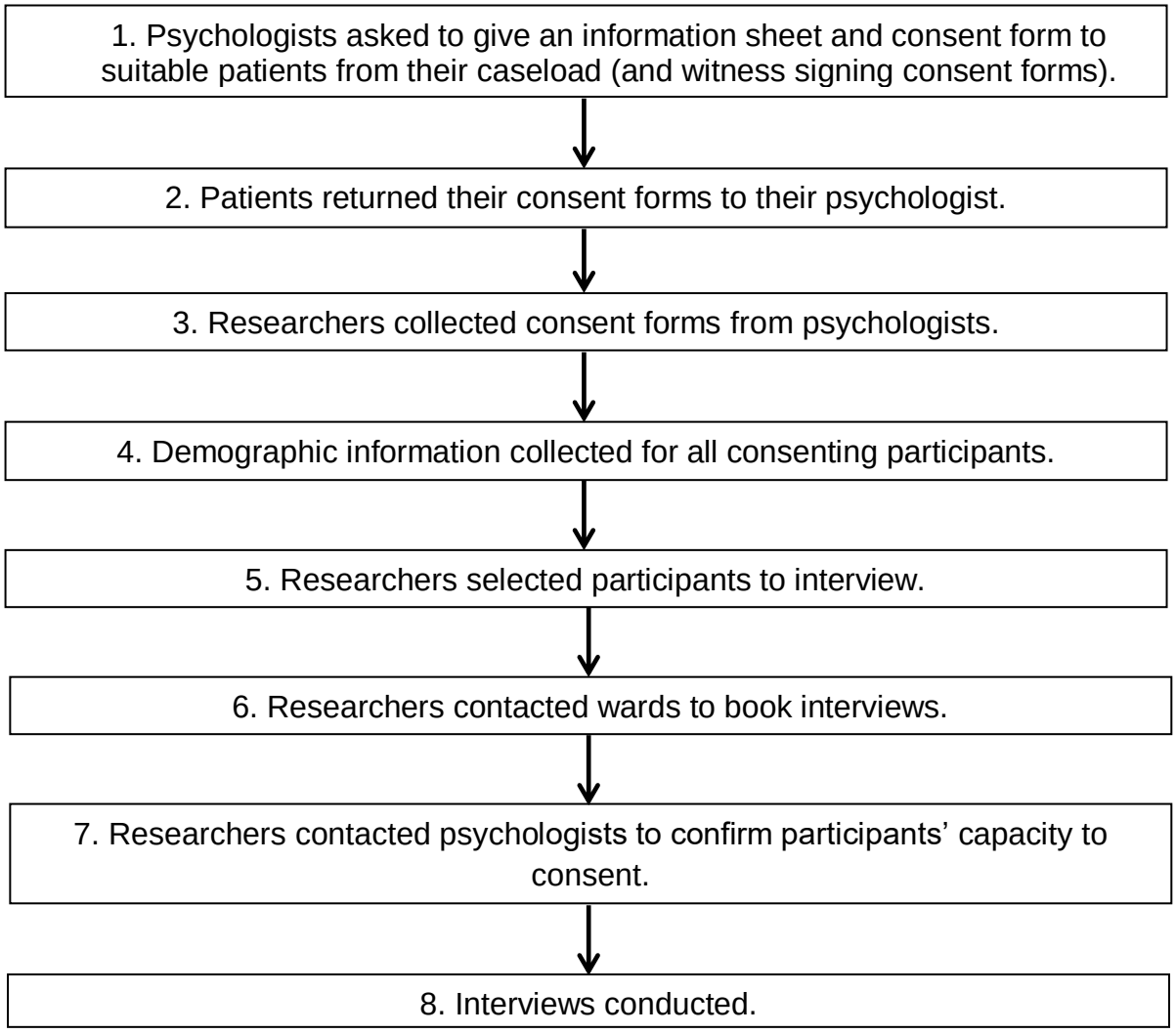
These participants were contacted via their ward to arrange an interview. Between booking and conducting each participant's interview the researchers spoke to their psychologist to confirm that they still deemed them to have the mental capacity to consent to participate.

Participants were interviewed in a room on or near the participant's ward, by a trainee clinical psychologist, with a researcher from the hospital present for

the safety of the researcher and the participant. The researcher was independent of the participant's care.

A semi-structured interview was conducted, focussing on their experiences as outlined above. This method was chosen as it is recommended as the best methodology for IPA data collection (Smith, 1996a). The interview schedule (Appendix 4) comprised open questions and prompts and all participants were asked all questions. The interview schedule was used flexibly, to guide questions and prompt response so the interview was as non-directive as possible. In keeping with IPA methodology, the questions were designed to elicit perceptions, experiences and interpretations, rather than descriptions (Pietkiewicz & Smith, 2012).

Figure 1: Flowchart of recruitment process.



The interviews lasted approximately two hours each and were audio-recorded using a dictaphone. The interviews were transcribed by two hospital administrative workers onsite to preserve participant confidentiality and minimise the amount of identifiable data being taken off the hospital site. This is common practice when conducting research within this hospital, as some patients have a high media profile and are easily identifiable. The transcribers also signed a confidentiality agreement (Appendix 5). This process was agreed with an administrative manager at the hospital. The recordings and transcripts were retained in the study archives, and personal identifiers removed.

Once the study was complete, participants were sent an information sheet summarising the research findings.

Demographic information

On interview, the five participants ranged in age between 24 and 53. They all resided on wards based within the Personality Disorder Service within a high secure hospital and were diagnosed with at least one type of personality disorder. Two participants also had comorbid mental health diagnoses. They were detained under a range of Sections of the Mental Health Act (2007). Two participants' index offences were sexual in nature and two participants' were violent. One participant had no formal index offence and thus was detained under a Section 3. Before their trial leave began, the participants had been detained in high secure hospital for an average of 57.2 months (4 years and 9 months), ranging between 16 and 101 months. None of the participants had previously been on trial leave. The participants had been living in high secure hospital again following their failed trial leave for an average of 36 months (3 years), with a range of 9 and 59 months.

Informed consent

All participants provided written informed consent before their inclusion in the study, by signing and dating the consent form, and ticking all relevant boxes, to indicate they understood the details of what was required. One copy of this was kept by the participant, one by the researchers, and a third retained in the patient's hospital records. The process for obtaining participant informed consent was in accordance with Good Clinical Practice and Research and

Ethics Committee (REC) guidance. The decision to participate in the study was entirely voluntary, and the researcher emphasized this to participants, and that consent regarding study participation could be withdrawn at any time without penalty or their future care being affected, or loss of benefits to which the participant would otherwise be entitled. Participants were informed that the researchers were external to their care providers, with no power to impact on their care.

It was explained to participants that they could withdraw from the study at any time but attempts would be made to avoid this. They were informed that if they withdrew before or during their interview, the interview would be terminated and the information collected up to that point would not be included in the study. However, if they declined to attend their interview or the interview was disrupted, another interview would be offered. Participants were made aware (via the information sheet and consent form) that if they withdrew from the study after they had been interviewed, the data collected to date could not be erased and may still be used in the final analysis. Participants who withdrew consent were replaced in the study. Participants were deemed to be complying with the study if they completed a full interview, allowing the researchers to ask all of their questions and providing answers. If participants did not comply with the study regime, they were replaced in the study.

Participants were not paid and were unlikely to benefit otherwise. Study participation was not cognitively challenging or complicated, and no long-term repercussions were expected to affect participants as a result of this study. However, the researchers were aware that due to the potentially sensitive nature of the experience discussed, participants could have found some aspects distressing. The researchers were sensitive to this, particularly during the interview, and showed the participants empathy and understanding in order to minimise their distress as much as possible. Following the interview, participants were advised to speak to a member of staff, perhaps a named nurse/keyworker, if they found the experience distressing.

The researcher also explained confidentiality policies and ensured the participant understood these. They explained, on consent forms and prior to interviews, that anything the participant disclosed would remain confidential within the research unless the researchers felt there was a risk of harm to the

participant or other people. They were told that, in this case, this would be discussed with the participant before reporting the risk to the appropriate agency. However, due to the presence of a staff member during interviews, confidentiality could not be guaranteed and the researchers made participants aware of this before the interview.

The researchers endeavoured to protect participants' rights to privacy, and adhered to the Data Protection Act, 1998. Confidentiality was maintained on study forms by assigning each participant a participant study number, used alongside their date of birth. Study forms collected the minimum information required, and were treated as confidential documents. They were held securely in accordance with regulations, in a locked room within the hospital. In order to allow for identification of participants, a record was made of participants' names, dates of birth, NHS number and participant study number, and held separately. Access to study documentation and computer-held data, including the interview audio-recordings, was restricted to the researchers and regulatory authorities. Computer-held data were held securely and password-protected.

Ethical approval

The study did not begin until the protocol and all study documents had received approval from the Research Ethics Committee (REC; Leicester South panel) and National Health Service (NHS) Research and Development (R&D) department (Appendices 6-9). The study was conducted in accordance with the ethical principles originating in the Declaration of Helsinki, 1996; the principles of Good Clinical Practice, and the Department of Health Research Governance Framework for Health and Social Care, 2005.

Data analysis procedure

All data analysis was completed on the hospital's computers to preserve patients' confidentiality.

Demographic information has been presented. Interview transcriptions were analysed using IPA as described by Smith, Flowers and Larkin (2009). The lead author systematically analysed each interview in turn, beginning by reading the transcript several times to promote "immersion" in the narrative and to become familiar with the material contained within it. The researchers simultaneously

numbered each line of the transcript to enable later cross-referencing and checking of the validity of the interpretations.

Once the material was familiar, the detailed analysis commenced (see Appendix 10 for an example). Initially, objects and descriptors were identified to structure the data. Then, preliminary interpretations and ideas that emerged relating to the participant's experience were noted within one margin of the page. The transcripts were re-read to generate initial themes that outlined a summary of the data. Each transcript was reviewed twice before the next transcript was begun.

Themes from the remaining transcripts were compared to those from the first transcript to identify further instances of these themes, contradictory themes, related themes and additional themes. Participant quotations were recorded verbatim alongside the related themes. The themes were checked against the original text to check the validity of the interpretations. The themes were then analysed, and similar themes were clustered to produce a list of superordinate themes which integrated the data from across the transcripts. These were recorded in a coherent order on a separate page. For each superordinate theme, examples from the transcripts were recorded with a line reference to the text.

The researchers kept a reflective diary to enable them to note their reflections throughout the research process. This aided their consideration of their pre-existing theoretical and personal preconceptions, and how these might have influenced their interpretation of the participants' experiences. The diary also included notes and observations which alluded to the findings in the literature review, questions about the methodological process, and perceptions about the congruence of participants' verbal and non-verbal communication while recounting their experiences. Detailed notes of the themes emerging from each step of the analysis were also noted in order to provide an audit trail. This was consistent with good practice of IPA.

Dissemination

Participants were sent an information sheet summarising the research findings once the study was completed. The research has been submitted as a requirement of the Trent Doctorate in Clinical Psychology. The researchers will

submit it for publication in a scientific journal in 2018 and may disseminate the findings at conferences. Participants will not be identifiable in publications.

The total cost of this study was £500, which was funded by Health Education England.

Quality assurance measures

In line with good practice of IPA, various quality assurance measures were employed. Due to the subjective and idiographic nature of qualitative research methodologies, different approaches to quality assurance have been developed, with the aim of increasing the credibility of the findings. The epistemological basis of qualitative methodologies means that trustworthiness, rather than reliability and validity, is used to establish quality (Koch & Harrington, 1998). For this study, Yardley's (2015) four quality criteria were employed: sensitivity to context, commitment and rigour, coherence and transparency, and impact and importance. Sensitivity to context occurs when researchers demonstrate that they have used qualitative methods to explore new topics and create new understanding (Camic, Rhodes & Yardley, 2003). In order to demonstrate a study's validity, researchers need to show that they have undertaken an analysis with sufficient breadth and depth: with commitment and rigour (Yardley, 2000). The coherence of a study relates to its consistency as a whole. Transparency refers to the ease with which a reader can understand exactly what was done and why. Research is undertaken to make a difference. The impact and importance of a study refers to the practical or theoretical implications that arise from it. The following steps were taken to adhere as closely as possible to Yardley's criteria, and to convey trustworthiness.

Supervision

The lead researcher accessed regular supervision from experienced IPA practitioners throughout the course of the study, particularly during the data analysis. This was especially important as she had not undertaken a large qualitative research study previously. Supervision aimed to increase the credibility and consistency of coding, and the depth of the interpretations made (Smith, 2015). Whilst accuracy and objectivity were not the focus of data

analysis, the supervisors ensured that the analysis was embedded within direct participant quotations, and that interpretations reflected the original accounts.

Reflexivity

As an interpretative approach in which the findings are based on the researchers' interpretations, IPA requires researchers to reflect on their preconceptions, beliefs and decisions, and make these explicit to the reader. This makes the process auditable, and allows the reader to understand why and how decisions were made, and determine whether the findings are trustworthy (Baxter & Eyles, 1997).

Throughout the research, the researchers kept a reflective diary to reflect on the research process at the different stages of the study, elaborating researchers' expectations, preconceptions, observations and challenges. The diary was begun during the planning of the study, before the interviews were undertaken. Researchers contributed to the diary at each significant event within the study process, particularly following interviews, during transcriptions and analysis. The diary was later used in accordance with Yardley's (2000) criteria to evidence transparency and coherence.

Dependability through audit trail

Smith, Flowers and Larkin (2009) emphasised the importance of adhering to IPA's systematic process, in order to ensure scientific rigour. Details of the procedure and analysis, and all decisions relating to these along with rationale, were logged to establish an audit trail, in order to increase transparency, coherence and dependability. The audit trail was necessary to ensure the study was scientifically rigorous and the findings were trustworthy (Denzin & Lincoln, 2011). It was hoped that this would increase confirmability (Lincoln & Guba, 1985) and allow replication of this procedure, and theoretical transfer of the findings to different populations in different contexts.

Theoretical transferability

Theoretical transferability is the ability to apply the data within a different context or population. To increase transferability, themes that were elaborated

in each interview were checked and compared against themes emerging from other interviews, to establish consistency and commonality.

Declaration of lead researcher's perspectives

The lead researcher was a female trainee clinical psychologist in her mid-twenties, who used cognitive-behavioural models in her clinical practice, informed by other psychological models and theories (e.g. attachment). She had previous experience of working in forensic services, including high and medium secure psychiatric hospitals, which is likely to have influenced her preconceptions about the participants and their experiences. She was aware that the problematic presentation of secure hospital patients sometimes stemmed from their vulnerabilities rather than their risks. She had noted that medium secure hospital providers were often wary of facilitating trial leave for high secure hospital patients, perceiving them as clinically complex, harder to treat, difficult to manage, and having the potential to be very risky and disruptive. Consequently, she was aware that these patients were often required to demonstrate lengthy periods of stable behaviour before they were considered for admission, and they were often admitted onto wards with patients whose mental state and behaviour was much less stable. As a result, she had seen trial leave patients struggle with this process.

Critics used to a positivist model might argue that this experience reduced the researcher's objectivity during data collection and analysis. However, IPA's double hermeneutic stance means that it does not seek objectivity. Rather, it values trustworthiness through transparency of decision-making. IPA acknowledges that the researcher's different perspective of the phenomenon being studied might result in deeper and richer meaning and interpretations, increasing theoretical sensitivity (Glaser, 1978). One of the key reasons for using the reflective diary was for the researcher to log expectations and assumptions related to her experience.

Interview process

All of the interviews were conducted by the same lead researcher to ensure consistency of interviewing style. The interview questions were designed to be as clear as possible, omitting jargon and complex grammatical structure.

Questions were developed to avoid biasing responses, and were open and non-leading. The interview schedule was piloted with a co-researcher with experience of conducting IPA studies, to reduce ambiguity and increase ease of understanding. Participants were asked to answer questions with as much detail as possible, outlining their own unique experiences.

Familiarisation with trial leave process

While the lead researcher had experience of working in secure psychiatric hospitals, some details of the trial leave process were unfamiliar to her. While planning the study, information was sought from the hospital's consultants and managers to learn the relevant details of the process. This allowed her to better understand the context of participants' verbalised experiences and the technical language used, in order to increase responsivity during the interview.

Credibility and transparency

The credibility of the data, as representative of participants' first-hand accounts, was established through the inclusion of direct quotations. This allowed readers the opportunity to develop their own view regarding the credibility and validity of the themes and interpretations identified (Elliot, Fischer & Rennie, 1999). This also increased the transparency of the interpretations made by the researchers.

The credibility of the participants' accounts in reflecting the true reality they had experienced could be queried if participants used the interview as an opportunity to promote their own agenda. In conducting the analysis, the researchers noted any inconsistencies, contradictions and incongruences during the interview, including non-verbal behaviours. Nonetheless, in the final analysis they accepted that this was a possibility and part of the participants' reality.

Participant transcription checks and validation

Lincoln and Guba (1985) suggest that the accuracy of the findings and the validity of the researchers' interpretations can be increased by asking participants to read and confirm the content of transcriptions. In this study, participants were asked to review their completed transcription and amend or

confirm it as they saw fit. However, participants were not asked to review the interpretations made from their (and others') transcriptions because of ethical limitations. Koch and Harrington (1998) noted that even if participants disagreed with the researchers' interpretations, they may still be valid since from a critical realist stance, multiple realities and meanings can exist. Also, in reviewing the researchers' interpretations, participants would have access to meanings derived from other participants' accounts, and their own interpretation might change between the interview and reviewing the transcription and interpretations. This would leave the researchers having to decide which of the interpretations is more valid.

Triangulation is another method of validating interpretations made. It seeks to cross-check information from different sources, and is used to check validity and reliability of the qualitative analysis, and corroborate interpretations made by the researchers (Olsen, 2004). However, from a critical realist epistemological position, multiple perspectives of reality can exist and the study did not aim to describe one single or objective truth. Thus, it is inconsistent with the double hermeneutic which is central to the IPA process (Madill, Jordan & Shirley, 2000). Triangulation was not undertaken in this study.

Impact and importance

Clinical implications were identified from the interpretations of the data. These could increase the understanding of clinical teams and service managers, as they implement trial leave processes, to increase the likelihood of success and to support patients who return from unsuccessful trial leave. The findings are likely to have relevance for patients in different levels of security as they approach discharge or transition to another hospital.

Results

Overview

The following section is an extension of the results section in the journal paper. A number of interconnected themes were identified from the analysis of the interview transcripts, which are summarised in Table 2. Smith (2011) noted that it is often more useful to describe a small number of themes at a deeper level rather than attempting to review all of the findings at a more superficial level. Thus, four themes have been elaborated below. Pseudonyms have been used to preserve the participants' confidentiality.

Table 2: Superordinate and subordinate themes identified from the data analysis.

Superordinate themes	Subordinate themes
I lost my safe attachments.	- My strong high secure hospital attachments ended abruptly. - Medium secure hospital offered me unsafe alternative attachments.
My trial leave experience was like my previous traumatic experiences.	- My trial leave process was abusive. - The abusive experience felt familiar to me.
The needs of the trial leave system overrode my needs.	- My needs weren't met. - I had to take responsibility for my trial leave failure. - Prioritising the system's needs affected my self-concept.
I was stigmatised because I came from high secure hospital and had a personality disorder diagnosis.	- I was misperceived as risky and treated as high risk. - I had different needs to medium secure hospital patients. - My vulnerabilities were overlooked.

1. I lost my safe attachments.

Participants all described attachments to various aspects of, and people in high secure hospital, including staff, the environment and routines and rules. Moving to a medium secure hospital from their high secure hospital required participants to leave their known staff team, to make new relationships and to adapt to living according to the different rules, regimes and procedures in their new environment.

Within this theme, two subordinate themes were identified as impacting on the level of difficulty experienced by the participants on transition. The first was the quality of their previous attachments within high secure hospital and the abrupt severing of these, and the second was their replacement in medium secure hospital with alternatives that they perceived as less safe. These are discussed below, along with the impact it had on the participants and their trial leave experience.

a. My strong high secure hospital attachments ended abruptly.

All the participants noted that they had good and trusting relationships with some of their high secure hospital staff and felt safe and contained in a known and predictable hospital environment. Participants knew the rules and procedures, understood the reasons for them and what was expected of them. These elements were lost when the participants went on trial leave to an unknown and therefore unpredictable environment. Robert's comment illustrates the importance of predictability and consistency in promoting a sense of safety within a hospital environment.

> "People get into routines, I was in a routine, I knew how things worked in [high secure hospital], I was comfortable with the regime in [high secure hospital]. To a certain point I felt safe with the staff, I didn't feel they'd ever do anything to hurt me" (Robert).

Participants also described the trusting relationships they had built with high secure hospital staff, in which they felt safe enough to disclose vulnerabilities and risky thoughts, feelings and behaviours. Participants' view of high secure

hospital staff was that they were consistent, reliable, understood their needs and had their best interests at heart. These perceived qualities allowed them to seek help when they needed it to manage their mental health difficulties and risk.

> "You can talk things out here [high secure hospital]…you could say to staff listen I feel like you're fucking bugging my room…they're not thinking wow this guy is going to fucking try and kill someone…these people understand that you talk to express your emotions" (Chris).

> "[High secure hospital] recognised a lot of my problems that other hospitals don't recognise. [High secure hospital] recognised my PTSD" (Robert).

Participants view of high secure hospital staff was that they were honest and understood their needs. Operating within the relationship over a significant period of time, these characteristics led the participants to believe that the high secure hospital staff had their best interests at heart. These qualities, along with consistency and openness, promoted trust so that participants were willing to follow advice and guidance from their staff.

> "She's a brilliant doctor, she never ever lied, whatever she said she meant and she stood by her guns" (Jason).

> "I just have more faith in the hospital that's looked after me for 4 years than the hospital that knows nothing about me. I listen to what [high secure hospital]'s telling me" (Robert).

The negative impact of the loss of the secure attachments and the safe and predictable environment was exacerbated by two factors. Firstly, it was unexpected as the participants had incorrectly based their expectations for their medium secure hospital on their experience of high secure hospital, but it was very different.

> "I based my expectations on [high secure hospital]...[medium secure hospital] is secure care so I presumed…some of the policies might be the same…so I was shocked…there was a lot of things that wasn't very logical

and I couldn't get my head round it and at one point I got questioning myself, like am I sounding irrational" (Robert).

Robert described how he quickly encountered differences from what he was used to in the environment, rules and routine in his medium secure hospital. The differences and consequences appear to have surprised him and resulted in the abrupt realisation that his environment was no longer logical, predictable or safe.

The second exacerbating factor for participants on the impact of losing their high secure hospital attachments was the abruptness of the loss and the way in which their attachments were severed. Danny's quotation illustrates a common experience among the participants in which they were given very little notice of their departure from high secure hospital.

"I didn't know I was going since the day before. Literally packed my stuff in the afternoon, I was gone the following morning…I didn't even get to say goodbye to my friends" (Danny).

Coupled with short notice of their transition, the majority of the participants also described an unexpectedly abrupt severing of their relationships with high secure hospital staff on arrival on trial leave. Participants reported feeling shocked, isolated and abandoned when these attachments were severed suddenly and unexpectedly, at a time when they felt most anxious and most in need of support.

"I said 'where's [high secure staff]?', [medium secure staff] went 'oh they've gone', I said 'what do you mean they've gone?', 'they went straight away as soon as you went'…You shouldn't do that because these are the people you respect who got you there. …Saying 'take it easy, well done, you can do this'…you need to hear those words…you can trust them…I went straight back to say 'thank you very much'. The night before I left, a staff nurse…put her arms around us, 'see you' and all that, 'you can do this', there's nothing meant more than that to us…it matters to hear it. From someone who cares" (Jason).

Apart from being unable to effect closure of significant and supportive relationships with the high secure hospital staff, the participants clearly elaborate their need for reassurance and encouragement at the start of their transition. Their inability to obtain this from their trusted relationships is likely to have left them feeling isolated and unsure of themselves. Not only was the departure of the high secure hospital staff after arrival on trial leave often abrupt, but participants' attempts to contact them later in their trial leave for support, often when they were struggling, were prevented.

> "I was told when I wanted to ring them, they didn't have [high secure hospital]'s number. With a straight face. 'We can't ring because we haven't got the number'…'well find someone who has got it'…but they wouldn't…I would have phoned P (psychologist) and relayed my concerns to him. Because I know he would have…dealt with them" (Danny).

b. Medium secure hospital offered unsafe alternative attachments.

A number of the participants described forming negative first impressions of their medium secure hospitals which immediately reduced their confidence in the ability of the hospital to care for them. They experienced difficult situations on arrival on trial leave and perceived the medium secure hospital staff as failing to rectify these situations.

> "The next bit that shocked me, I got shown where my bedroom was, there was no quilt, no pillows…I had to borrow a pillow off another patient and I slept under a bed sheet… Straight away I'm like, fucking hell, they knew I was coming and like 'what preparation?'" (Robert).

> "I asked for my property…'I need my toiletries and clean clothes and whatever' and he said 'no we will do it later'. Anyway I waited 3 days…I rang home and says to mum 'can you ring the site manager?' and that was the only reason why I got my stuff. So it did not start on the best terms" (Danny).

> "I got took to the ward, I go 'right, hang on, it's an acute ward', so I said '…you've got me mixed up with someone else, I'm going to a normal treatment ward'. They said 'no, no you're not'" (Danny).

As described above, these situations included a perceived failure to prepare for their arrival, application of inflexible rules so that participants' needs were unmet, and changes to previously agreed trial leave plans. As a result, participants felt unsupported, unwelcome, abandoned and uncertain about their trial leave care plans.

The differentness of the new regime, rules and procedures on trial leave meant that their new environment was less predictable. Participants described feeling confused and apprehensive as they encountered difficulties in adjusting to their new routines. They also perceived negative consequences for questioning or querying the rules.

> "My first initial experience…it was just totally different to this place...I thought am I just getting a bit paranoid here because it's a new environment and it's different, it's emotional, it's a bit like of a stressful experience...every unit runs a little bit differently anyway doesn't it, they all have their own little different rules and regulations" (Chris).

> "For a patient to have lived a certain way for 2 years to then go to something that is like the complete opposite, that is completely backwards, it was very difficult to try and adjust to…I was issued with a plastic bag, plastic fork, plastic plate bowl, I said 'in [high secure hospital] I was using metal stuff' and they actually said I was lying" (Robert).

> "I had the attitude of I'm going to another NHS psychiatric hospital, it's going to be the same work to how it is here, just more relaxed. I maybe got that bit wrong. You think you're going to have the same relationships with staff and things like that instead of realising it's somewhere completely differently new" (Steven).

Participants had come from stable high secure hospital wards, in which the emphasis was on preparing patients for progression through the mental health system. On transition, participants all described their new peer group as both unsettled and chaotic, and non-compliant with unit rules.

> "My perception of how it was going to be there was going to be chilled out, a lot of lads settled because it's medium secure. I got there and it was like

Beirut like honestly, it was like loads of lads really unwell, really unsettled" (Chris).

"I had patients trying to sell us fucking PlayStations what belong to the wards…trying to sell stuff to you that didn't belong to them, I thought fucking hell they're trying to get you in bother" (Jason).

The participants also noted that there were fewer staff present to safeguard them.

"At times there's no staff on that ward at all, when you're in [high secure hospital] where's there's got to be staff on the ward at all times, it's so surreal to be on a ward where…there's no members of staff anywhere, that was absolutely bonkers to get used to" (Steven).

Given the apparent unpredictability of the rules and procedures, and their experience of the consequences of rule-breaking as harsh, the participants experienced their new environment as shocking and unsafe. They were left unsure how to manage situations that they perceive as potentially dangerous, and their use of language illustrates this.

At the same time, participants' strong and trusting attachments with high secure hospital staff were replaced on trial leave by less safe alternatives. Some of the participants described how the relationships that they had begun to develop with medium secure hospital staff before their transition had been lost through staffing changes prior to their arrival.

"The nurse and the nursing assistant that come up to see me…weren't actually working in the unit when I got there…I felt quite alone as well getting there to be honest, I felt like there was a lot of support leading up to going…but then when I got there, there wasn't a familiar face" (Chris).

All of the participants felt that medium secure hospital staff were less available and less interested in developing relationships with them. Participants perceived staff as not listening to them or simply not engaging in everyday conversation. This appears to have made it very difficult for the participants to

develop relationships with them or use them as a support when they were struggling.

> "Out of all the time I was there, I don't think maybe one member of staff really wanted to talk to me. In fact if I haven't had spoke to them, they didn't speak to me…they never said a word to me" (Danny).

> "I thought I don't want to work with people, I don't trust you, I don't trust that you're going to listen to me…Half the reason I wasn't communicating my fears was they weren't really listening either. Like what's the point?" (Robert).

This left participants vulnerable to emotional dysregulation and distress. Participants also believed positive relationships with medium secure hospital staff were fundamental to trial leave's success, and when the staff did not appear to want to facilitate the building of relationships, participants' fear of readmission was triggered.

> "For them to show no interest means they're not investing a lot of interest. So I basically knew before Christmas I was going to be sent back" (Steven).

In addition, the participants' ability to contact their families was limited or delayed for significant periods after transition. For the participants who struggled with more difficult elements of the transition, the ability to receive support from people whose ability, care and judgment they trusted was removed.

> "I said to them 'you must have them on file, my next of kin, and their contact details', but yet 'we can't give you that information'…That was the first day, could not phone anybody" (Danny).

> "Family's a big thing for me so that was another element that added to why I was depressed because I didn't know when I was going to see my mum and dad… There, you're allowed 15 minutes a day to use the phone and you can only use it after 5pm…it added to that feeling of being isolated from…family and friends" (Robert).

Some of the participants acknowledged that they had struggled to trust people in the past and that building relationships was a core difficulty for them. Therefore, attachments that they were able to make were more important and new attachments were more difficult to develop. As a result, they struggled with anxiety about losing their current attachments to people and to their environment, and about making new attachments.

> "I suppose there was a bit of doubt like thinking well fucking hell, I know I've been here before, I've got to get used to new people" (Jason).

> "[High secure hospital]…taught us that all women weren't all the same, they weren't out to hurt you…I used to think they were…I didn't trust them" (Jason).

The impact on the participants of the loss of their previous trusting relationships with high secure hospital staff and attachments to the safe environment left participants feeling unsafe, unsupported and abandoned.

The replacement of these attachments with less safe alternatives left them feeling insecure, uncontained and vulnerable. This made participants feel isolated and unsafe so transition from high secure hospital to trial leave was harder. The participants described their response to this which appears to be a fluctuation between assertively seeking support and disengaging when no support was given:

> "I never used to get any answers, I used to ask a question, I used to say 'well if I did this what would be the outcome to that?'...nobody could give us a straight answer, not really" (Jason).

> "'They don't care why should I talk', so eventually I stopped talking completely and I ended up going back to old behaviours and dealing with things which was self-harm, the aggression, because…aggression keeps everybody at arm's length" (Robert).

and between hostility and seeking approval:

> "I started arguing with a female member of staff, 'you won't listen man', I says 'you're all the fucking same'…I just walked right up to her and I says

‘you total fucking idiot’ right because she was really starting to piss me off, ‘because that’s all you fucking do is lie’” (Jason).

“I was doing so many good things in there…something simple like I might’ve been in charge of cooking a communal meal…there’s so many positive things. …Someone’s telling you to do this behaviour and then good things will happen to you but good things don’t happen…if it doesn’t fuck it like, just give up man, I’m fed up of trying” (Chris).

The participants described how these strategies also then failed to elicit the support and safety that they sought. They found this demotivating and experienced feelings of desperation. Some participants reported feeling relieved on returning to high secure hospital and old attachments.

“I should’ve been devastated, yeah, I wasn’t, I just thought ‘you know what I don’t like going back to [high secure hospital] but…it’s better than that place’…I was glad to be out of there...it was a horrible place to be…here, they treat me with respect, they’re polite” (Danny).

“I was relieved a little bit that I would be coming back to people who I know I could actually trust and knew me” (Chris).

Some participants responded by resorting to previously learned maladaptive coping strategies.

“They wouldn’t listen to us and all that and I had to abscond for them to take any notice whatsoever” (Jason).

Robert described asking to return to high secure hospital and how each time his attempts to be readmitted failed, he escalated his behaviour.

“The [medium secure hospital] doctor told me ‘the only way you’ll go back to [high secure hospital] is if we can’t manage you’. We had another week or so of problems then…I said ‘I’d like transferring to another hospital’ because it wasn’t working, an argument ensued and they left the room…which was a regular theme…I got really angry, my anger got the better of me, the little room I was in, I smashed it up…they always gave the same response, ‘this is [medium secure hospital] not [high secure hospital]’…eventually it really

started to piss me off…I was so depressed…so I put a plastic bag on my neck, got blue lighted to hospital" (Robert).

These behaviours are likely to have caused the medium secure hospital staff to deem them unsuitable for medium secure hospital and to have increased their perception of the participants' risk and unpredictability. This likely impacted upon the decision to terminate trial leave and readmit them to high secure hospital.

To summarise, participants' attachments, trusting relationships and comfort in an environment that they felt was predictable were severed when they transferred to medium secure hospital. They were replaced by less safe alternatives: a chaotic and unpredictable environment and staff they felt did not provide the support they needed. As a result, participants reported feeling isolated, unsafe, uncontained and vulnerable. They resorted to behaviours which were perceived as risky and which eventually caused their trial leave to fail.

2. My trial leave experience was like my previous traumatic experiences.

Participants reported feeling let down and unjustly mistreated during their trial leave and perceived this as abusive. Some described how this reminded them of previous situations in which they had been betrayed or abused by others. People who have experienced trauma are often hypervigilant to betrayal and mistreatment. In these situations, they are likely to resort to previously learnt coping strategies. Participants reported feeling angry and vulnerable, and described anxieties about the intentions of medium secure hospital staff. They responded with a range of maladaptive coping strategies which staff interpreted as an escalation in risk, so led them to terminate the trial leave. The two subordinate themes identified within this theme are explored below: how participants perceived their trial leave experience as abusive; and how this paralleled previous experiences of trauma and abuse.

a. My trial leave process was abusive.

Participants reported that agreements made during preparation for trial leave were not upheld, partly because the staff members with whom they had begun to develop plans had left. They found themselves on wards that did not meet their needs with previously agreed treatment plans not followed. Participants felt disappointed, angry and eventually tricked by this.

> “Everybody had good intentions for you but nobody fulfilled them…it’s not fair” (Jason).

> “Before I left here everything was put in place with my team…for three months like just nothing happened…it felt like I’d been sold the wrong car…‘we’ve got a lovely red Ferrari there for you’…but underneath it’s like an old Micra…wow you sneaked one on me there” (Chris).

> “My social worker told me Friday that she had argued successfully, successfully argued that I should go straight to a rehab ward, not an admission ward…so I thought that was going to happen, obviously it didn’t” (Danny).

Participants reported that medium secure hospital staff failed to respond when they approached them for support, and they perceived this as a lack of compassion for their vulnerabilities. The participants felt unheard and rejected with their physical and emotional needs overlooked.

> “I couldn’t even get to the dentist…I was that much in pain…you know if you start fucking carrying on you get recalled back anyway, that’s not fair is it, that’s setting you up to fail” (Jason).

> “I thought I’d be allowed to talk on a daily basis, about what I was doing, what they expected and what was happening…If you’re not going to work with me, then you shouldn’t have accepted me” (Danny).

Some of the participants reported that, initially, they felt unwelcomed by the medium secure hospital staff. Overall, they found many of the staff members to be uninterested in them, disrespectful and rude. This led the participants to feel unwanted, isolated and rejected.

> “Staff were even very horrible and very rude, one of them told me to fuck off...They would sit next to me…and wouldn’t say hello…I haven’t been to a ward where the majority of them are disrespectful and rude as that and as cold” (Danny).

> “If a little bit more time and effort would have gone in, I do think it was still a place where I could’ve succeeded…whether they wanted me there...feeling wanted is probably one of the most amazing things…that wantedness would have like overrode everything” (Chris).

> “There was a feeling maybe I wasn’t really wanted there…not one member of psychology come to see us in 3 months…very little OT contact…so when I was sent back it wasn’t a surprise to us, I had a feeling it was going to happen” (Steven).

Participants described how they felt confused about the feedback they received from medium secure hospital staff, experiencing it as inconsistent and changeable. They also noted that staff often did not consult or even warn them about changes in their care plans or problems in their trial leave.

> “Everything was like through frosted glass, nothing was clear…things weren’t marrying up, it was like someone saying I’m colouring a crayon in green here but by the time it comes to the end it was in blue and it’s like what you started with and what you’re finishing with are two totally different things…like I’ve been told I can go on a treatment ward the next couple of weeks…and all of a sudden they’re telling me I might have to be sent back” (Chris).

> “I had a visit from [high secure hospital staff]. ‘I just want to chat and see how you getting on and things’. It wasn’t, what was happening, they had a meeting about an hour later and that was my discharge meeting back to [high secure hospital]. So they didn’t tell me” (Danny).

> “They’d have conversations with me but…they’d already made the decision…no matter what I said anyway it wasn’t going to change it” (Robert).

As time went on, this escalated into feelings of confusion about the intentions of the staff, with participants coming to believe that staff were being dishonest with them, and even trying to sabotage or find reasons to end their trial leave. This increased their already high levels of anxiety about making a mistake which could lead to readmission. As a result, they reported feeling unsafe and vulnerable.

> "They were both saying to me 'no, don't be silly, you're being paranoid…you'll be staying'…the decision to send me back had already been made" (Chris).

> "I was stitched up left, right and centre…they were trying to stitch us up…they made every excuse in the book to get us moved" (Jason).

> "They were looking for the first opportunity for you to be returned back to high secure...the first opportunity for things to go wrong…I'd kind of learnt to be careful of what I was saying…they were looking for me to say the wrong thing" (Chris).

The participants believed the staff were punitive, that they failed to reward good behaviour and often misperceived behaviour as manipulative so punished them. Participants also felt that the medium secure hospital staff overused the threat to terminate their trial leave and they experienced this as an abuse of power.

> "Whenever I questioned something…it was seen that I was trying to push boundaries or resist against something. No, I was just asking for an explanation…I'd tell them what worked with me and what helped me…they went 'no, we'll do it our way'...was almost seen as I was trying to push boundaries…or manipulate" (Robert).

> "The majority of the staff are brilliant…but it only takes one or two to fuck it all up for everyone and they'll start messing about and 'if you want to complain about it, we'll put you in seclusion', that's the answer to everything" (Jason).

"They've got your hands tied…you'll do everything they say…it's almost like a fear factor, we know you don't want to go back there, right, so we can take the piss really and push you to your limits because you're not going to react because you don't want to go back to high secure" (Danny).

Overall, participants reported that they experienced the process of trial leave and how they were treated by the medium secure hospital staff as abusive.

"When I got sent back it was an absolute disgrace the way it was passed over, the whole lot, it still doesn't make sense to this day and ethically not brilliant" (Steven).

"I was cheated, I was lied to on a daily basis…I've think I've got some PTSD thing, because it freaks me out, talking about it. It gets me really unnerved to talk about what happened…I was treated so badly" (Danny).

"I've been used and abused and let down left, right and centre...doctors in [another medium secure hospital] went 'this man has been totally let down by the system" (Jason).

Their experience of trial leave as abusive was exacerbated by their belief that their peers in medium secure hospital were not treated in the same abusive way: their needs were met and staff were willing to work with them. This left the participants believing that they were being singled out and treated unfairly, which made them feel confused, hurt and angry.

"They never said a word to me. They would have a conversation with other patients but never spoke to me" (Danny).

"I was thinking 'wow you're challenging me on asking for when a snooker session is going to be on but this guy's telling you to fuck off and spitting at you and you're getting his medication and asking him to calm down'…if I would have produced one action that the number of my peers were producing on that ward, I would have been sent back" (Chris).

b. The abusive experience felt familiar to me.

Some of the participants disclosed that they had been abused in the past. They described how their experience of feeling mistreated on trial leave reminded them of previous experiences of abuse and being let down.

> "The vast majority of people that abused me growing up, were people in authority…their lack of maybe understanding or lack of, how they worked basically just tapped into those core things, those core kind of problems I have…I was very suspicious of people, especially male staff" (Robert).

> "[High secure hospital]…taught us that all women weren't all the same, they weren't out to hurt you…I used to think they were…didn't trust them…I goes to [medium secure hospital]…this NA used to sit with us at night times and she used to talk to us…she went…'I'm not coming back, I love you'…it was like a bomb hitting us because I just thought we were getting on really well…imagine what it did to me…you were on about 'all women aren't the fucking same', that's exactly what they are" (Jason).

Participants demonstrated an awareness that they may have been hypervigilant to betrayal by the medium secure hospital staff and the threat of readmission to high secure hospital. Hypervigilance to threat in this way is common to people who have experienced abuse.

> "People's facial expressions and just the tone of how they talk…when a situation's coming up that's really emotional yeah you can become really hyper-sensitive so you pick up on these things more and more and we have a tendency to misread them…that's the nature of the type of people we are" (Chris).

> "It was always like it was too good to be true, like I knew it wasn't quite right…none of it felt, hang on really is this right, is this really happening…it just didn't feel real…I was terrified of being sent back…I go '…I'm starting to get paranoid about things'" (Steven).

> "Five male staff sat in the back of the van with me. Straight away my threat system went boom because one of the biggest things I struggle with…was males…it's in my trauma symptoms. Straight away my heart is thump, thump…my head is going 'something is not right here'" (Robert).

People who have been abused are more likely to resort to previously learned coping strategies when in situations where they perceive a threat or betrayal. Participants responded to their perception of abuse with previously learned coping strategies such as social avoidance, a failure to seek support, aggression and self-harm. The medium secure staff are likely to have perceived this as increasing risk so ended their trial leave.

> "You'll always go back to prepare safety mode when push comes to shove because that's all you understand, that's how you lived your life, that's how you're safe" (Jason).

> "I've never seen so many male staff…I straight away want to get up and run…I'm panicking…it gets too much for me. I kicked the side van door…I ended up biting a member of staff. Got bundled into seclusion" (Robert).

> "Because of the issues I have with trauma, trust, abuse, feeling safe…I'm thinking 'oh God…how am I going to keep myself safe? I can't do this', panic set in, I really panicked and I self-harmed for the first time in about a year, I cut my wrist" (Robert).

When trial leave failed, participants experienced feelings of personal failure and shame when others believed they had caused it to fail. They also felt anger at the perceived betrayal by medium secure hospital staff. Feelings of anger, guilt and shame are common following experiences of abuse (APA, 2013). These fluctuating feelings were reflected in their confusion about the reasons for trial leave failure and led to difficulties settling back into high secure hospital.

> "I still see staff that are like 'you threw it away'…I was devastated because [high secure hospital staff member] was disappointed…you think…you're never going to get that chance again, it terrified me...did I think about ending it, yeah…did I wallow in self-pity…did I get angry? Course I did…It took us a long time to let go…the injustice of it all sucked, and the fact people kept doing these unethical things" (Steven).

> "Medium secure was a step towards going home…I was gutted. I was also gutted for my team that helped me work to get there…I felt…disappointment

for letting people down, I felt like I let myself down…part of me just felt angry over what the doctor had accused me of" (Chris).

In summary, participants perceived their treatment by medium secure hospital staff as unfair, unsafe and abusive. They felt that they were not treated honestly and that agreements made before trial leave were not upheld. They felt singled out by staff who they experienced as disrespectful, rejecting and dismissive of their needs, noting that their peers were not treated in this way. The participants reported that this treatment and the feelings it evoked were similar to previous experiences of abuse and mistreatment. Some participants queried whether they were being hypervigilant to threat (as a consequence of previous trauma), and they described responding in ineffective and dysfunctional ways, which led to their readmission to high secure hospital. On their readmission, the participants described experiencing a sense of loss, shame and anger, which impeded their ability to reintegrate.

3. The needs of the trial leave system overrode my needs.

Participants perceived many instances in which the needs of the trial leave system were prioritised over their needs. Three subordinate themes were identified. The first describes several factors that made the transition to trial leave harder for participants, including the timing of various trial leave processes, the suitability of their medium secure hospital, the reliance on procedural and physical security, and decisions about their care being made by staff who did not know them. The second subordinate theme illustrates how participants felt coerced into addressing the reasons for trial leave failure, despite disagreeing with them. The third subordinate theme describes how the prioritisation of the system's processes impacted on the self-concept of the participants and their ability to work towards a second trial leave.

a. My needs weren't met.

Participants believed that the timing of the trial leave processes was determined by staff availability or the timing of other processes such as staff

waiting for the outcome of mental health tribunals. This often resulted in long delays in organising trial leave, so preparation and transfers were often rushed due to bed availability and deadlines to move patients. This meant that participants' preparation for medium secure hospital was limited and sometimes processes such as aftercare meetings which were designed to minimise transition issues were prevented. Overall, participants felt uninformed and unsupported on transition, and believed that this was detrimental to the success of their trial leave.

> "It all happened in a rush...[high secure hospital] rushed to get my treatment finished…there wasn't a lot of transition work done…I was flying blind…that was a problem…the 117 meeting…was on video-link…I didn't understand half of what [medium secure hospital staff] were saying… Work should have been done on…how I was going to handle it, the different things I could encounter…I was winging it and that's not always a great recipe for success" (Steven).

> "Tribunal agreed…for me to be in a place of lesser security and put a date on it. They had about 3 or 4 months to view this but it wasn't until the month I was meant to leave that anybody picked it up…the time between being assessed and me moving…was very quick. Because…there was an enormous amount of pressure to move me on quickly because it had been left so long. The 117 Aftercare Meeting…I didn't have until after moving…because it was done by video-link I couldn't attend" (Robert).

> "Waiting to get there was a really long process…I had to wait for bed dependent and waiting to go…but then…the move got delayed by about eight or nine months" (Chris).

Participants believed that there was little flexibility in the choice of medium secure hospital, so that they were sent to hospitals that they believed could not meet their needs. They saw this as a significant factor in the failure of their trial leave.

> “You hear about MSUs, some are good and some are bad, but everyone is unanimous that [medium secure hospital] is the worst, so I really didn’t want to go…but I had no choice of where I wanted to go” (Danny).

> “8 weeks after I come back, [medium secure hospital staff] come to visit us…we all questioned each other on…what went wrong and the discussions in the room mainly ended up being like ‘oh we think you should have been in a specialist PD unit’” (Chris).

All the participants were transferred to admissions wards with unsettled patient groups and more restrictions than they had in high secure hospital. Participants felt forced to comply with regimes that reduced their access to activities which they had learned to rely upon as coping skills to manage distress. As a result, they resorted to maladaptive coping skills which were likely to be perceived by medium secure hospital staff as increased risk, eventually leading to trial leave failure.

> “What keeps me…safe…it’s doing like an activity…distraction techniques…for three months, there was no activities…it did start to have an adverse effect after a while…because they had to increase the security on the ward and they wanted to find out how the drugs got in here” (Chris).

> “I tried to get on this educational course…‘can’t have that’…it was frustrating…I could have accessed quite a lot of different activities and stuff, it would have been a much better…place, but…we weren’t allowed to work in the shop or nothing and I said ‘well why’s that?’ ‘That’s because you’re on that ward.’” (Danny).

The participants felt that medium secure hospital staff relied on the use of procedural and physical security methods (such as restrictions, restraint and seclusion) rather than relational security (understanding the patients’ risk and working with them to help them manage risk). This further limited access to distraction activities and support to help them manage their distress.

> “‘We’ll put you in seclusion’, that’s the answer to everything, but it’s not is it? The answer is talk to the person, get to know the person, reassure the person, help them” (Jason).

> “They were like ‘because we work on a system of levels of what you could have…you’ve now dropped levels, self-harming’, so they had to take stuff out my room…I tried saying ‘…can I have a book…something to keep myself occupied’…I struggle even more because I have very little in my room for distraction, so my self-harm became worse…I flipped a football table…I said ‘…I’ve calmed myself down, let’s talk about it. ‘No, you have to go to seclusion’” (Robert).

Participants noted that throughout the trial leave process, from gatekeeping assessments through to readmission and subsequent treatment and care planning, decisions about their care were often made by staff who did not understand them or their needs, and who failed to liaise with staff who knew them better. They felt that their high secure hospital staff would have been better placed to make or influence informed decisions, having worked with them for an extended time, and with whom they had trusting relationships. The participants did not feel there was enough liaison between the hospitals’ staff once their trial leave had begun and felt that medium secure hospital staff did not follow recommendations for their treatment. Thus, participants felt misunderstood and unsafe, and some disengaged from their medium secure hospital care. This is likely to have led medium secure hospital staff to believe they were unsuitable for their hospital.

> “You’ll have a gatekeeper that’s had very little involvement, how do they know I’m ready for medium secure?…probably have no idea who I am…don’t know you at all, come and see you for an hour or read your files and…come back with all these things” (Robert).

> “What would have solved it…is having clear communication…with this place here…inviting down a member from your team here that…knows you…more clear communication with this place and your medium secure, like an aftercare” (Chris).

> “[High secure hospital staff] says ‘you just need to finish your course when you get there, the relapse prevention…otherwise he’ll start forgetting’…it never, ever happened…I’m being punished for what they didn’t do, it’s a joke. It’s not fair” (Jason).

b. I had to take responsibility for my trial leave failure.

On readmission, participants reported that they were expected to take full responsibility for the failure of their trial leave and address the reasons for readmission through treatment. While all the participants acknowledged that their behaviour contributed to trial leave failure, none of them believed that they were fully to blame and attributed some responsibility to the medium secure hospital staff and the trial leave process itself. Some of the participants did not accept that the reasons for readmission were valid, thus believed the treatment recommended by the medium secure hospital staff was unnecessary. They felt coerced into this treatment which they found unfair and unethical. They described feeling powerless to argue their case for fear of jeopardising further progress through the mental health system if they did not comply.

> "It's difficult to…explain where things have gone wrong because you…sound like you're…not accepting what you did wrong…actually, I shouldn't have self-harmed…shouldn't have assaulted a member of staff and I fully accept that. However, there were things they shouldn't have done but…from a medium secure perspective all the blame…is on me" (Robert).

> "Things I've had to do to meet criteria to go back I don't think are ethical…made us do a test nobody believes I should've been doing and the test is very invasive…to prove I didn't have problem with women…if you refuse it it looks like you've got something to hide…it took us a long time to let go because for quite a while it was the injustice of it all" (Steven).

At the same time, some participants felt that their feelings of loss, confusion, betrayal and injustice were dismissed. Overall, participants described the trial leave process and its consequences as coercive and unfair, and they struggled to settle after readmission and re-engage to work towards another trial leave.

> "I can't do any more about it…how can you make sense of something that doesn't make sense, you drive yourself mad…the system doesn't really accept responsibility for itself and that drove us mad for a little bit because it feels like you're a liar and things like that, and that didn't help" (Steven).

"My care team's shit…since I come back…I have to have people who support us…I don't believe that's what they're doing…they don't give a fuck…'you'll be fine, you're moving shortly', that's all I ever get out of them, 'you're leaving shortly anyway, it doesn't matter does it?'…it does matter" (Jason).

c. Prioritising the system's needs affected my self-concept.

The participants saw trial leave as their pathway out of the mental health system towards freedom, so failing represented the loss of their future life. They described grieving for their lost opportunity. Participants believed that their trial leave failure was not entirely their fault and experienced the process as unjust. They described feeling angry, frustrated and hopeless about their future. Some of the participants reported finding it difficult to settle back into their high secure hospital environment and responded to their distress by disengaging, withdrawing their compliance and becoming riskier.

"I was gutted because like medium secure was a step towards going home…that was a crisis for me, you know, your whole world's falling apart…your only option of going home…the main emotion I must admit was like failure and disappointment…I felt really angry for the reasons why it didn't work…it didn't feel like it was right" (Chris).

"At times I felt no hope and despair because I thought I'm never going to get out. It's always going to hang over me" (Robert).

Participants also saw readmission as shaming, experiencing a loss of face and a blow to their self-esteem. This caused them to lose confidence in their abilities and coping skills. For most, this was demotivating, so they stopped trying to behave well and did not seek support when they needed it. Some reported that their mental health and risk deteriorated initially as a result.

"People were like 'you must've done something to be sent back'…that was the most difficult thing…'I can't believe you've blown it'…when some patients are saying it, it doesn't really bother you…but when it's staff and

you haven't actually blown it, it's different…it was snatched away. My head fell apart…I ended up in an incident where I punched a patient" (Steven).

"Someone's telling you to do this behaviour and then good things will happen to you but good things don't happen…I've always thought…if it doesn't fuck it like, just give up man, I'm fed up of trying…disappointment of things failing, that's…hard for someone like myself to take…you don't set out to do things to fail" (Chris).

Participants all described factors that they could not control which made their trial leave harder and contributed to its failure. Apart from their perception of medium secure hospital staff as dismissive and non-responsive to their requests for support, and limitations on their access to learned coping strategies, they experienced a feeling of powerlessness and an inability to influence the success of their trial leave. The participants believed that medium secure hospital staff held all of the power and noted that staff did not involve participants in decision-making about their care. Proposed changes to care were not discussed and problems were not raised with them for fear of unsettling the participants and increasing their risk. This removed any opportunity for participants to resolve difficulties or change their behaviour in order to make trial leave succeed. This powerlessness led them to feel unsafe and vulnerable. As a result, they lost confidence in their self-efficacy to manage their distress and they lost faith in the mental health system.

"People were coming after me but leaving to go to treatment wards before me…I said 'I thought you said it was it was up to my behaviour or my mood?' And she laughed 'no you are here long-term'…the goal posts were moved and I was entirely kept out the loop" (Danny).

"They were just going through the motions of talking to me…no matter what I said anyway it wasn't going to change it, it wasn't going to change their approach" (Robert).

"Why is this happening to me…it did make me question really like life in general just like am I just a pawn in a fucking game and people are just making things up just to see my reaction?" (Chris).

Participants reported continuing confusion about the reasons for their trial leave failure. They questioned the validity of the primary reason for readmission given by the medium secure hospital staff but then struggled to understand why their trial leave had failed. However, all of the participants acknowledged that their behaviour had been difficult to manage at times. As a result, they felt confused about the decision which made it more difficult to come to terms with their readmission. This made it harder for them to work towards another trial leave opportunity.

> "I've been given a few different answers. When I counteract one, they come with another one. At first…I must not be taking my clozapine…once they kind of thrashed that out…'actually it was because of your behaviour'…then...'it's the clozapine that did it'…they couldn't give me a definitive answer…it takes two to tango and yes if I'm arguing with someone, I'm arguing with somebody but that doesn't mean it was all my fault. I didn't threaten anybody, I wasn't abusive" (Danny).

> "I can't put all the blame on [medium secure hospital] for me coming back because that'd be ridiculous…I accept what I did wrong, there was things I could've probably done but there's still part of me that feels…if I was at a different hospital I probably wouldn't have come back" (Robert).

While still confused about their trial leave experience, participants described having no alternative but to accept the loss of their trial leave and start working towards their next attempt. They fluctuated between feeling hopeful about the future, acknowledging their relief to be back in a familiar environment and the benefits from additional therapy, and seeing their failure as a traumatic loss, alongside a loss of confidence in their own worth and in the trustworthiness of the mental health system.

> "The more you try to make sense of it the more it doesn't make sense…you've got to take it for what it is, an experience…I can't do anymore about it so now I don't think too much about what's going to happen…I realised just believe in yourself, that's it…I'm stuck with a system that isn't perfect but I'm not perfect myself…accepting that is half the deal" (Steven).

"I felt really disappointed…I either put the effort in and try to move on or just to fuck it off and self-destruct…everything you've worked for has been crumbling down…the easiest thing to do right now is to lash out…what's the point of trying…to be a good person if nothing good comes from it" (Chris).

"[High secure hospital] staff would say '…there's things in place…you won't slip through the cracks' but that's exactly what happened…my belief and faith in the systems to help people move on, I don't have as much faith in it…it's been an eye opener, I've realised the system isn't perfect and things can go wrong…I have a lot more apprehension and anxiety about moving on" (Robert).

To summarise, participants believed that their needs were secondary to the rules and processes of the trial leave system and described many examples of how this made their trial leave more difficult. Participants felt frustrated and powerless to influence their future. These feelings continued after readmission when they were required to take responsibility for their failure and to address the reasons given for the failure, despite their perception of these as invalid. Alongside a feeling of loss for the trial leave opportunity, they felt confused and hopeless for the future because of the perceived injustice of their situation. Often, these feelings were overlooked by staff. Participants' sense of injustice and ongoing feelings of loss made it harder for them to reintegrate and re-engage in working towards progress through the mental health system. This is likely to have extended their stay in high secure hospital.

4. I was stigmatised because I came from high secure hospital and had a personality disorder diagnosis.

The participants believed they were stigmatised by medium secure hospital staff because they had come from high secure hospital, combined with having a personality disorder diagnosis. Three subordinate themes describe how this stigmatisation manifested. Firstly, the participants believed that their risk was over-perceived and that they were treated differently as a result. Secondly, their needs, which they believed to be different to their medium secure hospital peers were not met by the staff and care. Finally, they believed that their

vulnerabilities were not addressed. As a result, participants felt that they did not receive the care that they needed which led to trial leave failure.

a. I was misperceived as risky and treated as high risk.

The participants believed that coming from high secure hospital, and having a personality disorder diagnosis, affected how the medium secure hospital staff perceived them and their risk. The participants believed that the staff misinterpreted their behaviour and over-perceived their risk, focusing on their historical, rather than more recent, behaviour. Participants felt that the staff interpreted innocent behaviour (such as attempting to build relationships with staff) as challenging, risky and attempts to push boundaries. This misinterpretation and the subsequent failure to acknowledge attempts at positive behaviour demotivated the participants from continuing to attempt this.

> "Because you have the stigma of coming from high secure there's a perception of you already when you get there…they're expecting you to lose the plot and do something" (Chris).

> "There's such a stigma attached to high secure and personality disorder that sometimes if you have a rational argument it's difficult because people go it's high secure, or you're PD…I'm just saying at some point you've got to give me a chance" (Robert).

> "They were…not knowing really how to take us because of…things that had happened in the past…they think 'he could be a problem this one…he's in a medium secure now, we haven't got the facilities to contain him if he kicks off'" (Jason).

Participants felt that the medium secure hospital staff set higher and more rigid standards for their behaviour than for other patients, and they supervised them more closely. This is likely to have exacerbated already high levels of anxiety about making mistakes, fearing the consequences including readmission.

> “I was different so I was the one that the focus was on…if I…succumbed to…1% of what [medium secure hospital patients] did, they would have got rid of me…one had attacked the doctor, two…smashed up the office computer…nothing happened…if I ask for PRN medication it’s like ‘…do you think we can manage you if you’re going to kick off?’” (Chris).

> “I was getting room searches and drug tests every week…yet [patients] coming in after me weren’t getting that special attention…he said ‘well you come from [high secure hospital] so things are a bit different’...they’ve got a massive stigma…high secure patients…we are treated differently” (Danny).

> “They said…‘we don’t allow irons or razors on this ward’...I saw someone get to shave and use an iron…I said ‘I thought you said I couldn’t’, they said ‘no, what I meant was *you* can’t…in 2004 you took a hostage’…it’s always going to be on my record” (Danny).

This misperception of their risk made it harder for the participants to build relationships with the staff. They felt misunderstood and it felt unsafe to seek support. As a result, the participants felt rejected, vulnerable and misunderstood, eventually deciding to stop seeking support, which likely exacerbated their mental health difficulties and increased their risk.

> “I…wasn’t allowed to go off ward…I tried to put it across in a reasonable way but I get the same response ‘this isn’t [high secure hospital], this is how we work’…I don’t understand…their lack of maybe understanding…tapped into those core…problems I have…I stopped talking completely” (Robert).

> “I thought that I’d been set up. I didn’t say that because I don’t want them to say ‘that is my paranoia’…I got to spend a lot of time in my room, I came out when I had to…but I didn’t want to speak to them” (Danny).

> “Sometimes I can get paranoid, I think certain things are going on, I might need to come to you for advice…I do that with people I trust here, I need to build up that relationship…but…there was just no one to have that with” (Chris).

b. I had different needs to medium secure hospital patients.

Participants reported feeling fundamentally different to their peers in medium secure hospital and felt that the medium secure hospital care was designed to meet their peers' needs, but not their own specific needs. They believed that their medium secure hospital staff had limited experience in working with patients who had been transferred from high secure hospital or patients with personality disorder diagnoses.

> "I stood out like a sore thumb…they like really suffer with bad mental health and they were always self-harming…what keeps them safe…might be taking more medication…for me it's doing like an activity…none of the patients did…any activities or anything…I was more self-sufficient than the other people and I think staff found that difficult" (Chris).

> "I didn't have one psychological assessment…a lot of PD related behaviour is psychology-based not medication not psychiatrist, a lot of it's done by psychology" (Steven).

The participants also believed that the staff perceived their differentness as creating additional work and as not being suited to medium secure hospital care. They came to believe that staff did not want them to stay in the hospital, and they felt this view had been validated when they were returned to high secure hospital to complete work which they felt could have been done in medium secure hospital.

> "They thought I was a bit of a hindrance because they had to get off their arse and go and do something, whereas normally they'd just be sat in the office, give out medication...they just weren't pragmatic with someone that wanted to do stuff, they were so used to not having to do stuff" (Chris).

> "I had this CPA…they brought up 'we think this is…' I go 'I think we could work on that here with you, I don't believe I need to be sent back to high secure to do it'" (Steven).

c. My vulnerabilities were overlooked.

Participants described themselves as vulnerable and felt that the medium secure hospital staff under-perceived their vulnerabilities. As a result, they felt that their concerns were dismissed and they were not offered adequate support, but instead found themselves facing increased restrictions as their vulnerabilities were perceived as increased risk. Consequently, the participants struggled to find adaptive strategies to cope with distress and so resorted to maladaptive strategies which increased their risk.

> "Something little like me asking for medication turned into like a big thing, I had to go to my ward round and talk about was I stressed, who was I going to attack, is that why I wanted my medication" (Chris).

> "I queried why I had no self-harm care plan. [Medium secure hospital doctor] said '…I didn't think it was necessary', I said 'I've just moved from high secure which is quite stressful, stress triggers my self-harm, how could you not think a self-harm care plan would be relevant?'…that added to the anxiety I already had" (Robert).

In summary, participants believed that their history of care in high secure hospital, combined with their diagnosis of a personality disorder, caused them to be stigmatised by their medium secure hospital staff. They believed that staff over-perceived their risk, basing this on historical behaviour, and misperceived their behaviours designed to reduce distress as risky. Consequently, participants' vulnerabilities were ignored and they felt unsupported. Participants also believed that some of their clinical needs were not met because medium secure hospital care, regimes and staff skills were geared towards the needs of their peers, who represented a different patient group with differing needs. As a result, when participants struggled, they resorted to maladaptive coping behaviours which were in turn seen as evidence of increased risk and so led to trial leave failure.

Discussion

Overview

This section of the thesis expands on the discussion section in the journal paper. This study explored patients' experiences of high secure hospital readmission following unsuccessful trial leave. Four superordinate themes were identified from the participants' accounts:

1. I lost my safe attachments.
2. My trial leave experience was like my previous traumatic experiences.
3. The needs of the trial leave system overrode my needs.
4. I was stigmatised because I came from high secure hospital and had a personality disorder diagnosis.

The above superordinate themes are discussed here in relation to relevant research literature and theory in order to better explain them. This section of the thesis also provides a critique of the methodology and a review of the implications for clinical practice and future research. Finally, critical reflections on the study are provided.

1. I lost my safe attachments.

In line with previous research (Adshead, 1998), the participants described trusting relationships with high secure hospital staff who they saw as consistent and reliable, and they described feeling safe and contained within the predictable high secure hospital environment. From an attachment theory perspective (Main & Goldwyn, 1989), participants' perceptions of their relationships can be seen as a description of strong and secure attachments to high secure hospital staff, and a consideration of the high secure hospital as a "secure base" (Mann, Matias & Allen, 2014).

The prevalence of insecure adult attachment styles is relatively high in the general population (40%) but nearly twice as high in clinical populations (Bakermans-Kranenburg & van Ijzendoorn, 2009), and particularly high within secure forensic hospital patients (Frodi, Dernevik, Sepa, Philipson & Bragesjö, 2001; Fonagy & Levinson, 2004). Those with diagnoses of personality disorders

are even more likely to have insecure attachment styles (Barone, 2003; Stovall-McClough & Cloitre, 2003). Therefore, for high secure hospital patients with a personality disorder, the development of secure attachments should be seen as an indication of emerging recovery (Willmot & McMurran, 2016) since most will have entered the service with an insecure adult attachment style. For many high secure hospital patients, their time spent in high secure hospital is likely to have represented one of the most settled and stable periods of their lives.

It is not surprising then, to discover that, on moving away from their secure base and attachments, the participants reported experiencing a sense of loss and abandonment (Bowlby, 1988), much like grief. The long delays experienced by patients during the assessment for the trial leave process is well documented (Adshead et al, 2017; Tetley & Krishnan, 2011). This is likely to deter clinical teams and patients themselves from beginning a preparation process until a bed has been secured. Following acceptance, the minimal notice of transition to medium secure hospital described by the participants is likely to have limited their opportunities to prepare for their imminent loss of safe attachments. Thus, their reported experience was that their attachments were severed abruptly.

When distressed, adults with insecure attachment styles tend to express high levels of emotion and concern about their relationships (preoccupied style) or they tend to avoid attachment opportunities and become overly self-reliant (Main & Goldwyn, 1989). This response was reflected in participants' reported experiences. Studies have demonstrated how mental health staff can misunderstand patients' responses in this context and how this can adversely affect patients' progress and the development of new therapeutic relationships and new safe attachments (Diener & Monroe, 2011; Berry, Shah, Cook, Geater, Barrowclough & Wearden, 2008).

Modern models of grieving (e.g. Stroebe & Schutt, 1999) suggest that tasks focusing on restoration are as important as tasks focusing on the loss. In that respect, patients needed to find a new secure base in the medium secure hospital and develop new safe attachments with staff. However, the participants in this study described basing their expectations of medium secure hospital on their experience of high secure hospital. They reported finding that the regimes and patient mix were very different, and they described their new medium secure hospital wards as chaotic and unsafe in comparison. Participants'

experience of the wards as chaotic and unsafe is reflected in the Care Quality Commission's recent report in which they rated 45% of 85 secure hospital providers as either inadequate or requiring improvements in terms of safety (2018). At the same time, the participants described medium secure hospital staff as less available and less interested in them. Given that the development of safe attachments requires consistency, predictability, and emotional availability (Bowlby, 1988), staff shortages and the reliance on bank staff may make it more difficult for staff and patients to form safe and secure therapeutic relationships (Adshead, 2018).

It seems that moving from their secure base to an unsafe environment, and from secure attachments to unfamiliar staff who appeared disinterested, represented a re-enactment of the disruptions and difficulties of the participants' childhood attachments. They described their responses to these changes in a way that reflected a typical insecure attachment style. They reported high levels of emotional expression and fluctuations between assertively seeking and rejecting therapeutic relationships. These responses are likely to have further prevented them from developing a safe and secure base with medium secure hospital staff and raised the staff's concerns about their risk. Similar patterns of continuing destabilisation following the loss of secure attachments which lead to extreme forms of emotional expression have been described by Ma (2006). The participants' extreme expressions of emotion are likely to have contributed to their high secure hospital readmission.

2. My trial leave experience was like previous traumatic experiences.

Participants described their trial leave experiences as abusive. There is no universally accepted definition of emotional abuse but clinicians and researchers agree that it involves recurring exposure to behaviours such as verbal abuse, humiliation, threat, manipulation, denial of affection, making unrealistic demands, constant criticism and failure to reward good behaviour (Thompson & Kaplan, 1996). Emotional abuse can include acts of omission (such as neglect) and commission (such as intimidation) by others which may be intended or unintended (Gilbert et al, 2009). Participants' reports of how they experienced their treatment appear to be consistent with definitions of abuse. They described their perceptions of medium secure hospital staff as lacking in

compassion and interest in them. Participants also reported feeling let down and unable to influence their care, confused about what was required of them and unable to obtain positive feedback for any behaviour. The participants said they believed they were being treated punitively compared to their peers and that they were under threat of readmission if they did not meet the required behavioural standards.

Most forensic patients within secure services are detained under the Mental Health Act (2007) and this places limits on their capacity for autonomy and involvement in their care. Mezey, Kavuma, Turton, Demetriou and Wright (2010) argue that recovery approaches, aimed at empowering patients within mental health services, may be less applicable to patients in forensic services given that the therapeutic focus is on confronting risk rather than on validating the individual. Secure services must also focus on the need to protect the public as well as the patients' individual needs. Thus, secure hospitals can be perceived as holding power and control over the individual patients and this may lead to the participants' perceptions of the medium secure hospital's care as abusive. However, high secure hospitals also hold power and control over their patients, but the participants tended not to report this perception as abusive. Instead, they described perceiving high secure hospital staff as well-intentioned and acting in their best interests. This is likely to emanate from their safe attachments and view of high secure hospital as a safe base. On moving to medium secure hospital, the participants described facing an unfamiliar and unsafe environment with undeveloped relationships with staff (Adshead, 1998). In this context, the hospital's power and control is likely to have been perceived as a potential threat rather than a safeguarding or containment mechanism to keep people safe.

Additionally, many of the participants recognised that they may have overperceived the potential threat to themselves in the medium secure hospital. People who have a history of trauma have been demonstrated to have a bias in their attention towards trauma-related stimuli (Buckley, Blanchard & Neill, 2000). Particular emotional cues can be misperceived as potential indicators of threat (Pollack, 2001). Hypervigilance, an increased alertness to threat, alongside behaviours which aim to avoid the threat, is recognised by the DSM-V (APA, 2013) as a symptom of post-traumatic stress disorder (PTSD). Some of

the participants attributed their reported possible over-perception of threat, or hypervigilance, to previous experiences of trauma and abuse.

There is a growing body of evidence that among patients in forensic services, there is a high prevalence of previous abuse, often sexual and physical abuse or emotional abuse and neglect (Ballard, et al, 2015), and that almost half of these patients meet the diagnostic criteria for PTSD (Spitzer, Chevalier, Gillner, Freyberger & Barnow, 2006). There is also evidence suggesting high rates of abuse among patients with personality disorder diagnoses (Afifi et al, 2011). Willmot and Evershed (2018) described research that found that all patients from a high secure hospital sample had experienced significant childhood abuse, which included physical, sexual and emotional abuse and neglect. 71% of these patients had experienced more than one type of abuse. These authors note that it is highly likely that patients transitioning from high to medium secure hospital will have a history of abuse and trauma and that this may impact on their perceptions of the medium secure hospital care and their response to these perceptions.

The effects of child abuse can be profound (Miller-Perrin & Perrin, 2007) especially if the victim has experienced more than one type of abuse (Higgins & McCabe, 2001). The term ‘complex trauma’ has been used to describe the multiple, interacting cognitive, emotional and behavioural problems associated with multi-type trauma (Price-Robertson, Rush, Wall & Higgins, 2013). Specifically, complex trauma has been associated with difficulties relating to emotion regulation, self-awareness and interpersonal relatedness (particularly fear of intimacy) (Briere & Rickards, 2007; Suveg, Morelen, Brewer & Thomassin, 2010). Research has also demonstrated a link between childhood abuse and suicidal behaviour (Turner, Taillieu, Cheung & Afifi, 2017) and violence in adulthood (Widom & Wilson, 2015).

Most modern theories of trauma and personality disorder view the behaviours linked to these characteristics as survival or maladaptive coping strategies (e.g. Young, Klosko & Weishaar, 2003) where the function is to keep the person safe from threat. From this perspective, when the participants were moved into an environment they perceived to be unsafe, they reported that their trauma histories caused them to associate this with previously unsafe environments. They said that this association led them to overperceive factors

in their situation as threatening. Young, Klosko and Weishaar (2003) would describe this process as the participants' perception of threat triggering an early maladaptive schema, 'mistrust/abuse', which is common among those who have experience childhood abuse. The mistrust/abuse schema is described as "the expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. It usually involves the perception that the harm is intentional or the result of unjustified or extreme negligence" (Young, Klosko & Weishaar, 2003). Schema theory describes three general ways in which people manage schemas when they are triggered: surrender; avoidance; and overcompensation (Young, Klosko & Weishaar, 2003). In this context, examples of surrender coping behaviours might include trying hard to fit in at the medium secure hospital but also presenting as constantly in crisis. Avoidant coping could include avoidance of developing relationships with medium secure hospital staff and denial of difficulties encountered. Overcompensatory behaviours might include challenging medium secure hospital staff or aggressively seeking support. It is recognised that disruption to attachments alongside exposure (and re-exposure) to trauma reactions are likely to destabilise people and make them vulnerable to extreme behaviour (Wayland, 2008).

Avoidant or overcompensatory responses from participants might have presented as increased risk to the medium secure hospital staff and are likely to have contributed to patients' high secure hospital readmission. Previous research has suggested that the most common reasons for trial leave failure were engagement in unmanageable behaviour such as aggression and absconsion, volatile presentations or failure to engage (Blattner & Dolan, 2009; Tetley, Evershed & Krishnan, 2010).

3. The needs of the trial leave system overrode my needs.

The participants reported believing that their needs were secondary to the rules and processes of the trial leave system, and that the needs of the system were prioritised over their needs. Previous studies have indicated that high secure hospital patients, with a personality disorder in particular, encounter more difficulties in the admission process to medium secure hospitals (Department of Health, 2003; Dolan, Thomas, Thomas & Thornicroft, 2005).

Participants described little flexibility in the choice of medium secure hospital placement so that they were placed on wards that could not adequately meet their needs. This perception is consistent with Adshead and colleagues' (2018) argument that a "one-size-fits-all" service provision is unhelpful. In line with previous research (Tetley, Evershed & Krishnan, 2011), the participants described how their opportunity to prepare for trial leave had been adversely affected by timing issues in the trial leave process. The inherent delays in the transition process are well known (Adshead et al, 2017; Durcan, Hoare & Cumming, 2011; Tetley & Krishnan, 2011).

Durcan, Hoare and Cumming (2011) noted that the admission process itself is time-consuming, with patients often being assessed on several occasions by different professionals before they can be admitted. They, and other authors (e.g. Duggan, 2007), have also suggested that medium secure hospital staff can be risk averse in their decision to admit patients. If the assessing medium secure hospital does not accept the patient, further assessments from other medium secure hospitals are then required, delaying the process further (Durcan, Hoare & Cumming, 2011). Tetley, Evershed and Krishnan (2010) noted that 45% of high secure hospital referrals to medium secure hospitals were unsuccessful.

Furthermore, the limited provision of medium secure hospital beds (Harty et al, 2004; Meltzer et al, 2004) was noted to cause significant delays in transfer (Grounds, Meltzer, Fryers, & Brugha, 2004). The financial imperative to maintain high bed occupation in medium secure hospitals also results in limited bed availability at any time (Durcan, Hoare & Cumming, 2011). In this regard, Lelliott, Audini and Duffett (2001) suggested that patients from high secure hospital personality disorder services were given low priority in accessing available medium secure hospital beds. Thus, high secure hospital clinical teams may be forced to consider any available medium secure hospital bed regardless of how well it can meet the patient's needs. Teams may also be under pressure to transfer the patient quickly once a bed becomes available, if they are to transfer them without extending already lengthy waiting times.

Thus, the protracted assessment process combined with the relatively low acceptance rate of high secure hospital patients is likely to deter clinical teams from offering patients preparatory work for trial leave until a medium secure

hospital bed has been secured. However, at the point of acceptance, the transfer can happen very quickly. If preparation has not begun by this time, a quick transfer can impede the amount of psychoeducational and psychological work to prepare for transition.

Participants reported that they were placed on admissions wards on their transfer to medium secure hospital, and that they experienced these wards as more chaotic, and their peers as more unstable, than at high secure hospital. This view is corroborated by Durcan, Hoare and Cumming's research (2011) which noted that medium secure hospitals accept a high proportion of people from prisons (approximately 43%) and from low security hospitals (approximately 16%), who are likely to have acute mental health problems and/or ongoing risky behaviour which have triggered their admission.

The participants also noted the availability of illegal substances on their medium secure hospital wards, which is supported by previous research (Durand, Lelliot & Coyle, 2006). Participants reported that the unstable patient group and access to substances, combined with the lower staffing levels of medium secure hospital, made them feel unsafe. In order to manage the patient group and resolve security issues, the medium secure hospital staff teams may have relied more heavily on physical and procedural security measures, which the participants described. In line with Tetley, Evershed and Krishnan's (2011) research, the participants may therefore have encountered restrictions and limitations on their movement and activities which were contrary to their expectations. Mann, Matias and Allen (2014) noted the difficulties faced by secure forensic services in balancing the use of individualised approaches to better meet patients' needs (e.g. the use of therapeutic activity to manage emotional dysregulation) and the need to provide "blanket" or "one-size-fits-all" approaches, to provide consistency and reliable security.

Participants described how decisions made about their care throughout the trial leave process were often made by people who did not know them well, and that at the start of the trial leave, there appeared to be a lack of liaison between their current and previous clinical teams. Durcan, Hoare and Cumming (2011) also noted a lack of communication and liaison between the different stages of the mental health pathway as patients progress. They described a lack of "joined-up working" which could impact negatively on patients' progression and

cause them to lose faith in the mental health system. There are existing formal mechanisms to promote consultation and liaison between teams, such as Section 117 aftercare meetings, but these tend to occur on discharge rather than trial leave transfer.

The participants described how, on readmission, they were required to accept full responsibility and undertake work to address the reasons for their trial leave failure, despite having concerns about the validity of these reasons. All of the participants acknowledged that their behaviour may have contributed to their readmission but reported that there were also factors outside of their control which led to the failure. Attribution theory posits that people behave as "naïve psychologists" trying to make sense of their world (Heider, 1958). Jones and Nisbett (1971) described two types of attribution: situational attribution, where people attribute cause to situational factors, and dispositional attribution, where people attribute cause to personal characteristics. Participants reported believing that the medium secure hospital clinicians held them entirely responsible for their trial leave failure, which represents a dispositional attribution. The participants reported that they struggled with the reasons given for their failure, and while they accepted that their behaviour contributed to the failure, they attributed some responsibility to the trial leave process and medium secure hospital care which represents a situational attribution. Jones and Nisbett (1971) noted a tendency for people to attribute other people's behaviour to dispositional factors but attribute their own behaviour to situational factors. In the participants' cases, it is likely that this attributional style would have been exacerbated by their reported feelings of powerlessness and lack of involvement in their care during their trial leave. This powerlessness may have diminished their sense of self-efficacy and led to a tendency to further attribute difficulties externally. Participants reported that the mismatch between their own attributions and those of the medium secure hospital clinicians left them feeling confused and let down by the mental health system.

Additionally, as expected, participants described having seen their trial leave as a gateway back to community living and they reported feelings of loss on readmission, which Kubler-Ross (1969) described as "a deprivation of something valuable". The participants described fluctuating feelings of acceptance and non-acceptance of their situation, experiencing grief, anger and

hopelessness, while also attempting to “move on”. The participants’ reported differing emotional needs reflect the importance of using a dual-processing model which focuses on loss and restoration, described by Stroebe and Schutt (1999).

The participants described how their feelings were not addressed by the high secure hospital care following readmission and how this unmet need interfered with their ability to resettle and re-engage. Forensic services tend to prioritise therapeutic work to reduce risk rather than broader, recovery-focused work (Mezey, Kavuma & Turton, 2010).

Participants described a loss of face and feelings of shame on readmission resulting from their failed trial leave, and the negative impact this had on their self-esteem. The experience of failure is noted to negatively impact on self-esteem and emotional distress (Jones & Sheffield, 2007) and some participants described deterioration in their mental state and behaviour on readmission. Resilience research has indicated that self-esteem is a potential protective factor against emotional distress arising from failure, and as such its reduction would have increased the participants’ risk of deterioration (Johnson, Panagioti, Bass, Ramsey & Harrison, 2017).

4. I was stigmatised because I came from high secure hospital and had a personality disorder diagnosis.

Participants reported believing they were stigmatised by the medium secure hospital staff because they had a personality disorder diagnosis and because they had come from high secure hospital. Stigma has been defined as the social rejection of an individual, based on a negative perception of particular characteristics, which leads to them developing “a spoiled identity” (Goffman, 1963). Link and Phelan (2001) identified four characteristics of stigma: the person is perceived as different to others; those differences are deemed to be undesirable; the person is seen to be part of a negative “outgroup”; and their power, opportunities and status are reduced as a result.

There is a large body of evidence suggesting that clinicians believe that patients with personality disorder have poorer treatment outcomes, are more difficult to manage (Newton-Howes, Tyrer & Weaver, 2008) and are less deserving of care (Lewis & Appleby, 1998). Markham and Trower (2003) noted

that patients with personality disorder diagnoses are often met with pessimism, negative judgements and hostility, and are rejected or denied access to services more frequently than other patient groups (Bowers, Carr-Walker, Allan, Callaghan, Nijman & Paton, 2006). Recognising their stigmatisation, efforts have been made over the last ten years to improve staff attitudes to patients diagnosed with personality disorders (National Institute for Mental Health in England, 2003). However, Beryl and Völlm (2018) demonstrated that staff attitudes to patients with a personality disorder diagnosis had not improved, noting that initiatives to train staff in order to address stigmatisation had not been continued.

The researchers could find no literature examining medium secure hospital staff attitudes towards patients with a history of high secure hospital care. However, there does seem to be a perception that patients in high secure hospital are more dangerous, which may be a valid perception given the admission criteria, and that they are more difficult to treat (Murie, 2010). Risk aversion was noted to be common among medium secure hospital clinicians (Durcan, Hoare & Cumming, 2011) and Duggan (2007) reported that staff in medium secure hospital are wary of working with patients who they believe to be at high risk of committing further serious offences. Lammie, Harrison, Macmahon and Knifton (2010) noted that, whether accurate or not, the perception of a patient as dangerous contributes to stigmatisation. They argue that the label of ‘dangerous’ can sometimes be given to patients automatically, rather than being informed by their current risk assessment.

These negative perceptions of patients will inevitably influence the way in which staff work with them (Adshead, 2002). Research has demonstrated that staff perceptions of patients as dangerous and personality disordered can elicit helplessness and therapeutic pessimism (Beryl & Völlm, 2018) which results in efforts to maintain social distance (Markham & Trower, 2003). This may explain participants’ reported perceptions that they were subject to higher standards and closer supervision from staff, and that their behaviour was often misinterpreted as challenging. Studies have also found that stigmatisation is likely to contribute to difficulties for patients in forming therapeutic relationships, being involved in their care and in their ability to seek support (Lewis & Appleby, 1998; Newton-Howes, Tyrer & Weaver, 2008), which is in line with the

participants' reported experiences. The participants' expressed attribution that the medium secure hospital staff's limited experience of working with high secure hospital patients with personality disorders contributed to their stigmatisation is corroborated by Beryl and Völlm's (2018) research showing that 44% of staff in secure hospitals had no formal training in this area. Staff lacking confidence in their ability to work with people with personality disorder is likely to increase therapeutic pessimism and negative labelling, thus leading to stigmatisation (Beryl & Völlm, 2018; Krawitz, 2004).

The needs of patients with a personality disorder diagnosis coming from high secure hospital are known to be complex, both in manageability and clinical presentation. Comorbidity is high and can include affective, psychotic and autistic spectrum disorders (Moore, Evershed, Kilkoyne & Jones, 2014). As described above, most high secure hospital patients with a personality disorder have a history of childhood abuse (Willmot & Evershed, 2018) and attachment difficulties (Barone, 2003; Fonagy & Levinson, 2004) which are likely to have contributed to dysregulations in affect, interpersonal relationships and self (Moore, Evershed, Kilkoyne & Jones, 2014). The additional stressors placed on patients during transition to trial leave have also been noted (Adshead et al, 2017) and are likely to exacerbate their difficulties. The commonly reported negative beliefs about this patient group can result in therapeutic pessimism, wariness, blaming and labelling and a desire for social distance (Thornicroft, 2006). This may explain why patients reportedly felt that their attempts to seek support and build relationships were dismissed.

Rejection of this kind, along with the other aspects of their stigmatisation (negative labelling and misperceiving behaviour as risky) has been shown to lead to reduced self-esteem (Wright, Gronfein & Owens, 2000), feeling isolated (Farina, Allen & Saul, 1968) and reduced support-seeking (Schomerus & Angermeyer, 2008). These reactions are similar to those described by the participants in this study.

Chronic stress (Link & Phelan, 2006) is also recognised as a response to stigmatisation. Ingram and Luxton (2005) used the diathesis-stress model to explain how the symptoms of mental disorders can be exacerbated by stress. These can be further affected by a lack of accessible support (Albrecht & Goldsmith, 2003).

Critique of the methodology

There is a dearth of research evidence looking at the utility of trial leave or problems it creates for patients and services. There is even less research exploring patients' experiences of the trial leave process, and nothing to the researchers' knowledge that specifically explores patients' experiences of failing trial leave. The current study goes someway to address this gap in our understanding.

Although the scope of this study was small, the researchers found all five participants to be articulate about their experience of the trial leave process and it appeared that they had spent time before the interviews reflecting on this. The participants all appeared keen to participate, stating that they hoped that sharing their views on their experience and the difficulties they faced could improve the trial leave system.

The researchers acknowledge a number of methodological limitations to the study. Firstly, in line with IPA methodological guidance, a small number of participants were interviewed in depth. The lack of breadth in the participant group means that readers should be cautious about generalising the findings to all high secure hospital patients.

While the study aimed to recruit participants from both the mental health and personality disorder directorates within one high secure hospital, no patients within the mental health directorate met the inclusion criteria for the study. This suggests that more patients fail trial leave from the personality disorder directorate than the mental health directorate. One explanation for this could relate to the fourth superordinate theme identified, that the stigmatisation of the personality disordered patients meant they were more likely to fail trial leave. The lack of patients with a primary mental health diagnosis in this study means that this theme in particular should be regarded with caution when generalising the findings to patients with mental health diagnoses.

Of the participants who met the inclusion criteria, five consented to take part in the research and so were included in the study. No monetary rewards were offered for their participation and it was made clear that the interviewer was independent of the hospital and so could not influence their care. It is unclear what motivated the participants to volunteer for the study, but in light of the

findings that they felt their views and emotions had been dismissed and that they had not had an opportunity to explore these and their impact, perhaps they had a desire to discuss their experiences in order to better make sense of them. It is also possible that the participants believed that they had had particularly adverse experiences on trial leave so wished to have their perceptions and emotions validated by the interviewer. The participants expressed their belief that the system should be improved and stated that they hoped their participation would contribute to this. It is also possible that those who participated were those who had managed their reaction to the trial leave failure sufficiently enough to be able to talk about it. It may be that some patients who did not consent to participate had experienced more traumatic reactions and continued to struggle with their mental wellbeing as a result. Regardless of the reasons for their volunteering to take part in the research, the possible skewedness of the data should be considered when reviewing the findings.

Additionally, all of the participants had spent a significant amount of time in high secure hospital since their readmission before the interviews occurred (between nine months and over five years). Given that the study asked for retrospective accounts of the trial leave, some details may have been forgotten. This did not appear to be a problem as none of the participants reported any gaps in their memory of the experience and they were all able to provide a full and detailed account of their perception of the events. Additionally, all of the participants reported having reflected on their experience and therefore it is possible that their accounts comprised a script that they had become accustomed to telling. If so, it is unclear how this would have affected the findings of the study. Furthermore, it is possible that, given the long period available for reflection, participants' perception of their experience may have changed since their readmission. However, the aim of this research was to explore how the participants perceived and made sense of the experience at the time of interview.

All of the interviews were conducted on participants' wards in their high secure hospital, in the presence of a researcher from the hospital. The interviews were also monitored by participants' ward staff on CCTV (without audio) and the staff were aware of the interview topic. It is possible that this interfered with the participants' perception of the interview's confidentiality thus

limiting what they disclosed. However, all of the participants disclosed sensitive information about themselves including information that placed them in a negative light, and they did not voice concerns about their confidentiality.

As this study used a cross-sectional design, interviewing only those patients whose trial leave had failed, it is unknown whether there are differences between these patients and the patients whose trial leave has succeeded. However, guidance from Smith, Flowers and Larkin (2009) suggests that best practice in IPA methodology involves a homogenous participant group who have experienced a similar phenomenon. Therefore, in line with IPA's idiographic approach, the findings may not be representative of all patients who fail trial leave, and so generalisations should be made with caution. Nevertheless, the findings can contribute to the current literature and clinical practice regarding patients making transitions between services.

In line with the IPA approach (Smith & Osborn, 2008), the researchers assumed that the participants were able, cognitively, linguistically and affectively, to describe their thoughts and feelings about their trial leave experience. If participants struggle to express their thoughts and feelings, IPA researchers may be too interpretative of their accounts during analysis. However, in the current study, all of the participants were notably articulate and spoke at length about their perceptions, beliefs and complex emotional responses to their experience. This may be attributable to the significance they placed on the experience and the degree of reflection on it they had undertaken prior to the interview.

Smith, Flowers and Larkin (2009) note that IPA research skills are developed through experience. While undertaking the study, the primary researcher was inexperienced in conducting IPA research. In order to address this inexperience and ensure the methodology was as robust as possible, the researchers adhered to IPA guidelines including keeping a reflective diary and a detailed audit trial. Additionally, the primary researcher sought regular supervision from experienced IPA researchers. These supervisors oversaw the data analysis and reviewed the findings as they emerged, and they were able to validate the way in which the primary researcher arrived at their interpretations, adding rigour to the analysis.

The use of IPA required the researchers to focus entirely on the participants' accounts of their experiences. IPA methodology required the researchers to interpret meaning from participants accounts of their experiences, involving a double hermeneutic. In line with IPA methodology, triangulation was not undertaken and so the findings represent accounts of the participants' expressed experiences, rather than an objective account of the reasons their trial leave failed. Thus, despite the systematic approach taken, which conformed to IPA methodological standards, the findings should still be seen as tentative because of the researcher's subjectivity. Smith, Flowers and Larkin (2009) described how the process of bracketing enables researchers to acknowledge previous understanding and experience, but still make valid interpretations of the data. In the current study, supervision from experienced IPA researchers facilitated discussion and exploration of the primary researcher's preconceptions and how these might influence their interpretations. Nevertheless, the primary researcher's interpretations of the data were inevitably affected by their prior knowledge and experience, and their expectations of the study outcome.

Implications for clinical practice

This study may be of particular interest to commissioners, clinicians and managers within high and medium secure forensic mental health services who are responsible for the care and management of mentally disordered offenders as they progress towards the community. However, the study may also be of relevance to commissioners, managers and clinicians working in services where patients are required to make transitions across services in order to progress.

The study highlights the difficulties experienced by some patients when transitioning from one service to another. Considering the findings, and given the relatively high proportion of trial leave failures (20%; Tetley, Evershed & Krishnan, 2010) and the high cost of keeping beds open during trial leave (Durcan, Hoare & Cumming, 2011), it seems that it would be beneficial for high and medium secure services to review the ways in which patients could be better supported before, during and after transitions.

From an attachment theory perspective, if the patients view their high secure hospital as a "safe base" (Jamieson, Taylor & Gibson, 2006), some work with

the patients prior to trial leave on the likely difficulties the transition might incur would likely be helpful for them. Adshead and colleagues (2017) trialled a high secure hospital leavers' group, set up to focus on issues of attachment and to support patients with their transition away from the secure hospital base. This group showed some success in reducing readmission rates from failed trial leave, suggesting that preparation can minimise the impact of loss of attachments. Alongside this psychological focus, more practical preparation, including visits to the medium secure hospital before their transition, would provide patients with a chance to familiarise themselves with their new environment so that it becomes more predictable. This would also afford them the opportunity to start to develop new attachments to the medium secure hospital staff. These experiences could then be reflected on with trusted high secure hospital staff.

Participants reported that when trial leave failed, their experiences of loss and grieving interfered with their ability to work towards another trial leave because they struggled to engage in work addressing the reasons for their readmission. A great deal of research has demonstrated the importance of addressing engagement issues or "therapy interfering behaviours" prior to beginning core therapy (McMurran & Ward, 2010; Linehan, 1993). It may be beneficial for services to consider preliminary work with patients on readmission to address this difficulty using a psychological model of grief (such as Neimeyer and Sands, 2011 or Stroebe and Schutt, 1999). Since a situational (external) attributional style is known to be a protective factor against distress emanating from failure (Johnson, Panagioti, Bass, Ramsey & Harrison, 2017), patients' re-engagement in core work might also be assisted if there was some acknowledgment of the situational factors linked to their trial leave failure. Validating patients' external attributions regarding their trial leave failure might prevent the participants' reported feelings of powerlessness, confusion, demotivation and hopelessness from interfering with their work towards another trial leave (Neimeyer & Sands, 2011). Validating and meeting patients' emotional needs in this way might also repair some of their reported lost faith in the mental health system, and from a recovery perspective, may go some way to restoring their hope for the future.

Many of the findings in this study support recommendations for staff training. Beryl and Völlm (2018) noted that a lack of confidence in skills to work with people with personality disorders is likely to increase therapeutic pessimism and negative labelling, thus leading to stigmatisation. They suggested that training staff in the understanding and management of personality disorders would be a key protective factor in reducing stigmatisation. Willmot and Evershed (2018) recommend staff awareness training in the management and treatment of personality disorder. They advocate that services employ a trauma-informed approach such as Schema Therapy when treating and managing patients with a personality disorder diagnosis. Increased awareness of such an approach might help medium secure hospital staff to understand and manage the distress and challenging reactions that could be generated on transition. Adshead (2002; 2018) recommends providing staff awareness training in attachment theory to provide a better understanding of how transitions including trial leave and the associated loss of attachments can destabilise patients. It would also improve staff skills in helping patients to develop new safe attachments and improve staff confidence in managing patients with complex needs including attachment difficulties.

At a service level, the participants reported that long delays in organising trial leave hindered their ability to plan and prepare for trial leave. It may be beneficial to develop a collaborative and dynamic trial leave pathway with a timetable, so that patients can better prepare practically and psychologically for each stage of their transition and the transition process becomes more predictable. This would also provide deadlines for services to work towards.

The trial leave process contains structures and processes to facilitate communication between the high and medium secure hospital staff regarding the care and management of the patients. However, a number of factors including competing priorities, geographic distance and staff shortages can hinder liaison processes. Duggan (2007) recommended improved integration between high, medium and low secure hospitals in order to make forensic pathways more efficient. His recommendations included improved communication about therapeutic approaches for individual patients, particularly in situations where problems are arising. It may be helpful for the high secure hospital staff, who retain legal responsibility for patients on trial leave, to

consider the use of ‘transition teams’ to better manage continued liaison between the high and medium secure hospitals throughout trial leave. These teams could be attachment-informed and based on a similar model to those transitioning patients from child and adolescent services to adult services. Opportunities for regular communication between the teams, before and during the trial leave, could be timetabled into the dynamic trial leave pathway.

On handover to the medium secure hospital, and if difficulties arise during trial leave, team formulation with staff from both hospitals might be a useful medium for exploring potential problems and possible solutions. Team formulation has been demonstrated to improve clinicians’ understanding of patients and their risks (Ramsden, Lowton & Joyes, 2014) provided that it is based on a structured model that is understood by all participants (Geach, Moghaddam & De Boos, 2017). The medium secure hospital staff could also use this as an opportunity to consult staff with experience of working with the patient and managing their behaviour.

This study focused on a small number of patients who all failed trial leave, thus the results may be skewed. Nevertheless, the findings add to a current movement in the literature which suggests that there is a mismatch between the current structure and process of the forensic mental health system and our growing knowledge of the newer models of forensic mental health and recovery. Adshead and colleagues (2018) argued that clinicians need to challenge “short-term, one-size-fits-all” service provision for people with insecure attachment styles. They noted that patients are required to move from stable and secure settings to new and unpredictable environments in order to progress through the mental health system. Patients’ struggles, which reflect their history of chaotic and abusive experiences, are seen to affect their progress detrimentally (Madders & George, 2014). Placing these patients in specialist services which have been designed for people with complex attachment and trauma needs, rather than generic mental health services, would be more appropriate and make transitions more likely to succeed. Furthermore, forensic services should focus on building hope, self-acceptance and autonomy, in addition to challenging and confronting risk, if they are to be considered recovery-focused services (Mezey, Kavuma, Turton, Demetriou & Wright, 2010).

Recommendations for future research

As this study used IPA methodology, triangulation was not undertaken; the focus was entirely on the participants' reported experiences. Thus, it was not possible to determine how far their perceptions of their experiences matched those of the clinicians involved in their care. This is particularly pertinent given the participants' reported confusion and sense of injustice about the reason given for their trial leave failure. The ability of patients and services to work together appears fundamental for trial leave to succeed. Thus, research investigating how medium secure hospital staff experience trial leave and its failure would complement the current study.

Given that this study only focused on patients who had unsuccessful trial leave experiences, it would be helpful if future research explored the experiences of people who have completed trial leave successfully. It would be helpful to understand if these patients experienced similar difficulties to participants in the current study, and if so, how they and the staff managed them. It would also be helpful to explore how their experiences differed, since this might indicate what the critical factors are that lead to failed trial leave.

Participants in this study were limited to those within the personality disorder directorate of one high secure hospital. It would be helpful to broaden the scope of future research to explore how the experiences of other patient groups differ from those in the current study, and how far the results are influenced by the particular services involved and how a patient's diagnosis might affect their experience.

Conclusions

Trial leave failure is common (Blattner & Dolan, 2009; Tetley, Evershed & Krishnan, 2010) and costly to services. There is a lack of qualitative or detailed research exploring patients' experiences of failing trial leave and readmission to high secure hospital. The current research supports existing evidence to suggest that patients experience transitions between high and medium secure services as difficult and distressing, and that patients' existing difficulties (history of trauma and insecure attachment styles) may be exacerbated.

Participants reported that they experienced distress on losing their secure attachments to high secure hospital and staff. They described struggling to build

new attachments with their medium secure hospital staff and perceived those that were offered as less safe. They experienced their trial leave as abusive, describing elements of how they were treated as similar to previous experiences of abuse. Participants reported feeling that their needs were overridden by requirements of the trial leave system and so were not met. On readmission, they described feeling forced into taking full responsibility for their trial leave failure but continuing to believe this was unjust as some responsibility lay with medium secure hospital staff and other aspects of the trial leave system itself. Participants said they felt stigmatised by medium secure hospital staff because of their history of high secure hospital care and their personality disorder diagnosis. They reported that they over-perceived their risk and that their vulnerabilities were overlooked. The participants believed that their needs were different to their peers in medium secure hospital, and they were not met as the service had not been designed to address them. Participants described how they coped with their resulting distress by engaging in behaviours that the medium secure hospital staff deemed risky, thus ending their trial leave. Participants reported that this experience negatively impacted upon their self-concept and interfered with their ability to settle in high secure hospital on readmission and begin to work towards recovery again.

These findings build on existing research, providing a detailed and patient-focused account of the experience of unsuccessful trial leave and readmission. This research also suggests that patients do not always feel supported by the trial leave system and that aspects of it, particularly processes, timing, staff experience and capabilities, can lead to further distress. The study supports previous recommendations regarding the potential benefits of additional practical and psychological preparation for patients, and staff training in the dynamics of attachment and grief, the impact of abuse, and the understanding and management of personality disorder.

Reflections

This section provides critical reflections on some aspects of the research process, including key scientific, ethical and theoretical issues that were raised. Excerpts from the primary researcher's reflective diary are included to illustrate

these issues. As this section is an account of the personal reflections of the primary researcher, it is written in the first person.

Scientific and ethical issues

While working in previous clinical roles, I became aware of the high rate of failed trial leave in this patient group. Given the high financial cost of trial leave and its failure, I was surprised that so little research had been conducted into why the failures were occurring. In particular, I noted that there was a gap in knowledge about patients' perspectives on this, which would be important to understand in order to intervene to try to improve the success rate and patients' experiences following readmission. As a scientific methodology, IPA offered the opportunity to gather rich data about a topic for which little research existed.

However, IPA is limited in its scope as it offers only individualised perspectives of participants which may not be representative of the wider group. This research aimed to explore the experiences of five male patients within one high secure hospital, who had experienced a failed trial leave. I initially attempted to recruit participants who had a primary mental health or personality disorder diagnosis but this was not possible as no patients in this hospital with a primary mental health diagnosis met the inclusion criteria. This further limited the participants' representativeness and as a result, I queried the utility of the study. However, IPA guidance recommends interviewing a homogenous participant group in order to increase the validity and relevance of the findings to that particular group. So, while the generalisability to patients with other primary diagnoses, and those from other hospitals, was compromised, the representativeness of the findings to male patients from this high secure hospital with a primary diagnosis of personality disorder was increased. While analysing the data and generating themes, my confidence in their validity increased as they corroborated previous research findings and as I noticed the consistency between participants' accounts.

> "I spoke to a supervisor yesterday about a recruitment issue: I've been told that no patients from the mental health service will be taking part as the only person who meets the inclusion criteria at the moment has decided not to participate. This means all participants will have a PD diagnosis and I'm not

sure whether this will affect the usefulness of any clinical implications that come out of the research. On reflection, we agreed that the participants will be more similar so implications will be more relevant to a small group but less representative overall."

As an external researcher conducting interviews within a high secure hospital, I was not allowed to be alone with the patients at any time. Thus, another member of staff was present. Additionally, the interviews were conducted on the participants' wards in rooms that had CCTV (without audio). From the outset of the research I had to consider how far this would compromise the participants' ability or willingness to give full and honest accounts of their experiences. This became a particular issue during the first interview. Immediately prior to this interview I was inadvertently told the official reason for this participant's readmission to high secure hospital. I was aware throughout the interview that although he loosely alluded to it, he avoided disclosing the reasons given by the medium secure hospital staff. This caused me to wonder whether he had omitted other aspects of his experience and whether this would affect the quality of the results. Furthermore, there is a commonly held belief that forensic patients with a personality disorder diagnosis are likely to be dishonest and I wondered if this might affect my interpretations of their accounts.

"Unfortunately, a member of staff accidentally told me before I went into the first interview that the participant was readmitted because he had pornography in his possession. Throughout the interview he maintained that the reason for his readmission was that the medium secure hospital staff wrongly deemed him as a sexual risk. However, he did not explicitly mention the pornography. I'm not sure why he omitted this. Was he minimising his wrongdoing? Was he ashamed? Was he trying to give a more socially acceptable explanation? Or perhaps he didn't understand or accept the reason the medium secure hospital staff gave. Either way, I'm disappointed that the issue of the honesty of participants' accounts has arisen so early. However, it has forced me to consider whether it matters if the participants distort or leave out parts of their experience."

On reflection, I accepted that querying the truthfulness of their accounts emanated from a stigmatisation of this patient group, as there are many factors (e.g. shame and fear of consequences) that might cause any participant to omit or distort parts of their experience. In fact, there was no evidence to suggest that they would be respond with less integrity than any other participant group. This also led me to reflect on the difference between qualitative research, which prioritises a search for meaning (involving participants' understanding and acceptance), compared to quantitative research which seeks objective reliability and validity. On revisiting the aims of the research, I concluded that I was not seeking objective truth but the participants' perceptions of their experience. Additionally, in line with the process of bracketing, I tried to acknowledge and set aside any concerns about participants not providing full and open accounts.

The IPA methodology required me to interpret participants' verbatim accounts to identify themes. As there is a risk that researchers may incorrectly interpret participants' meaning, I was careful throughout to adhere to IPA guidelines (e.g. bracketing) in order to avoid this. However, the security constraints of the high secure hospital meant that I was unable to review the audio tapes of the interviews so had to rely on transcripts typed by other people. Although I was able to review the transcripts promptly and annotate them with paralinguistic cues (e.g. emphasis, laughter, hesitation), I was aware that some of this information was lost. This may have affected the quality of my interpretations. However, I noted in my reflective diary after all of the interviews that the participants had spoken articulately and at length about their experiences, and that there were very few points in the transcripts in which the meaning was unclear. Again, since there was much consistency between participants' accounts, and the emerging themes supported previous literature and research, I was more confident in my interpretations.

> "I'm looking for key themes across the transcripts. It's reassuring (from a methodological perspective) that the issues they raise seem to be common across all of the interviews. Their specific experiences are sometimes different but the meaning they attach to these are so similar. It makes me

feel confident that the emerging themes are true to the participants' experiences."

To complete the research, I asked the participants to discuss a difficult experience. However, given that they would likely be talking about this experience in detail as part of their recovery plan and work towards another trial leave, I did not believe the interviews would cause any additional distress. I noted in my reflective diary that the participants seemed very keen to talk about their experience and have this experience heard and validated. They made a number of comments about the distress caused by their failure not being acknowledged and some talked about the importance of research on this topic. Perhaps the interviews provided an opportunity for some of these needs to be met.

"I was warned by staff before the interview began that this participant would probably not speak to me for very long. However, he spoke for over two hours and seemed reluctant to stop, telling me that it was a relief to share his experience and feelings about the readmission."

Theoretical issues

On writing the discussion, it became clear that many of the findings of this study supported previous research and that many of the recommendations for clinical practice closely echoed suggestions made by different researchers. For example, several writers have recommended that medium secure hospital staff are provided with attachment-informed teaching (e.g. Adshead, 2018). I wondered why these repeated recommendations appeared not to have been executed. On reflection, I considered the possibility that clinicians and commissioners may not have prioritised their implementation as the number of patients going on trial leave is small, and although the failure rate is high, the majority of trial leaves succeed. Further, it may be that clinicians and commissioners attribute the failure of trial leave entirely to characteristics within the patient (dispositional attribution) according to the predicted bias of attribution theory (Jones & Nisbett, 1971). This would explain the emphasis of the high secure hospital on addressing risk issues highlighted by the reason for

readmission. I also considered the possibility that these recommendations may have been executed at some medium secure hospitals, where more patients had completed trial leave successfully. Further research would be required to investigate this.

Given the high failure rate of trial leave, I was surprised that so little research had been conducted into its efficacy or ways to improve this. I wondered whether this was because it applied to such a small group of patients. However, the extremely high financial costs and personal costs to patients incurred by trial leave failure justify further research. I also noted that research into patients' perspectives of trial leave failure and readmission is limited. Many of the current IPA research and other qualitative studies being conducted in mental health services have likely arisen as a result of the popularity of the recovery approach, which values patients' perspectives and involvement in their care. In completing this study, I became more aware of the opinion that the recovery approach may not be applicable to patients in secure services, which may explain why these patients' views are under-represented in research. I hope that the current study demonstrates the value and applicability of researching the perspectives of patients in secure hospitals.

> "While writing my discussion, I am again surprised by the lack of research looking at patients' experience of trial leave (and secure hospital patients' perspectives generally). It's interesting that this reflects comments that participants made about not being listened to or involved in their care. All of the participants were very articulate in their interviews and all made recommendations for the trial leave process that seemed sensible. Why aren't their views represented more? Is this related to the stigma they experience?"

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APPENDICES

Appendix 1: Participant information sheet.

The University of Nottingham
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Participant Information Sheet
Final Version 4 – 09/12/2017

Title of study: Patients' experiences of high secure hospital readmission following unsuccessful trial leave

Name of Researchers: Alice Conlin, Mark Gresswell, Thomas Schröder, Phil Willmot

We would like to invite you to take part in our research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. Talk to others about the study if you wish. We will answer any questions you have so ask us if there is anything that is not clear.

This research will contribute to the completion of a doctorate in clinical psychology for Alice Conlin.

What is the purpose of the study?
20% of patients are readmitted to a high secure hospital following trial leave to a medium security hospital. Some patients who are not readmitted also experience difficulties during their transition between hospitals. So far, research has not explored patients' experience of the difficulties faced during trial leave, or their experience of readmission to high secure hospitals.

This study will look at how patients experience being readmitted to a high secure hospital following trial leave to a medium secure hospital. The focus of the study will include patients' experiences of the lead-up to the trial leave, their transition between hospitals, the benefits and problems they encountered during trial leave, and their readmission to high secure hospital and the implications of this for their future.

It is expected that this study will improve our understanding of why trial leave can sometimes be unsuccessful and identify ways this can be improved. The research will highlight patients' needs before and during trial leave, and following readmission to high secure hospital.

Why have I been invited?
The researchers asked psychologists at [redacted] Hospital to identify any of their male patients who had been readmitted to [redacted] Hospital following trial leave at a medium security hospital, within the last five years, and who speak English fluently. Your psychologist identified you. We are inviting all of the patients identified by the psychologists to take part. We expect there will be approximately nine patients who consent to take part in the study.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to participate you are asked to sign the attached consent form and return it to your psychologist. You can withdraw at any time without giving a reason and this would not affect your legal rights or the care you are receiving, and you would not suffer any penalties.

What will happen to me if I take part?
The researchers (Alice Conlin and Phil Willmot) would look at your clinical notes for basic information about you (e.g. information about your mental health and your trial leave). Using this, they will choose five patients who are most alike on a number of factors, and interview these patients. The other patients will not be approached for an interview. If chosen for an interview, the researchers will contact your ward office to arrange a convenient time to interview you. The interview will be conducted individually with a trainee clinical psychologist (Alice Conlin) and there would be a member of research staff from [redacted] Hospital present in the room. This member of staff would not be someone involved in your care. The interview would last about two hours and would be in a room on or near your ward. The interview would be about your experience of being readmitted to [redacted] Hospital following trial leave to a medium secure hospital. The interview will also be audio-recorded so that the conversation can be typed up afterwards. The researchers will then read the conversation to identify the important topics you have spoken about.

What are the possible disadvantages and risks of taking part?
If you take part in the study it is possible that talking about some of your experiences may upset you. If this happens, you would not be expected to continue talking about upsetting things if you wish to stop. The researchers also cannot guarantee confidentiality from people not involved in the study (e.g. the member of [redacted] Hospital staff present during the interview). Participants will also not be paid to participate.

What are the possible benefits of taking part?
We cannot promise the study will help you but the information we get from this study may help to improve the transition process between high and medium security hospitals, and the readmission process to high secure hospitals.

What if there is a problem?
If you have any concerns about this study, you can phone the telephone number provided at the end of this information sheet and speak to the researchers, who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting your local Patient and Liaison Service (PALS) on 01777 247396.

Will my taking part in the study be kept confidential?
We will follow ethical and legal guidelines and all information about you will be handled confidentially. If you take part in the study, some parts of the information collected for the study will be looked at by authorised people from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check the study is being run correctly. All of them will have a duty to keep your information confidential, and we will do our best to meet this duty.

All information collected about you during the research will be kept **strictly confidential**, stored in a locked office, on a password protected database. Any information about you which leaves the hospital will have your name and address removed (anonymised) and a unique code will be used so you cannot be recognised from it. It would be stored on a password-protected memory stick.

Personal information collected about you will be destroyed once the study has finished. Information from the interview will be made anonymous and may be kept securely for up to 7 years after the end of the study. After this time it will be destroyed. During this time, all precautions will be taken by everyone involved to maintain your confidentiality, and only members of the research team (listed above) will have access to your personal data. This is in line with the Nottingham Code of Research Conduct and Research Ethics guidelines.

Although what you say in the interview is confidential, if you say anything which we feel puts you or anyone else at any risk, we may feel it necessary to report this to the appropriate person.

What will happen if I don't want to carry on with the study?
Taking part is voluntary and you can withdraw your information at any time until your interview has finished, without giving a reason, and without your rights or care being affected. If you withdraw before or during the interview, the interview will be cancelled and your information collected up to that point will not be included in the study. If you decide not to attend your interview or it is disrupted, another interview will be offered. If you choose to withdraw after the interview is finished, the information collected so far could not be erased and may still be used in the research.

What will happen to the results of the research study?
You will be sent a letter about the results of the study, unless you request not to be sent this. The results will be included in a report as part of an educational qualification. The researchers intend to publish the results in 2018. Participants in the research will not be identifiable in any report or publication.

Who is organising and funding the research?
This research is being organised and funded by the University of Nottingham. All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and approved by the Health Research Authority through the Leicester South Research Ethics Committee.

Further information and contact details
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Wollaton Road
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NG8 1BB
0115 9515361

Appendix 2: Consent form.





Consent Form
Final Version 4 – 04/01/2018

Title of study: Patients' experiences of high secure hospital readmission following unsuccessful trial leave

Name of Researchers: Alice Conlin, Mark Gresswell, Thomas Schröder, Phil Willmot

IRAS Project ID: 219825

Name of participant:

Please initial box

1. I have read and understood the information sheet (Final Version 4 – Dated 09/12/2017) for the above study and have had the opportunity to ask questions. ☐
2. I understand my participation is voluntary and I can withdraw at any time, without giving a reason, and without my medical care or legal rights being affected. I understand that if I withdraw before the interview then my information will not be used in the study, but if I withdraw after the interview, the information collected so far cannot be erased and may still be used in the research. ☐
3. I understand that relevant sections of my medical notes and information collected in the study may be looked at by authorised people from the University of Nottingham, the researchers and authorised people ensuring the study is run correctly, where it is relevant to me taking part in this study. I give permission for these individuals to access these records and collect, store, analyse and publish information obtained from me taking part in this study. I understand my personal details will be kept confidential. ☐
4. I understand the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐
5. I understand that a member of [redacted] Hospital research staff will be present during the interview. ☐
6. I agree to take part in the above study. ☐

_____ _____ _____
Name of participant Date Signature

_____ _____ _____
Name of person taking consent Date Signature

Please tick this box if you would prefer not to be contacted with the results of this study. ☐

Appendix 3: Proforma for demographic information.

PROFORMA FOR DEMOGRAPHIC DATA COLLECTION

PATIENTS' EXPERIENCES OF HIGH SECURE HOSPITAL READMISSION FOLLOWING UNSUCCESSFUL TRIAL LEAVE

Participant study number	
DOB	
Ethnic origin	
Current mental disorder diagnosis	
Mental Health Act Section	
Index offence	
Number of previous admissions to psychiatric hospitals	
Date admitted to [redacted] Hospital	
Start date of trial leave	
Trial leave location	
Date of readmission to [redacted] Hospital	

Appendix 4: Interview schedule.

INTERVIEW SCHEDULE

PATIENTS' EXPERIENCES OF HIGH SECURE HOSPITAL READMISSION FOLLOWING UNSUCCESSFUL TRIAL LEAVE

- Greeting and introductions
- Confirm participant consents to interview and begin recording interview
- Remind participant of confidentiality issues
- Remind participants that the interview will last approximately two hours overall
- Answer any questions the participant has.

- Introduction to the interview: the research I am doing is looking at people's experiences of being readmitted to this hospital after going on trial leave to a medium security hospital. I would like to hear as much of your experience of that as you can share with me. That will include before you went to the medium security hospital, what is was like while you were there and what is was like coming back here.

- Overview
  - You have been readmitted to [redacted] Hospital following trial leave at a medium security hospital. Please could you describe your experience of what happened from start to finish?

  Possible prompts:
  - Why do you think you were readmitted?
  - How do you feel about it all?
  - How have other people reacted to your readmission?

- Preparing
  - How do you think you got to the point of being referred to medium security hospital?

  Possible prompts:
  - How did you feel about being referred to medium security?
  - What was your experience of how you were prepared in the long-term?
  - Looking back, how much of your preparation was helpful and what could have been done differently?
  - What thoughts or concerns did you have about moving?

- Going
  - What was your experience of the move and the first few days in the new hospital?

  Possible prompts:
  - How did it compare to your expectations? What were your first impressions?

- Can you remember how you felt or what you were thinking? (If anything negative: How did you cope with the difference?)
- What do you think other peoples' first impressions of you were?

- What went wrong
  - What went well and what were the major difficulties that you experienced while you were there?

  Possible prompts:
  - What happened that led to you coming back to [redacted]? (If not sure: did no one tell you or explain to you?)
  - How did you feel at the time and how did you react to those feelings?
  - What was done to try to resolve the problems, and what effect did that have?
  - What went well or was helpful for you?
  - What were your concerns or expectations about coming back?

- Coming back
  - Tell me about your experiences of coming back here.

  Possible prompts:
  - How did people react to you being back at [redacted]?
  - How did you feel being back?
  - What went well and what was a problem for you when you came back?

- The future
  - How do you think this experience will impact on your future?

  Possible prompts:
  - What is your plan for the future?
  - How would you feel about moving again to a new hospital?
  - What is happening or needs to happen to help you make progress?
  - What is getting in the way of that happening?
  - How do you make sense of the whole experience?

  - End interview and thank participants for their involvement in the study and the time they have given.

  - Answer any questions the participant might have.

Appendix 5: Transcriber confidentiality agreement.

UNIVERSITY OF LINCOLN

Data Protection Act 1998 Confidentiality Agreement for Transcribers

This Agreement is made as of _____ (Date), by and between the University of Lincoln, with principal offices at Brayford Pool Lincoln LN6 7TS (the University) and _____ with principal offices at _____, (the Transcriber).

The Transcriber has been appointed by the University of Lincoln to transcribe audiotapes/audio files and documentation resulting from research undertaken by _____ which will involve the disclosure to the Transcriber of personal data held by the University. Accordingly the Transcriber is required to deal with any such information in accordance with the terms of this Agreement and the Data Protection Act 1998.

The Transcriber undertakes to respect and preserve the confidentiality of personal data. Accordingly, for an indefinite period after the date of this Agreement the Contractor shall:

- maintain the personal data in strict confidence and shall not disclose any of the personal data to any third party;
- restrict access to employees, agents or sub-contractors who need such access for the purposes of the contract (and then only if the employee, agent or subcontractor is bound by conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University's request);
- ensure that its employees, agents or sub-contractors are aware of and comply with the Data Protection Act 1998; and
- not authorise any sub-contractor to have access to the personal data without obtaining the University's prior written consent to the appointment of such sub-contractor and entering into a written agreement with the subcontractor including conditions of confidentiality no less strict than those set out in this agreement, which the Transcriber shall enforce at the University's request.

The Transcriber agrees to indemnify and keep indemnified and defend at its own expense the University against all costs, claims, damages or expenses incurred by the University or for which the University may become liable due to any failure by the Transcriber, its employees, agents or sub-contractors to comply with any of its obligations under this Agreement.

For the avoidance of doubt, the confidentiality imposed on the Transcriber by this Agreement shall continue in full force and effect after the expiry or termination of any contract to supply services.

The restrictions contained in this Agreement shall cease to apply to any information which may come into the public domain otherwise than through unauthorised disclosure by the Transcriber.

This Agreement shall be governed by and construed in accordance with the laws of England and the parties hereby submit to the exclusive jurisdiction of the English courts.

Signed for and on behalf of _____

Signed: ..... Name: .....

Title: ..... Date: .....

Signed for and on behalf of the University of Lincoln

Signed: ..... Name: .....

Title: …..... ..... Date: .....

Appendix 6: Sponsor approval letter.

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Research, Enterprise and Graduate Services
University of Nottingham
King's Meadow Campus
Lenton Lane Nottingham
NG7 2NR

Our reference: RGS 17030
IRAS Project ID: 219825

0115 8467906
sponsor@nottingham.ac.uk

Health Research Authority
Research Ethics Committee

Dr Thomas Schröder
Associate Professor in Clinical Psychology;
Room B12 YANG Fujia Building,
Jubilee Campus,
Wollaton Road,
Nottingham, NG8 1BB

26 May 2017

Dear Sir or Madam,

Sponsorship Statement

Re: Patients experiences of high secure hospital readmission following unsuccessful trial leave

I can confirm that this research proposal has been discussed with the Chief Investigator and agreement to sponsor the research is in place.

An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.*

Any necessary indemnity or insurance arrangements will be in place before this research starts. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.

Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.

The duties of sponsors set out in the NHS Research Governance Framework for Health and Social Care will be undertaken in relation to this research.**

* Not applicable to student research (except doctoral research).
** Not applicable to research outside the scope of the Research Governance Framework.

Yours faithfully

Angela Shone
Head of Research Governance
University of Nottingham

world-changing research
from The University of Nottingham

Appendix 7: HRA approval letter.

NHS
Health Research Authority

Dr Thomas Schröder
Room B12 YANG Fujia Building,
Jubilee Campus, Wollaton Road,
Nottingham
NG8 1BB

Email: hra.approval@nhs.net

16 October 2017

Dear Dr Schröder

Letter of HRA Approval

Study title:	**PATIENTS' EXPERIENCES OF HIGH SECURE HOSPITAL READMISSION FOLLOWING UNSUCCESSFUL TRIAL LEAVE**
IRAS project ID:	**219825**
Protocol number:	**N/A**
REC reference:	**17/EM/0273**
Sponsor	**University of Nottingham**

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

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

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

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

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the HRA website, and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the HRA website.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application

IRAS project ID	219825

procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **219825**. Please quote this on all correspondence.

Yours sincerely

Nabeela Iqbal
Assessor
Email: hra.approval@nhs.net

Copy to: *Ms Angela Shone, The University of Nottingham, Sponsor contact*
Dr Shirley Mitchell, Nottinghamshire Healthcare NHS Foundation Trust, Lead NHS R&D contact

Appendix 8: REC approval letter.

NHS
Health Research Authority
East Midlands - Leicester South Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

16 October 2017

Dr Thomas Schröder
Room B12 YANG Fujia Building,
Jubilee Campus, Wollaton Road,
Nottingham
NG8 1BB

Dear Dr Schröder,

Study title:	**PATIENTS' EXPERIENCES OF HIGH SECURE HOSPITAL READMISSION FOLLOWING UNSUCCESSFUL TRIAL LEAVE**
REC reference:	**17/EM/0273**
Protocol number:	**N/A**
IRAS project ID:	**219825**

Thank you for your letter of 13 October 2017, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
GP/consultant information sheets or letters [RC Approval Form]	Final Version 3	10 October 2017
GP/consultant information sheets or letters [RC Permission Form]	Final Version 3	10 October 2017
GP/consultant information sheets or letters [RC Information Sheet]	Final Version 3	10 October 2017
Interview schedules or topic guides for participants [Interview schedule]	Final Version 3	10 October 2017
IRAS Application Form [IRAS_Form_13102017]		13 October 2017
IRAS Checklist XML [Checklist_06092017]		06 September 2017
IRAS Checklist XML [Checklist_13102017]		13 October 2017
Non-validated questionnaire [Proforma for demographic information]	Final V1	06 May 2017
Non-validated questionnaire [Proforma]	Final Version 3	10 October 2017
Other [Initial Assessment for REC]	1.0	19 July 2017
Other [Sponsor letter]	Final Ver3	10 October 2017
Other [Liability]	Final Ver3	10 October 2017
Other [Flowchart of recruitment process]	Final Version 3	10 October 2017
Other [Amendments made to IRAS form 12/08/2017]	Final Ver3	10 October 2017
Other [Transcription confidentiality agreement]	Final Version 3	10 October 2017
Participant consent form [Consent form]	Final Version 3	10 October 2017
Participant information sheet (PIS) [Participant Information Sheet]	Final Version 3	10 October 2017
Research protocol or project proposal [Protocol]	Final Version 3	10 October 2017
Summary CV for Chief Investigator (CI) [CI CV]	Final Version 3	10 October 2017
Summary CV for student [Student CV]	Final Version 3	10 October 2017
Summary CV for supervisor (student research) [Supervisor CV]	Final Version 3	10 October 2017

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

17/EM/0273	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely,



Mr John Aldridge
Chair

Email:NRESCommittee.EastMidlands-LeicesterSouth@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Ms Angela Shone,*
Dr Shirley Mitchell, Nottinghamshire Healthcare NHS Foundation Trust

Appendix 9: REC amendment approval letter.

NHS
Health Research Authority
East Midlands - Leicester South Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

03 January 2018

Miss Alice Conlin
Trainee Clinical Psychologist
Nottinghamshire Healthcare NHS Foundation Trust
Yang Fujia Building, Jubilee Campus,
Wollaton Road, Nottingham,
NG8 1BB

Dear Miss Conlin,

Study title:	**PATIENTS' EXPERIENCES OF HIGH SECURE HOSPITAL READMISSION FOLLOWING UNSUCCESSFUL TRIAL LEAVE**
REC reference:	**17/EM/0273**
Protocol number:	**N/A**
Amendment number:	**1**
Amendment date:	**09 December 2017**
IRAS project ID:	**219825**

The above amendment was reviewed on 02 January 2018 by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Decision: No ethical issues.

Approved documents

The documents reviewed and approved at the meeting were:

Document	*Version*	*Date*
Notice of Substantial Amendment (non-CTIMP)	1	09 December 2017
Participant information sheet (PIS)	4	09 December 2017
Research protocol or project proposal	4	09 December 2017

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

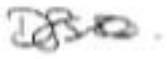
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our Research Ethics Committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

17/EM/0273:	**Please quote this number on all correspondence**

Yours sincerely



PP
Mr John Aldridge
Chair

E-mail: NRESCommittee.EastMidlands-LeicesterSouth@nhs.net

Enclosures: *List of names and professions of members who took part in the review*

Copy to: *Dr Shirley Mitchell, Nottinghamshire Healthcare NHS Foundation Trust*
Miss Alice Conlin, Nottinghamshire Healthcare NHS Foundation Trust

Appendix 10: Example of analysis

Chris' interview transcript

The beginning of Chris' interview transcript is presented below. This transcript was the first to be analysed by the researchers and so the listed emerging theme labels are early versions of the finalised themes which were identified from the complete analysis of all the transcripts. The table indicates the line location of the transcript comment in column one. Column two gives the participant's original comment within the transcript and the object of the comment is listed in column three. The final column lists the emerging theme as interpreted by the researcher.

Line	Transcript	Objects	Emerging themes
1-3	"Waiting to get there was a really long process with mine because there was building works going on at medium secure so I had to wait for bed dependent and waiting to go, but the contact with them leading up to it was really good"	- Waiting	- System needs overriding my needs - timing
10-12	"They were very welcoming, very eager and helpful for me to settle in but I also found that they weren't really…I went to a unit that was mental health only and I was a PD patient with mental health diagnosis"	- MSU - Self - MSU ward	- TL as abusive experience - staff didn't want me - Loss of attachment - new ones not safe - System needs overriding my needs - my needs not met
13-14	"Staff had become accustomed to was medication based therapy"	- MSU staff	- System needs overriding my needs - my needs not met

16-17	“There was no like nursing interventions and like someone talking”	-	MSU care	-	System needs overriding my needs - my needs not met
				-	Loss of attachments
18	“It was just totally different to this place”	-	MSU care	-	Loss of attachment - loss of secure base
22-24	“I felt like if you were to articulate how you were feeling and what was going on, I kind of got the impression that although they were welcoming and that, that they were looking for the first opportunity for you to be returned back to high secure”	-	MSU staff	-	TL as abusive experience - staff didn’t want me
				-	Loss of attachment - new ones not safe
27-28	“I kind of felt like coming from high secure you were judged a little bit differently, everything was judged on a risk to risk basis”	-	Self	-	Stigmatised me - over predicting risk
		-	Risk		
36-38	“A nursing session would be taking place in the day room and coming from this environment it’s patient confidentiality is like key to most things, there that didn’t happen”	-	MSU care	-	Loss of attachment - new ones not safe
41-42	“I just didn’t think they were ready for the practice of someone to be articulated enough to say”	-	MSU staff	-	Stigmatised me - staff not experienced
				-	TL as abusive experience - staff didn’t want me
43-46	“I knew the system quite well, a lot of other people coming there have not come from high secure, they didn’t know the system that well…that kind of went against me”	-	Self	-	Stigmatised me - staff not experienced
		-	Unmanageability	-	Stigmatised me - different needs
48-49	(Interviewer: You said they were looking for opportunities to find things, was that specifically high secure patients?) “Yeah definitely, like there was me from high secure, not even with all high secure patients, I kind of felt like it was just mainly me”	-	Risk	-	Stigmatised me - over predicting risk

51-56	“He actually assaulted a doctor…I openly seen staff sitting with him about two days later, he went to his room and he stayed in his room for a couple of days, he didn’t even get put in seclusion, and he was sat there and I heard staff openly like supporting him going yeah but, you know, this is the best place for you, you’re getting the help that you need and we’re doing this”	- MSU staff	- Stigmatised me - more rigid rules - TL as abusive experience - treated differently to peers
56-58	“Something little like me asking for medication turned into like a big thing, I had to go to my ward round and talk about was I stressed, who was I going to attack, is that why I wanted my medication”	- Risk - MSU care	- Stigmatised me - over predicting risk - Stigmatised me - vulnerabilities overlooked
59-60	“With myself they were looking for an opportunity for me to be returned rather than an opportunity for me to stay”	- Readmission risk - MSU staff	- TL as abusive experience - staff didn’t want me - Loss of attachment - new ones not safe
71-77	“I don’t know if they’d had anyone on a PD nature that’d done violent offences…people of a mental health nature, they might have done something under schizophrenia and not been accountable for their actions but I don’t think they were ready for someone to come there and hold their hands up and go yeah I actually wanted to do this crime…I don’t think they were ready for that type of, I don’t know, intelligence from a person, but used in a bad way”	- Self - MSU care	- Stigmatised me - staff not experienced - TL as abusive experience - staff didn’t want me - Stigmatised me - different needs
80-85	“I’d built up a good relationship with them and we’d come up with strategies like if I was getting stressed and that we would put things in place…the nurse and the nursing assistant that come up to see me that started putting these action plans together weren’t actually working in the unit when I got there so that stuff kind of went out the window”	- Preparing - MSU staff	- Loss of attachments - Loss of attachment - new ones not safe - TL as abusive experience - broken promises
85-87	“I felt quite alone…I felt like there was a lot of support leading up to going there from your team here and your team there but then when I got there, there wasn’t a familiar face”	- MSU care - Self	- Loss of attachments - Loss of attachment - new ones not safe

92	“Seemed a bit disorganised”	-	MSU care	-	Loss of attachment - loss of secure base
95-98	“The only things I found difficult during my time there was the answer to everything there was medication and go behind your door and like in this place PD behaviour’s taught to be challenged and for you to challenge yourself really and say listen this is what’s going for me”	-	MSU care Self	-	System needs overriding my needs - my needs not met System needs overriding my needs - reliance on procedural security
100-103	“Just a disagreement over the news channel on TV, something minor like, it was nothing major but when I went into my nursing session and I said like listen this has really pissed me off like and like the first thing to them was like are you thinking about attacking someone right now”	-	Risk Self	-	Stigmatised me - over predicting risk Stigmatised me - vulnerabilities overlooked
103-107	“I felt like sometimes the way the questions were put towards me it felt like a little bit like entrapment, it felt like they were wanting me to say yeah, I just don’t know, I just felt like they were always looking for me to say yes I feel like being violent, right you can go back. I think they felt like an obligation to take me rather than wanting me”	-	Self MSU staff Readmission risk	-	Stigmatised me - over predicting risk Stigmatised me - vulnerabilities overlooked TL as abusive experience - staff didn’t want me

Patients' Experiences of High Secure Hospital Readmission Following Unsuccessful Trial Leave

Alice Conlin, Mark Gresswell, Thomas Schröder, Phil Willmot & Danielle de Boos

Trent Doctorate in Clinical Psychology, University of Nottingham

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

Background

Discharge from high to medium secure hospital is preceded by trial leave where patients transfer to medium secure hospital but remain under their high secure hospital's care.

Patients often encounter difficulties during trial leave and many are readmitted (20-46%; Tetley, Evershed & Krishnan, 2010; Blattner & Dolan, 2009). The cost of trial leave failure is high and patients experience psychological distress and disrupted recovery.

Trial leave failure, particularly patients' experiences of failure, remains relatively unexplored, and little research has investigated their experiences following high secure hospital readmission. Thus, patients' needs during trial leave failure and readmission are unclear. The lack of investigation into patients' underlying difficulties makes it difficult to address them (Thomas Peter, 2002; Wallace, 2012).

Objective: To explore patients' experiences of high secure hospital readmission following unsuccessful trial leave.

Methodology

5 male patients were interviewed about their experience of readmission to high secure hospital following failed trial leave. Questions explored their experiences before, during and after readmission. Transcripts were analysed using IPA.

Participants:
- Were in the high secure hospital's Personality Disorder service.
- 2 had comorbid mental health diagnoses.
- Had not previously been on trial leave.
- Had spent on average 57 months (range 16-101 months) in high secure hospital before trial leave.
- Had been back in high secure hospital for an average of 36 months (range 9-59 months).

Results

Superordinate themes	Subordinate themes
I lost my safe attachments.	- My strong high secure hospital attachments ended abruptly. - Medium secure hospital offered me unsafe alternative attachments.
My trial leave experience was like my previous traumatic experiences.	- My trial leave process was abusive. - The abusive experience felt familiar to me.
The needs of the trial leave system overrode my needs.	- My needs weren't met. - I had to take responsibility for my trial leave failure. - Prioritising the system's needs affected my self-concept.
I was stigmatised because I came from high secure hospital and had a PD diagnosis.	- I was misperceived as risky and treated as high risk. - I had different needs to medium secure hospital patients. - My vulnerabilities were overlooked.

Discussion

4 superordinate themes were identified:
- Participants experienced distress when they abruptly lost safe high secure hospital attachments. They struggled to build new attachments in medium secure hospital and those offered were perceived as less safe.
- Participants experienced their trial leave as abusive, describing elements of their treatment as similar to previous abuse. They felt vulnerable but noted their possible hypervigilance to threat.
- Participants felt their needs were not met as they were overridden by requirements of the trial leave system. They felt coerced into taking responsibility for their trial leave failure, despite attributing some responsibility to aspects of the trial leave system. They noted this affected their self-concept.
- Participants believed medium secure hospital staff stigmatised them for their high secure hospital history and their personality disorder diagnosis, over-perceiving their risk and overlooking their vulnerabilities. They felt that their needs, which were different to medium secure hospital peers, were not met.

These findings build on existing research, providing a rich, patient-focused account of the experience of unsuccessful trial leave and high secure hospital readmission, adding to the theoretical and empirical understanding.

Implications
- Work preparing patients for attachment losses has been shown to be helpful (Adshead et al, 2017) and could be offered alongside practical information and ward visits to build predictability and develop new attachments.
- On readmission, addressing grief and validating patients' external attributions of their failure may help them to re-engage.
- Staff training, particularly in trauma- and attachment-informed models of personality disorder treatment, could help staff support patients during transitions
- A collaborative, dynamic and timetabled trial leave pathway could help patients prepare practically and psychologically.
- Attachment-informed 'transition teams' could improve liaison between teams and the co-ordination of transitions.

Limitations
- Limited representativeness of the findings: only 5 patients were interviewed, all with a personality disorder diagnosis.

Future research
- How do participants' experiences compare to their clinicians' views?
- How do these patients' experiences compare to those of patients who succeed trial leave?
- How do patients with other diagnoses experience failed trial leave and high secure hospital readmission?

Key references

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