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Doctoral Thesis:

Exploring the experiences of staff working in forensic mental health settings.

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Thesis Abstract

Forensic mental health (FMH) is described as a complex and challenging specialism to work in. The experiences of staff working within FMH settings have important influences on the quality of care provided to patients. This thesis explored the experiences of both multidisciplinary staff and clinical psychologists.

A meta-synthesis of international qualitative studies was conducted to explore the experiences of staff working in FMH settings. Sixteen papers were synthesised, revealing five themes: 1) The impact of safety; 2) Psychological and emotional impacts; 3) Trying to maintain control; 4) The double-edged sword of support; and 5) A special insight into humanity. The findings point to the importance of understanding how staff manage the impacts of working in FMH settings in order to develop effective support systems.

Eight clinical psychologists were individually interviewed to explore their lived experiences of compassion satisfaction when working in UK forensic mental health settings. Five themes were identified using interpretative phenomenological analysis: 1) The magnitude of trust; 2) Adjusting expectations; 3) Being both lock and key; 4) Needing time and resources; and 5) Variety and complexity. The results highlighted important distinctions in how compassion satisfaction can be experienced by clinical psychologists in this specialty, and what may influence these experiences.

A critical appraisal of the process of carrying out the research was conducted. Issues regarding ethical approval, recruitment, and methodology were discussed, in addition to the impact of the study on the researcher.

Declaration

The research reported in this thesis was undertaken for the Doctorate in Clinical Psychology Programme at the Division of Health Research at Lancaster University between December 2016 and November 2017. The word length of this thesis conforms to the permitted maximum. The work presented is the author's own except where due reference is made. The research reported here has not been submitted for any other academic award elsewhere.

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In loving memory of my Nana Connie: thank you for your endless warmth, kindness and compassion.

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Section One: Literature Review

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**Experiences of working in forensic mental health settings: a meta-synthesis of
qualitative research.**

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8, 140 (excluding Abstract, Tables, Figures, References, and Appendices)

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Prepared for *Legal and Criminological Psychology* (see Appendix 1-A)

Abstract

Purpose: Forensic mental health (FMH) is described as a challenging specialty to work in as staff hold responsibilities for both delivering care and managing security. The current review aimed to synthesise the findings from published qualitative studies which had explored the experiences of staff working in FMH settings. This was with a view to increasing understanding around the impact of this work, informing practice guidance, and highlighting areas for future research. Method: A systematic search of international literature was conducted across four electronic databases using a combination of thesaurus and key search terms. An inclusion/exclusion criteria and a quality appraisal tool were applied which resulted in 16 relevant papers being selected for review. Results: A meta-synthesis of the selected papers was conducted which identified five themes: 1) The impact of safety; 2) Psychological and emotional impacts; 3) Trying to maintain control; 4) The double-edged sword of support; and 5) A special insight into humanity. Conclusions: The available research highlights the importance of understanding staff experiences related to working in FMH settings and how these are managed. The findings are discussed with reference to clinical practice and policy guidelines. Further research should continue to extend this knowledge to help develop supervisory and support systems that effectively meet the needs of staff working in FMH contexts, which in turn will enhance the quality of patient care.

Keywords: staff, forensic mental health, experiences, qualitative.

The specialism of “forensic mental health” (FMH) is broadly defined as involving “the assessment and treatment of those who are both mentally disordered¹ and whose behaviour has led, or could lead, to offending” (Mullen, 2000, p.307). As such, FHM settings require conditions of security to meet their core intentions of caring for patients² in contact with the criminal justice system and protecting the public; these roles require careful balancing and can conflict each other (Rogers & Soothill, 2008).

The number of prisoners has nearly doubled in England and Wales since 1993 (The Prison Reform Trust, 2016) and has increased by 20% internationally since 2000 (World Prison Brief, 2016). Across the world the prison population has comparatively higher documented levels of mental health difficulties than the general population (Brinded, Simpson, Laidlaw, Fairley & Malcolm, 2001; Brugha et al., 2005; Holley, Arboleda-Flórez & Love, 1995). These statistics, along with the increasing consensus that prison environments are not suitable for people with serious mental health needs (Department of Health, 2009), suggests that more people than ever are in need of specialist FMH services. Worldwide research also indicates staff³ working in FMH encounter a range of challenges, yet the exploration of these experiences and how staff manage the impact of working in this field has overall received little attention.

Internationally a range of FMH systems are currently in operation (Abdalla-Filho & Bertolote, 2006; World Health Organisation, 2008) with countries mostly delivering services within correctional environments or in secure units based within or separate to prisons. Different security levels (high, medium and low) are operationalised according to levels of risk presented by patients (Joint Commissioning Panel for Mental Health, 2013), and specialist community FMH teams are now provided in some parts of the world, though local

¹ The term ‘mentally disordered offender’ is not used in this paper though this is used within the literature.

² The term “patient” will be used throughout this paper; though this term is discouraged by the British Psychological Society (BPS, 2015), it is traditionally used in the FMH research base and relevant legislation.

³ Throughout this paper the term “staff” will be used to refer to those who work in FMH services.

delivery of these can be 'patchy' (Mohan & Fahy, 2006). According to Bartlett (2010), within any given jurisdiction the type of clinical and legal practices also differ across locations.

Therefore, the boundaries of FMH services are indistinct and differ globally, across historical periods, professions, and service contexts (Rogers & Soothill, 2008).

Staff working in FMH settings care for patients with complex mental health needs who may or may not be at the intersection of the criminal justice system (Bowring-Lossock, 2006). Patients may have been transferred directly from the court/prison system or from mainstream mental health services that were unable to contain the presented risks (Schanda, Stompe & Ortwein-Swoboda, 2009). Patients in FMH usually do not have the right to choose their care (Gustafsson & Salzman-Erikson, 2016), and length of stay is significantly longer in FMH services than for patients who remain in prison (Prins, 2005).

Similar to mainstream mental health, present-day FMH services are often delivered by multidisciplinary teams (MDTs) of staff within a recovery-oriented paradigm (Mann, Matias & Allen, 2014; Simpson & Penney, 2011). Five main professional groups are employed in FMH services: psychiatry, psychology, nursing, social work and occupational therapy (OT) (Rogers and Soothill, 2008), in addition to staff occupying unqualified support worker roles. Interestingly the nursing, social work and OT professions have no recognised 'forensic' training routes; some have argued 'forensic' mental health nursing is thus not a distinct role (Kettles & Woods, 2006) as the role is defined by the patient group and not by specialised training. Nevertheless, the roles of FMH staff are indeed different to those working in other fields in that they are centred around the 'dangerousness' of patients, connections with legal systems, and secure facilities (Forshaw, 2008), and as such their experiences should be afforded separate consideration within research.

Patient aggression is a widely reported issue in FMH settings (Mason, 2000) and many patients have committed index offenses of a violent nature (Coldwell & Naismith,

1989). Compared to acute inpatient mental health wards, a higher proportion of patients in FMH services are responsible for violent incidents both within and across countries worldwide (Bowers et al., 2011). Therefore, a key issue for FMH staff relates to the dilemma of balancing security with therapeutic support, also known as the ‘custody-care tension’ (Peterjn-Taylor, 2000; Rask & Hallberg, 2000; Swinton & Boyd, 2000). The co-existence of therapeutic care and security is demonstrated by a study in the Netherlands, whereby aggressive incidents reduced with better nursing support (Ros, Van Der Helm, Wissink, Stams, & Schaftenaar, 2013), highlighting the reciprocal nature of these concepts.

The quality of patient care in FMH settings across the world is questionable. In one Swedish study, some patients reported their treatment by staff in a maximum secure FMH hospital was uncaring and at times humiliating with only ‘pockets’ of good care, which created feelings of needing to cooperate with staff (Hörberg, Sjögren, & Dahlberg, 2012). Patients in a Finnish study of FMH services also reported feeling humiliated and controlled by staff (Askola et al., 2016). Though power imbalances are inevitable in secure facilities, these findings may reflect a deeper issue regarding deficits in compassionate care, a concern which has been highlighted across healthcare services in the UK (Francis, 2013) and globally (Mannion, 2014).

In relation to what may impact on compassionate care, the psychoanalytic literature can help explain how FMH staff can be affected in profound and unconscious ways (Casement, 1988) when working with a patient population with severe psychological and social difficulties. It is a well-established proposal that staff may develop defensive counter-therapeutic practices and attitudes if difficult emotions are not processed via tools such as clinical supervision (Menzies-Lyth, 1960). Psychoanalytic ideas and the concept of counter-transference have been applied to understanding the experiences of FMH staff by Gordon and Kirtchuk (2008), who advocated the awareness of patients’ feelings is an essential component

of care as this is often the primary vessel for patients to understand their own emotions. However, the practice of relational security, which is a key element of risk management in secure services (Royal College of Psychiatrists, 2015) may impact on the formation of close therapeutic staff-patient relationships due to the need to maintain appropriate and non-negotiable boundaries. Hence, the complexity of the custody-care tension in FMH settings is emphasised, with staff expected to know their patients' emotional needs well enough to facilitate therapeutic support whilst also remaining professionally boundaried.

Quantitative research regarding work satisfaction in FMH staff has produced mixed findings. Some studies have reported FMH staff have high overall levels of satisfaction (Burnard, Morrison & Phillips, 1999; Happell, Martin & Pinikahana, 2003); other studies have reported low levels of compassion satisfaction (Lauvrud, Nonstad & Palmstierna, 2009) and higher levels of occupational stress (Kirby & Pollock, 1995). Greater levels of staff burnout and stress from high caseloads have also been identified in community FMH settings (Coffey & Coleman, 2001), which emphasises that the challenges of working in FMH services are not limited to secure units. Other research has found higher overall levels but no significant differences in stress between general mental health nurses and FMH nurses, as different sources of stress were identified according to each working environment (Chadler & Nolan, 2000).

The studies cited above were all comprised of FMH nursing staff from the UK, Australia and Norway, which may limit the generalisability of the findings to other disciplines and other countries. A recent study by Elliott and Daley (2013) did recruit multidisciplinary staff in secure FMH settings, and also reported high levels of burnout and occupational stress. However, this involved two FMH Learning Disability services which may have influenced the findings due to the different needs of this patient group.

A small number of systematic literature reviews have been published which again have focused on FMH nursing staff, and have adopted a specific focus such as nursing role tensions (Mason, 2002), experiences of social climate (Doyle, Quayle & Newman, 2017), and interactions with patients (Gildberg, Elverdam & Hounsgaard, 2010). Many authors cite the paucity of research in the FMH field as a considerable barrier to conducting meaningful reviews. For example, a systematic review of patient involvement in structured violence risk management within FMH facilities only yielded three papers (Eidhammer, Flutttert & Bjørkly, 2014) again highlighting this issue. Similarly, in a recent quantitative literature review Brown, Igoumenou, Mortlock, Gupta, and Das (2017) argued there is insufficient evidence to suggest FMH staff experience higher levels of stress than non-FMH staff. This links to the previous point that quantitative studies have produced mixed findings regarding staff satisfaction in FMH.

Together, the available research indicates staff working in FMH settings can face a range of distinct challenges, yet few papers have qualitatively explored their experiences, and many have focused on the perspectives of nursing staff. The National Institute for Health and Care Excellence (NICE, 2007) recommend that staff should have access to supervision and support in ... "managing [the] stress associated with working in the criminal justice system and how this may affect their interactions with people and their own mental health and wellbeing" (p.28, NICE, 2007). However, no additional details are provided on how this support should be structured or delivered. A small number of qualitative studies have been published which have enabled staff to express their experiences using their own words, however these studies have often explored specific experiential aspects of working in FMH such as therapeutic relationships with patients. A more holistic understanding of the experiences and impacts reported by staff across all disciplines cited in qualitative studies could identify wider themes and clarify the types of support staff may require.

The Current Review

Though there has recently been a small rise in qualitative studies exploring the experiences of staff working in FMH from various disciplines, no systematic review of these studies has yet been published. A meta-synthesis of the themes reported across these papers would enhance the understanding of staff experiences and address a gap in the literature, given there has been a dominance on nursing staff views. Reviewing a set of studies using techniques such as a meta-synthesis can help to produce fresh insights into a particular issue (Walsh & Downe, 2005) and develop broader findings which reach “higher analytic goals” (Sandelowski, Docherty & Emden, 1997, p. 367). Thus, it is increasingly acknowledged that meta-syntheses are valuable in informing developments in clinical practice (Dixon-Woods & Fitzpatrick, 2001).

This review is therefore important as it will add to the research base and has the potential to help inform current policy and practice guidance. Hence, this review aimed to identify: “What are the personal experiences and impacts of staff who work clinically in FMH settings, and how do staff manage these experiences?”

Method

The Context, How, Issues and Population (CHIP) tool was utilised (see Appendix 1-B) and a CHIP mind map of relevant keywords was developed (see Appendix 1-C) as described by Shaw (2010) to identify synonyms, refine the research question and develop the literature search strategy. The reporting guidelines outlined in the ‘Enhancing Transparency in Reporting the Synthesis of Qualitative Research’ (ENTREQ) statement (Tong, Flemming, McInnes, Oliver & Craig, 2012) were followed in this review.

Searching for Papers

A comprehensive search of four electronic databases of international peer-reviewed papers was conducted up to and including 3rd February 2017 using Academic Search Complete, the Cumulative Index to Nursing and Allied Health (CINAHL), PsycINFO, and MEDLINE. These databases were selected for their coverage of allied health professions, nursing, science and mental health, and therefore would include worldwide research in FMH across a range of professions. Databases were searched from their earliest coverage dates without applying date limiters.

Each database was searched individually using a combination of subject headings and key search terms associated with the following concepts: 1) qualitative methodology, 2) forensic mental health, and 3) clinical staff. A specialist academic librarian was consulted regarding the search strategy. Key search terms were applied to the title (TI) and abstract (AB) of papers to reduce the likelihood of irrelevant results.

Boolean operators including 'AND' and 'OR' were utilised, in addition to truncation using the wildcard asterisk function (*). Where appropriate, subject headings were exploded and irrelevant subject headings were manually removed where possible (such as 'school psychologist'). See Table 1 for database search strategies and Table 2 for the inclusion and exclusion criteria.

Table 1: Database search strategies and results conducted up to 3/02/2017.

Database (years of coverage)	Thesaurus / MeSH / Subject Headings (applied to all fields) Key search terms (applied to title and abstract only)	Strategy
Academic Search Complete (1984-2017)	(ZE "mental health personnel" OR ZE "psychiatric nursing" OR ZE "social workers" OR ZE "psychologists" OR ZE "psychiatrists" OR ZE "occupational therapists") OR (clinician* OR staff OR nurs* OR "mental health professional*")	AND
	(forensic OR "secure unit*" OR "secure setting*" OR "secure hospital*" OR "secure mental" OR "secure psychiatric" OR "low secur*" OR "medium secur*" OR "high secur*")	AND
	(ZE "qualitative research" OR ZE "qualitative research -- methodology" OR ZE "focus groups" OR ZE "ethnology") OR (qualitative OR experien* OR interview* OR narrative* OR phenomenolog* OR thematic OR "grounded theory" OR "focus group*" OR "content analysis" OR ethnolog* OR perspective* OR interpret*)	
	= 499	
CINAHL (1996-2017)	(MH "Mental Health Personnel+" OR MH "Psychiatric Nursing" OR MH "Nursing Assistants" OR MH "Psychiatrists" OR MH "Social Workers" OR MH "Occupational Therapists") OR (clinician* OR staff OR nurs* OR "mental health professional*")	AND
	(forensic OR "secure unit*" OR "secure setting*" OR "secure hospital*" OR "secure mental" OR "secure psychiatric" OR "low secur*" OR "medium secur*" OR "high secur*")	AND
	MH "Qualitative Studies" OR (qualitative OR experien* OR interview* OR narrative* OR phenomenolog* OR thematic OR "grounded theory" OR "focus group*" OR "content analysis" OR ethnolog* OR perspective* OR interpret*)	
	= 121	
	(= 80 when duplicates removed)	

MEDLINE (1973-2017)	(MH "Psychiatric Nursing" OR MH "Social Work, Psychiatric" OR MH "Psychology" OR MH "Psychiatry" OR MH "Psychotherapy" OR "Occupational Therapy") OR (clinician* OR staff OR nurs* OR "mental health professional*")	AND
	(forensic OR "secure unit*" OR "secure setting*" OR "secure hospital*" OR "secure mental" OR "secure psychiatric" OR "low secur*" OR "medium secur*" OR "high secur*")	AND
	MH "Qualitative Research" OR (qualitative OR experien* OR interview* OR narrative* OR phenomenolog* OR thematic OR "grounded theory" OR "focus group*" OR "content analysis" OR ethnolog* OR perspective* OR interpret*)	
	= 600 (= 326 when duplicates removed)	
PsycINFO (1953-2017)	(DE "Mental Health Personnel" OR DE "Clinical Psychologists" OR DE "Psychiatric Hospital Staff" OR DE "Psychiatric Nurses" OR DE "Psychiatric Social Workers" OR DE "Psychiatrists" OR DE "Psychotherapists" OR DE "Clinicians" OR DE "Therapists" OR DE "Occupational Therapists" OR DE "Physical Therapists") OR (clinician* OR staff OR nurs* OR "mental health professional*")	AND
	(forensic OR "secure unit*" OR "secure setting*" OR "secure hospital*" OR "secure mental" OR "secure psychiatric" OR "low secur*" OR "medium secur*" OR "high secur*")	AND
	DE "Qualitative Research" OR (qualitative OR experien* OR interview* OR narrative* OR phenomenolog* OR thematic OR "grounded theory" OR "focus group*" OR "content analysis" OR ethnolog* OR perspective* OR interpret*)	
	= 919 (= 697 when duplicates removed)	
Total= 2, 139 Total (after duplicates removed) = 1, 602		

Table 2. Inclusion and exclusion criteria.

Inclusion Criteria	Exclusion Criteria
1) The paper explored the personal internal experiences of clinical staff working in FMH settings or services.	1) The paper focussed on staff experiences of issues that were only specific to a certain service (i.e. a therapeutic programme) and were not indicative of the general experiences of working in FMH services.
2) The paper was published in the English language in a peer-reviewed journal.	2) The paper focussed solely on staff attitudes, understandings, or perspectives of a particular external issue (rather than their own internal experiences).
4) The paper had collected qualitative data using interview methodology.	3) The study was set within prisons, general mental health or Learning Disability services, or the service context was not clearly specified as FMH.
5) The paper had used an inductive analysis to explore staff experiences.	4) It was unclear if qualitative methods had been used.
6) The sample included clinical staff.	5) The sample only involved service users, carers, prison staff or non-clinical staff.
7) The paper reported direct participant quotes.	
8) A sufficient proportion of the study themes were relevant to the research question (i.e. at least one theme or sub-theme).	

Papers using mixed methods research designs were considered only if qualitative data were clearly identified. Likewise, papers exploring staff and non-staff experiences (such as patients/carers) were included where staff data could be clearly identified and extracted (for instance see Holmes, Murray & Knack, 2015).

Search Results

Results for each database were limited to records published in English in peer-reviewed academic journals. MEDLINE records were removed from the final CINAHL search results in order to avoid duplication. A total of 2, 139 papers were obtained from the search. Duplicated papers were identified using EndNote software and removed resulting in

1, 602 papers. The search results were initially screened by title and abstract. If it was unclear if a study was eligible for inclusion, the method and results sections were read and considered against the inclusion/exclusion criteria.

To identify additional papers not already noted in the electronic searches the references of the selected studies were hand-searched and citations since publication were reviewed using the Lancaster University Onesearch and Google Scholar search engines. No additional papers were identified for the final meta-synthesis this way. A total of 16 papers met the inclusion criteria; see Figure 1 for the literature search and screening process.

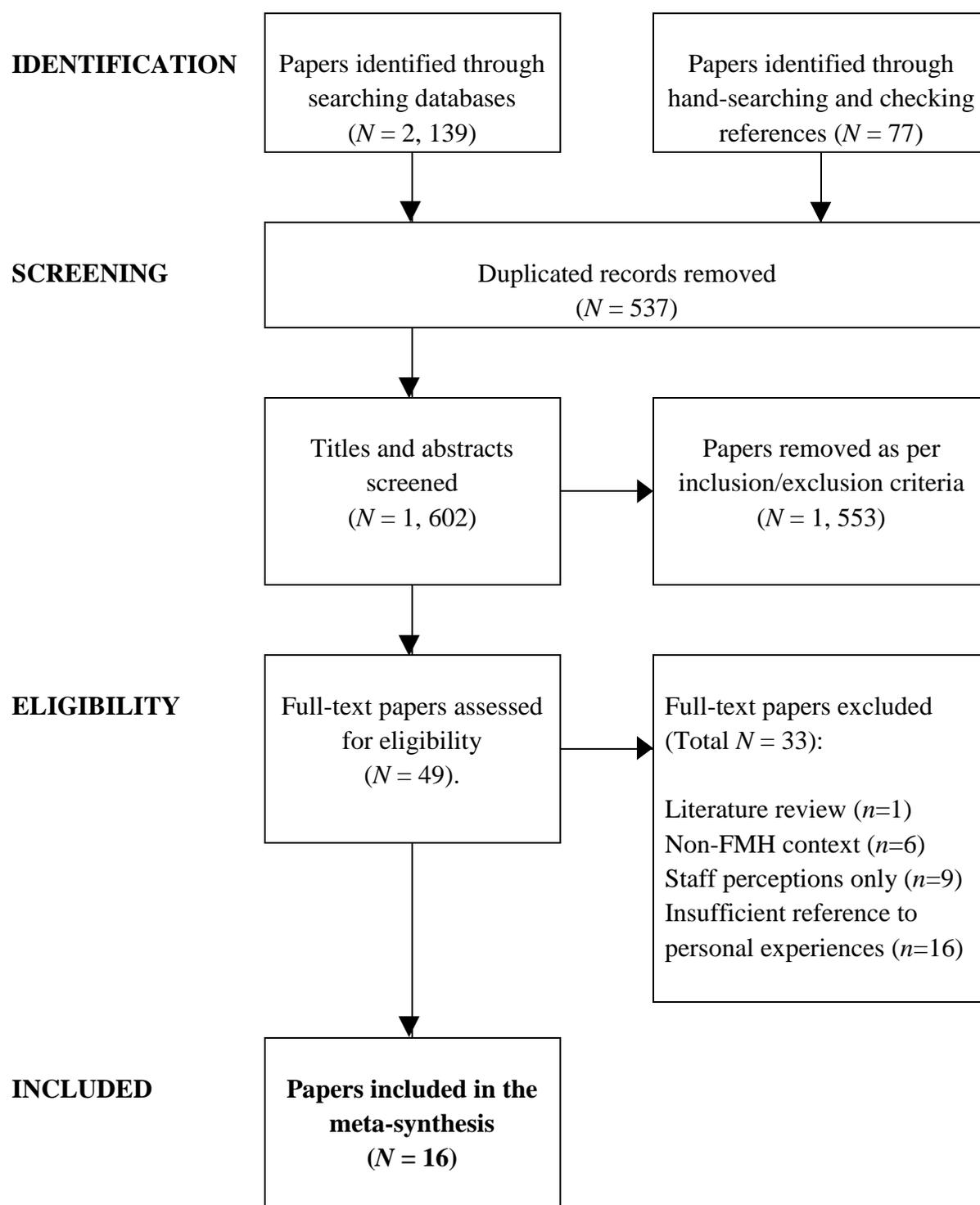


Figure 1. Flowchart⁴ to illustrate the process of paper selection.

⁴ Adapted from Moher, Liberati, Tetzlaff & Altman's (2009) 'Four phase flow diagram'.

Critique of the Selected Papers

The reporting quality of selected papers were appraised using the Critical Appraisal Skills Programme (CASP) (Public Health Resource Unit, 2006). Though other tools are available, Katrak, Bialocerkowski, Massy-Westropp, Kumar and Grimmer (2004) argue no optimal tool exists, so the author should use one that works best for them. The CASP was chosen as it was considered to be a widely used, clear and comprehensive tool.

The CASP assesses the reporting quality of papers based on ten areas considered necessary for a study to be judged as 'high quality'. All selected papers passed the two screening questions: 1) is there a clear statement of the aims of the research? and 2) is a qualitative methodology appropriate? Eight additional areas are then assessed: research design; sample recruitment; data collection; researcher's reflexivity; ethical considerations; data analysis; findings; and research value.

Duggleby et al.'s (2010) three-point rating system was used to allocate the selected papers a quality score for each of the ten CASP areas, ranging from 1) "weak": little/no justification of a particular issue; 2) "moderate": addressed but not fully elaborated on the issue; or 3) "strong": extensively justified and explained the issue (see Appendix 1-D). This system yields a maximum total CASP score of 30 for each paper.

Scores for selected papers ranged from 18 to 25. The perceived quality of the papers was not used as a criterion for exclusion from the review given there is no consensus on how to implement this (Dixon-Woods, Booth & Sutton, 2007). The mean total score for the quality of the selected papers was 22.7 out of 30 (75.7% of achievable CASP score). Table 3 displays an overview of total CASP scores for each study. For simplicity, papers are arranged alphabetically and assigned a corresponding numerical code.

Table 3. Overview of total CASP scores for each study.

Study code number	Study authors	Total CASP score	Percentage of CASP achieved
S1	Aiyegsburi & Kelly (2015)	19	63.3%
S2	Beryl, Davies & Völlm (2016)	25	83.3%
S3	Boyle, Kernohan & Rush (2009)	22	73.3%
S4	Clark (2013)	24	80%
S5	Evans, Murray, Jellicoe-Jones, & Smith (2012)	24	80%
S6	Gustafsson & Salzman-Erikson (2016)	25	83.3%
S7	Harris, Happell, & Manias (2015)	22	73.3%
S8	Holmes, Murray, & Knack (2015)	25	83.3%
S9	Jacob & Holmes (2011)	23	76.6%
S10	Kumpula & Ekstrand (2013)	22	73.3%
S11	Kurtz & Jeffcote (2011)	22	73.3%
S12	Kurtz & Turner (2007)	18	60%
S13	Niebieszczanski, Dent & McGowan (2016)	25	83.3%
S14	Rose, Peter, Gallop, Angus, & Liaschenko (2011)	21	70%
S15	Sequeira & Halstead (2004)	23	76.6%
S16	Tema, Poggenpoel, & Myburgh (2011)	23	76.6%

All studies justified the choice of a qualitative research design and most were explicit in the reporting of the findings and in considering the value of the research. However, 10 of the 16 studies were rated as ‘weak’ on the reporting of reflexivity, such as describing how the researcher’s role may have influenced the results. A number of studies also did not elaborate

on ethical considerations beyond stating approvals had been granted, such as how participant confidentiality was maintained, which may have been due to journal word limits.

Features of the Selected Papers

General characteristics of the final studies were extracted into a summary table detailing the main features of the selected papers (see Appendix 1-E), including the authors' names, date of publication, research aims, country, participants, methodology, and type of service.

The selected papers were published between 2004 and 2016. The studies were international with 11 conducted in Europe, three in Canada, one in South Africa, and one in Australia. Of the 11 European studies, eight were conducted in the United Kingdom, one in Northern Ireland, and two in Sweden. Sample sizes ranged from five to 27, and most studies involved nursing staff. All studies used face-to-face individual interviews except one (Harris et al., 2015) which used a focus group then offered participants a follow-up individual interview. A range of data analysis methods were used including: grounded theory methods ($n=5$), Interpretative Phenomenological Analysis (IPA; $n=4$), content analysis ($n=2$), thematic analysis ($n=1$), thematic content analysis ($n=1$), framework analysis ($n=1$), Tesch's open coding method ($n=1$), and a general inductive approach ($n=1$). The majority of studies were conducted in secure units, with two conducted in community FMH settings.

Importantly, all but three UK studies (Kurtz & Turner, 2007; Kurtz & Jeffcote, 2011; and Sequeira & Halstead, 2004) clearly specified appropriate ethical approvals had been granted prior to conducting their research. Two studies (Gustaffson & Salzman-Erikson, 2016; Kumpula & Ekstrand, 2013) stated ethical principles were followed but that formal approvals were not required for the type of research in their host country (Sweden).

Synthesising the Selected Papers

The selected papers were analysed using Noblit and Hare's (1988) technique for synthesising interpretative research, often referred to as 'meta-ethnography'. This approach provides a "rigorous procedure for deriving substantive interpretations about any set of...interpretative studies" (Noblit & Hare, 1988, p.9) and is one of the most commonly cited techniques in qualitative meta-syntheses (Dixon-Woods et al., 2007). The aim is to compare, analyse and translate qualitative studies into one another to arrive at fresh interpretations of the data, and also to identify 'refutational' studies that stand in opposition to one another.

The seven phases in Noblit and Hare's (1988) meta-ethnographic approach were followed as described in the worked example by Britten et al. (2002). The specific process of translating themes is often difficult to describe and as such "cannot be reduced to a set of mechanistic tasks" (Britten et al., 2002, p.211). In the current review, relevant themes reported in the 16 studies were compared and contrasted by creating individual tables of participants' quotes and authors' themes relevant to the research question. Reading and re-reading each paper facilitated the identification of translations and refutations, which were collated into a single table with the researcher's interpretations. Table 4 summarises the steps taken in the current meta-synthesis.

Table 4. Steps completed in the meta-synthesis as per Noblit and Hare (1988).

Phase	Actions
1	Getting started. The research question and search terms were developed using the CHIP tool and forming a CHIP mind-map.
2	Deciding what is relevant to the initial interest. The search strategy was developed and refined, screening and identification of suitable papers was conducted.
3	Reading the studies. Hardcopies of all selected papers were obtained; these were read and re-read to familiarise the researcher with the authors' reported themes.
4	Determining how the studies are related. Key participant quotes ('first order constructs') and relevant interpretations by the study authors ('second order constructs') were transferred into individual tables (one table per study).
5	Translating the studies into one another. Similarities and differences were identified across the studies and broader themes which translated across the studies were developed.
6	Synthesizing translations. Study translations were grouped into a single table to facilitate further synthesis and the development of five overarching themes, often named 'third-order constructs' (Britten et al., 2002).
7	Expressing the synthesis. A lines-of-argument (LOA) approach was adopted in order to consider how the studies related to each other and to construct a comprehensive picture of FMH staff experiences.

Reflexivity

It is important to acknowledge the position of the researcher in the above stages. As Noblit and Hare (1988) comment, conducting a meta-ethnography "reveals as much about the perspective of the synthesiser as it does about the substance of the synthesis" (Noblit & Hare, 1988; p.14). Hence, it should be noted the researcher had previously worked in a medium secure FMH setting as an Associate Practitioner, which was both rewarding and challenging.

Therefore, it was anticipated a variety of positive and negative themes would be generated from the synthesis.

Furthermore, meta-ethnography adopts an 'objective idealist' approach which assumes "there is a world of collectively shared understandings"; this differs from the researcher's 'critical realist' view of research which proposes "knowledge of reality is mediated by our perceptions and beliefs" (both cited in Barnett-Page & Thomas, 2009; p.5). Supervisory feedback was thus sought regarding the researcher's interpretations of themes.

Results

Five overarching themes were generated from the current meta-synthesis. These reflected the experiences of a range of staff working in FMH settings. Themes included: 1) The impact of safety; 2) Psychological and emotional impacts; 3) Trying to maintain control; 4) The double-edged sword of support; and 5) A special insight into humanity. These themes were all relevant to the experiences and emotional impacts of working in FMH, and how staff may manage these experiences. The identified themes are depicted in Figure 2. Examples from the final meta-synthesis for each theme are provided in Appendix 1-F.

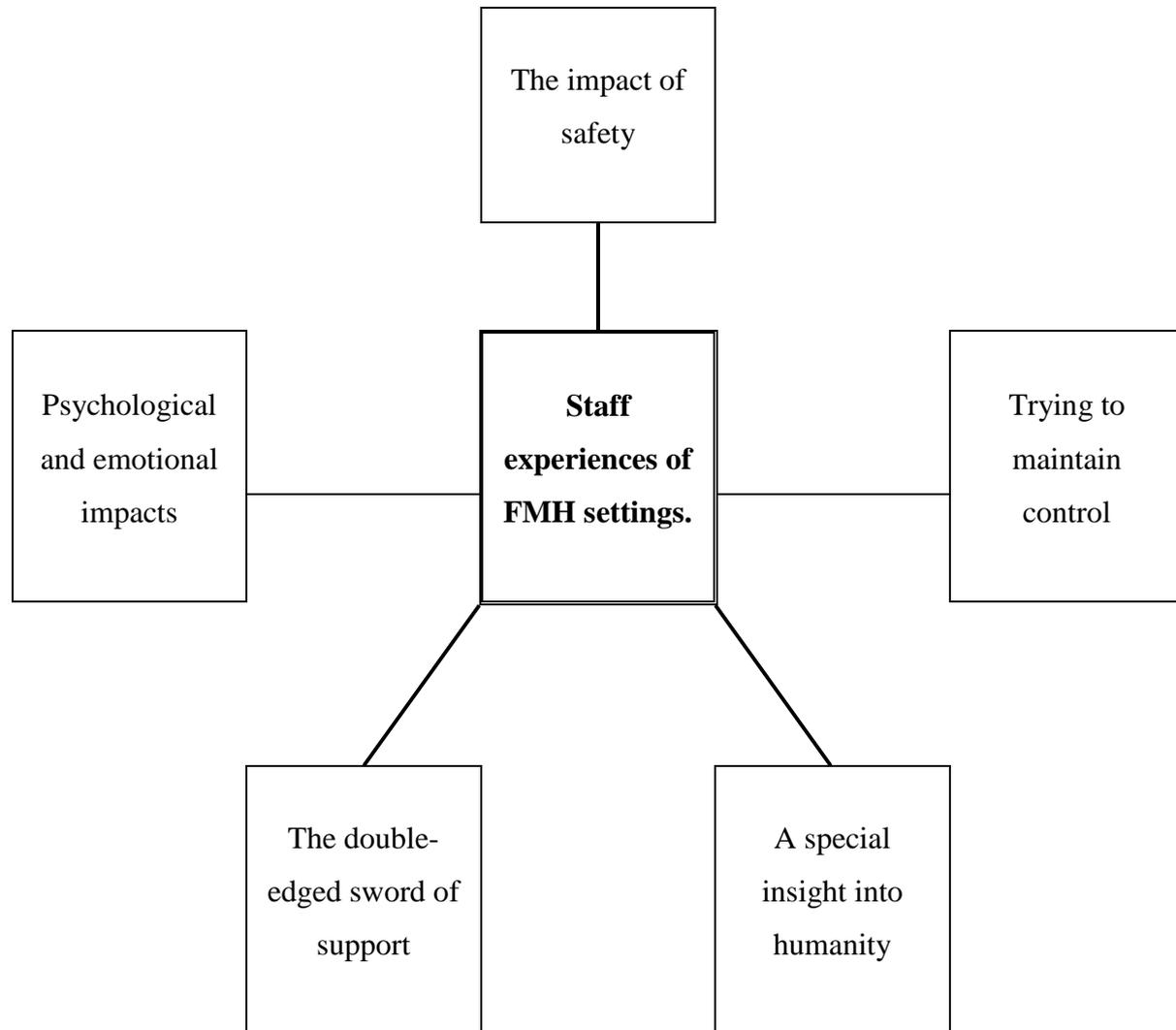


Figure 2. Themes identified in the current review.

The Impact of Safety

This theme captured how the experiences and impacts of safety in FMH workplaces appeared to occur on a spectrum, from FMH settings being very unsafe places to work, to FMH being safer than other specialties. In addition, experiences of safety vacillated in response to incidents and resourcing issues such as staffing levels. The findings reported in eleven papers contributed to this theme.

There was a sudden realisation that physical safety in FMH can be seriously threatened by patient violence, for example, "...the first real big incident that I had it scared me, it did scare me, I thought 'Shit what have I let myself in for'...I was very worried that I'd get hurt..." (S15, p.6). Fear of physical assault by patients was reported in numerous papers. Some reported passing on the fear of potential risks to student nurses (S9), and others believed that it was protective to hold on to this fear, "I don't think you should become blasé...if there is a patient who's effing and blinding and blowing their top...I get butterflies and I feel nervous and God what could happen here?" (S11, p.252).

Fear over personal safety led to some staff recognising the usefulness of forcible interventions in order to prevent harm, such as the physical and medicinal restraint of patients (S7, S8, and S15). In papers focusing on enforced interventions, staff depicted rapid emotional fluctuations from fear to relief once safety was restored, such as when unsettled patients were locked into seclusion rooms (S8). In refutation to this, other staff reported experiencing fear then terror as they became the target of patients' threats, "...he looked at me and said he is going to do something to me. I was terrified." (S16, p.920).

Emotional safety was achieved through the maintenance of boundaries, especially when staff shared personal information with patients (S2, S5). Yet, safety was heightened by getting to know a patient's mind-set closely, which was still anxiety provoking, for example, "...relational security talks about knowing your patient...I mean really knowing the patient,

really understand what it is that makes them tick...getting into their minds, scary as that is.” (S7, p.134). Equally, one support worker theorised that knowing a patient’s crime or reputation increased their anxiety and affected the therapeutic rapport, and so was not preferred, “I prefer not to [know about the patient first] and then to form my own relationship.” (S5, p.109). This highlights differences in how staff manage their experiences of safety and fear in FMH contexts.

Three refutational studies were identified (S4, S9, S11) as some staff reported feeling comparatively safer within the FMH world due to the extra focus on security, “...in the secure hospitals you actually go ‘oh we’re safer than any open psychiatric ward’...people are just more aware...staff tend to be more in control.” (S11, p.252). Overall, this theme indicates working in FMH involves a flux of safe and unsafe individual experiences, and staff navigate the impact of these in different ways.

Psychological and Emotional Impacts

This theme illustrated the powerful personal experiences staff encountered when working in FMH settings, including trauma, distress, crying, repulsion and shock, which over time led to fear, desensitisation and cynicism. These were related to a number of work areas, including the therapeutic relationship, responding to incidents, and wider organisational issues. Ten papers contributed to this theme.

The vivid use of language indicated that the witnessing of disturbing events such as patient self-harm was overwhelming, “...[the patient] grabbed a CD, split it in two, dug it well deep into her skin...I couldn’t bear seeing the blood gushing out...” (S1, p.286). This was also apparent from vicarious events, “...[the patient] starts to describe ‘Oh there was blood all over the floor’...suddenly I have got this damn picture in my head and it is bloody awful...” S7, p.133-134). Sleep disruptions also highlighted the consuming nature of these images (S2 and S16). Stress was attributed to restraining patients, complaint processes, and

the unavoidable transference of patients' pain, "It's always helplessness and despair and anger, so I know why I'm crying and what I'm feeling is hers...it's not mine...but I've been left with it." (S15, p.8).

Across the papers there was a sense of dread and hypervigilance related to issues such as patient self-harm, implementing interventions, and the risks associated with accepting a complex case. The anticipation could be more burdening than the incident:

...we have women who you could sit in an empty room and they would still life threateningly self-harm...waiting is draining because you know it's going to happen, you've done as much as you possibly can to prevent it, but you still know it's coming...that's probably the worst bit, more than the actual event itself. (S2, p.4).

Some staff described becoming 'hardened' to distressing situations and interventions over time, "A lot of stuff blows your hair back when you are new. But as you get going on in your career, a lot of stuff just rolls off. You file it somewhere. It gets easier." (S9, p.74). This desensitisation was also a perplexing experience, "I used to think 'Oh my goodness...I couldn't deal with that. I couldn't', and now, to me it's just...it's normal. How strange." (S2, p.6). Furthermore, the ethics of becoming accustomed to interventions such as patient restraint were questioned (S6).

Cynicism was described towards both patients and colleagues which appeared to dampen the intensity of staff emotional experiences. For example, there was a sense that efforts to care for particular patients were costly and ultimately futile, "You're trying to do your best, you're trying do as much as you can ... but is it actually going to result in anything? And that's being really honest". (S13, p.431).

Trying to Maintain Control

This theme captured staffs' conscious separation of the realms of work and home, controlling outward expressions of emotion at work, and having distinct 'professional' and 'personal' identities. It appeared many staff encountered feelings of powerlessness in FMH, and so tried to preserve a sense of control over their own experiences. The findings reported in eleven papers contributed to this theme.

There was an impression that for some, segregation of work and home was a simple, actively made choice, "Compartmentalise your life so that's the Unit Z and then like the rest of my life is completely separate" (S4, p.219). Others became encultured to this process gradually, and physically entering the workplace helped to segregate personal and professional identities:

You learn to put up a face. You kind of leave yourself at the gate, I suppose, you come through the gate, pick your keys up, and you leave part of yourself outside...and when you go outside, you pick that person up and go on. (S2, p.6).

In contrast, some clearly felt the strain of trying to control such distinctions between work and home life, "...it's horrible and you go home with a horrible feeling. You have to really work hard at turning off all these horrible feelings" (S15, p.8). Others acknowledged experiences at work will unavoidably infiltrate home life, "There's certain incidents that may happen...it really affects you and you try not to take it home but sometimes you do, you can't help it" (S5, p.111). This infiltration outside of work-time was also felt to be understandable, "...it's not normal coming home after being battered by a patient and then carrying on like nothing's happened" (S2, p.6). One experienced practitioner candidly expressed the benefits in relinquishing control and accepting that working in a FMH realm inevitably permeates into home life:

...you can't separate the personal from the professional. I gave up on that years ago (laughter) and I settled into my professional and my personal lives much better because I wasn't fighting to have any demarcation lines between either...Acknowledge it and know it for what it is. (S3, p.305).

The curbing of instinctive fight-flight reactions was also noted, such as refraining from reacting to patient aggression (S5), and there was a sense that staff were compelled to control their emotions and conceal their own distress from colleagues and patients. Having open communication with colleagues was interestingly referred to as “fantasies” by one staff member (S12, p. 429), suggesting withholding the true nature of the personal impacts from colleagues was a regular part of practice. Being openly ‘emotional’ was also equated with ‘incompetence’ and thus required self-discipline:

I am in charge of this ward and you know I can't let myself look...you know – unprofessional. As it's the patients as well as if they don't see us in control emotionally that's when they get stressed out as well... (S15, p.8).

The Double-Edged Sword of Support

This theme captured how support was experienced as both positive and negative in FMH settings, yielding either extreme benefits or extreme detriments. Thus, across the papers there was a polarity in how staff managed these experiences, from actively seeking support to creating distance with colleagues and supervisors. The findings of eleven papers contributed to this theme.

Across the studies support was described in both ‘informal’ terms, such as being in a team generally, and ‘formal’ terms via individual or group supervision, support groups, and

reflective practice groups. The benefits of accessing support were seen as protecting both staff and patient well-being (S1, S6 and S11), processing emotions to avoid harming patients via countertransference (S3), and achieving a sense of validation and boosting team morale (S12). The value of having good support in FMH is highlighted below:

...if you are to rely on your own resources you are likely to burn out in this environment...you live with these patients. They come in here for a very long period of time...so to receive attacks from them on repetitive occasions, not having an identified outlet makes it very difficult...being in a group or even 1:1 supervision and venting out my feelings and then getting support in processing some of those feelings [is useful]. (S1, p.290).

Conversely, staff felt the perils of seeking and accepting support included the risk of being re-traumatised by engaging in post-incident reflective processes (S3 and S6), feeling unsafe when openly communicating with colleagues (S4, S11 and S15), and wanting to conceal fear to prove to colleagues they were competent (S9). Staff navigated these issues by creating physical or relational distance, such as by non-attendance at formal support groups/supervision, or by being selective in what they shared, for example, "...there is so many that would be so anti it...scared of it...would only express things that were deemed acceptable. I would be quite apprehensive too- to express my feelings." (S15, p.10).

Interestingly, accessing peer supervision and sharing feelings was deemed by some as simply too exposing within an FMH setting, "They in fact wouldn't go...[to clinical supervision] because they felt it was too touchy feely...that was spilling your guts in front of their peers, that they didn't want other people to know." (S7, p.135). This fits with the previous theme of controlling the outward expression of emotion and suggests privacy was preferred over the potential emotional vulnerability associated with seeking support.

A Special Insight into Humanity

This final theme captured how working in FMH settings afforded staff with unique observations into humankind, including in patients, other professionals, the wider public, and in themselves. The findings from fifteen papers supported this theme.

Working with a complex patient population meant staff felt an important part of their job was to ‘see’ the entire patient and not just surface level characteristics such as offenses, illnesses, or behaviours (S10, S12, S13). There was a sense of needing to ‘work’ to achieve this deeper level of understanding, especially when patients were distressed, as illustrated in this quote:

They [the patient] could be hurting...they want you to hurt as well...It’s a way of telling you: “This is the way that I am hurting.” You need to stop and think: “Oh no, this is what she is trying to say to me, she’s got problems. I need to get in there and try to work with her through whatever is going on”. (S1, p.287).

Feelings of compassion and empathy towards patients were reported across the papers, as were feelings of guilt or sympathy arising from knowledge of patients’ traumatic backgrounds, mental health difficulties, and when patients were secluded or restrained. There were concerns about how those outside the FMH field, including professionals (S4) and the media (S11), misjudged the needs of the patients they cared for. Thus, trying to view patients through a ‘humanistic lens’ was seen as fundamental to working in FMH, which occurred naturally with time:

I just think it just sort of came as time went by, [...] and I think I started seeing them as human beings and not just a statistic on a chart with, you know two counts of murder or two counts of rape...you have to be able to, or you cannot work...(S9, p.74).

Across some studies, staff reported they were not affected by patients' offenses, but that they still laboured in order to find the positive qualities in patients, "We've got murderers on here...even though they've murdered they are nice people if you dig deep enough" (S5, p.109). Patient aggression that was related to mental distress was not seen as part of the 'authentic' human (S16), for example, "They could be cussing at you...spitting at you...hitting you. But you got to put all that aside because you know that's not the "real" person you were talking to the day before." (S8, p.209). In contrast, other staff were vexed by patient aggression that was deemed 'deliberate' and not due to their mental health (S15).

Experiences of humility were evident; some staff reflected on how they themselves were essentially no different to the patients they worked with, "There but for the grace of God goes I, you know, different upbringing, different social circumstances, different life events, who knows?" (S11, p.251). Positive impacts of working in FMH were focused on interactions with patients as human beings, with feelings of joy, fulfilment, gratification and surprise when patients showed signs of progress or recovery. Being able to positively influence patients was described as a rare but incredibly rewarding part of working in FMH, "You do get the odd patient, they don't come along very often that you do feel that you made a difference to them...they're pretty much the only thing that makes it worthwhile" (S4, p.221). This is also captured by the following quote by a community FMH staff member:

...people with a forensic history can have a gentle side also...you can see that people may be genuinely mentally ill, and may have criminality in their life, and may have perpetrated, it's down to a genuine mental illness, and you can see the human being there. Other members of society don't get to see that aspect of humanity that we do...I've had the privilege of seeing that, I suppose. (S3, p.309).

Discussion

The current review aimed to synthesise the findings from published papers that explored the experiences of clinical staff working in FMH settings. The synthesis of data reported in 16 relevant qualitative studies led to the development of five overarching themes, which included 1) The impact of safety; 2) Psychological and emotional impacts; 3) Trying to maintain control; 4) The double-edged sword of support; and 5) A special insight into humanity. The findings of this meta-synthesis offer a broader insight into how staff may experience and manage the impacts of working within FMH environments.

An initial theme was developed around the impact of safety in FHM settings and how both the experiences of safety and ways of coping with this varied widely between staff. Across the papers security was a dominant issue, with feelings of personal safeness being seen as crucial to staff work-related performance. The risk of patient assault was frequently cited as a threatening part of the work, which is in line with research that suggests violence and aggression is more serious in FMH settings (Bowers et al., 2011). Of note was the relaying of potential risks to students, which is theoretically relevant to Bandura's (1972) Social Learning Theory; this would propose that less experienced staff may replicate the behaviour of their supervisors, thus perpetuating a culture of anxiety over personal safety in FMH. The experiences of restraining patients varied between relief and terror, similar to the binary oppositions of fear-confidence which Mason (2002) proposed occur in daily FMH nursing practice. Preferences regarding relational boundaries with patients also differed between staff; furthermore, some reported feeling FMH was a comparatively safer place to work. Overall, this theme captured how the impacts of safety can fluctuate greatly within and between staff working in FMH.

A second theme was generated regarding the psychological and emotional impacts of working in FMH settings, including trauma, sleep disturbances, constant hypervigilance and

stress, which is consistent with the psychoanalytic literature base (Gordon & Kirtchuk, 2008). Though the reviewed papers often explored specific issues in FMH, the powerful emotional impacts were apparent across a range of work areas, such as witnessing patient self-harm, complaints processes, and physical restraint, and were thus integrated together into this overarching theme. Of note was that staff described becoming 'hardened' to distressing situations with time; though it was unclear if this process was voluntary, it appeared to help manage the intensity of experiences. There was a sense of cynicism towards both patients and colleagues which appeared to serve as protective function when working in FMH. Though again it was not clear if this was voluntary, cynicism fits with the behavioural symptoms associated with burnout (Figley, 2002) which also supports previous studies that suggest FMH staff may be more prone to experiencing negative work-related impacts (Coffey & Coleman, 2001; Elliott & Daley, 2013; Kirby & Pollock, 1995; Chadler & Nolan, 2000).

A third theme was generated relating to staff endeavouring to maintain a sense of control over their experiences. Contrary to the notion that staff in FMH assume a position of power due to their security and custodial responsibilities, across a number of papers staff made references to feeling powerless. This theme therefore regarded staff controlling the separation of work and home, inhibiting expressions of distress or emotion to others, and having a 'professional' identity which was distinct from their personal identity. The ability to control work-home life permeations was varied, with some struggling to achieve this and others believing some crossover was unavoidable and even understandable. Recently, Johnson, Worthington, Gredecki and Wilks-Riley (2016) reported levels of work-home conflict in FMH professionals were ameliorated if staff perceived the organisation they worked in also supported the separation of work and home. Overall, being openly emotional with patients and colleagues was often experienced as unacceptable, and thus staff felt a need to exert self-control.

The fourth theme captured the notion that support in FMH was a double-edged sword, resulting in a polarisation between staff actively seeking and avoiding supportive practices such as supervision groups. The detriments of support were related to exacerbating the negative personal impacts of the work, such as being re-traumatised by incident reviews, in addition to feeling unsafe around colleagues. These impacts were managed by maintaining physical or relational distance from formal support systems. This finding is of concern given staff work with patients with complex needs in FMH; for instance, the crucial role of supervision when working with patients with personality disorders in FMH settings is emphasised by Kurtz (2005). Also, it is a long-standing proposition that processing difficult emotions is important in staff minimising the development of defensive practices and attitudes (Menziés-Lyth, 1960). The benefits of support were centred on the improvements of patient care, yet across some papers staff preferred to conceal their true feelings rather than share these with colleagues in supervision groups. This also links to the previous theme of hiding emotions from patients and colleagues, and suggests supervision in FMH can be experienced by some as simply too emotionally exposing, and is thus counter-supportive.

The final theme captured the sense that staff working in FMH felt they had access to a unique and special insight into humanity. This insight spanned across their patients, other staff, the public, and themselves. This stemmed from working with a complex patient group and having to see past the external characteristics of their patients, such as criminal offenses and aggressive behaviours. Across the papers staff reported feelings of compassion, empathy, guilt and sympathy towards patients, and some believed seeing patients in a humanistic way was essential to their work. Humility was reported in that some staff realised they were not unlike the patients they cared for. In line with previous studies reporting high levels of satisfaction in FMH nurses (Burnard, Morrison & Phillips, 1999; Happell, Martin & Pinikahana, 2003), this theme also captured the positive impacts from making a difference to

some patients, which was reported as an uncommon but satisfying part of working in FMH environments.

Strengths and Limitations

The current review has identified broader understandings of the experiences of staff in FMH settings and has incorporated studies from across the world including Australia, Canada, Europe, and South Africa. The coverage of global research is a strength as it has enabled the synthesis of issues on an international basis and is therefore not dependent on a particular model of FMH care. This also highlighted the lack of qualitative research from other continents, namely Asia and America, which may have been due to the different operationalisations of FMH services and exclusion of papers not written in English. Furthermore, the lack of published research regarding FMH in cultures such as Islam (Abdalla-Filho & Bertolote, 2006) combined with the exclusion of papers not written or translated in English will have further restricted access to such research.

The current review included studies which explored the experiences of staff across a range of disciplines, which reflects the multidisciplinary nature of FMH staff teams. Despite this, nine of the 16 reviewed studies focused solely on nursing staff, which points to a gap in the research base regarding non-nursing or 'minority' staff groups in FMH services, such as clinical psychologists. The experiences of unqualified support staff are also lacking in the reviewed studies, with only one paper solely focussing on this group. This is important given support workers in inpatient mental health settings have been found to have more direct contact with patients than qualified nurses (Bee et al., 2006). Though community FMH settings are arguably different to secure units, the inclusion of these is a strength as it again reflects the variety of FMH service delivery models in operation.

Due to the small number of eligible qualitative studies it was not possible to synthesise papers which all used the same data analysis; this is a limitation given that Noblit

and Hare (1988) advise caution when synthesising studies which use different methodological approaches. In addition, most studies did not specify where staff were interviewed or who else (if anyone) was present. It is possible that interviews conducted in the workplace during working hours influenced how much staff felt able to share, especially as this review identified themes around inhibiting emotive demeanours and avoiding supervision groups in FMH. One study collected data via focus groups (Harris et al., 2015), which may have influenced the staffs' ability to talk about their experiences freely and honestly with colleagues present; indeed, six staff opted to complete an individual follow-up interview, with some citing concerns over confidentiality.

Lastly, applying the CASP appraisal tool (Public Health Resource Unit, 2006) revealed the reporting quality of the reviewed studies were overall acceptable, and signifies the rigour applied to critiquing the included papers. Furthermore, the transparency of the current review was upheld by following the systematic approach outlined in the ENTREQ (Tong et al., 2012), including the systematic search strategy and use of participant quotes to illustrate how themes were rooted in the original data.

Clinical Implications

Across the reviewed papers the distinct challenges faced by staff working in FMH settings were identified, including themes around feeling safe, balancing disparate demands, accessing supervision and emotional coping. These findings have a number of implications for clinical practice.

Current guidelines place minimal attention on the needs of staff working with patients with offending and mental health needs; for instance, there is no mention of staff support mechanisms in the Bradley Report (Department of Health, 2009). Current NICE guidelines briefly mention that training and supervision should be provided to staff delivering direct patient care in “managing stress associated with working in the criminal justice system and

how this may affect their interactions with people and their own mental health and wellbeing” (p.28, NICE, 2007). While it is not clear what this support looks like in practice, promoting effective support mechanisms for FMH staff is clearly paramount in contributing to the safety and sense of care that FMH patients will experience.

One such source of support could be via the training of staff in psychosocial interventions, which was found to reduce levels of burnout in a sample of nurses (Ewers, Bradshaw, McGovern, & Ewers, 2002). Furthermore, Adshead (2002) draws on attachment theory regarding the importance of forensic institutions providing a secure base for staff to recognise the emotional impact of their work, and that caring for staff ultimately benefits patients more than any direct therapeutic input. The understanding of staff experiences from an attachment perspective is particularly relevant to the work of clinical psychologists (CPs), who are part of the MDT in FMH settings, and often support staff via supervision and systemic ways of caring for patients (Division of Clinical Psychology, 2010).

The impact of safety and notion that staff may become more accepting towards using physical interventions has implications for patient care, given research has shown patients find such interventions can be traumatic (Knowles, Hearne, & Smith, 2015). Finally, the themes around staff maintaining control over emotional expression and avoiding support suggests group supervision in FMH contexts may not always be experienced as helpful, therefore offering the option of 1:1 supervision or support could ameliorate this.

Suggestions for Future Research

It is important that researchers continue to seek the experiences of staff from a range of disciplines working in FMH settings whilst acknowledging the contextual influences on how these experiences may be shared in interviews. Gaining further information relevant to this topic would have the potential to benefit staff and patients by identifying other important issues to FMH service managers. This could also provide much-needed detail that is lacking

in relevant policy guidance pertaining to the support needs of staff. Researchers need to remain mindful of the potential for fear, distress or re-traumatisation to occur when interviewing FMH staff about difficult experiences at work, which would warrant researchers to be vigilant in effective monitoring and debriefing procedures.

There is a clear need to include staff from all disciplines in future research; furthermore, explorations should include the future FMH workforce, such as student workers. In particular, research that further explores the barriers staff face in sharing their experiences could help to develop supervisory practices and support systems that counteract such concerns. More qualitative studies into the emotional impacts of working clinically in FMH contexts will also help organisations to recognise the distinct challenges staff may encounter when working in these settings, and to then support staff in ways that are effective rather than a routine response to policy.

Conclusions

In conclusion, this meta-synthesis identified 16 published qualitative studies that explored staff experiences of working in FMH settings, with a particular focus on the emotional and personal impacts of this work and how these are managed. Relevant themes across the studies were synthesised and further interpretations of the data were developed. Several broader themes were identified in this review, such as the variations in how personal safety is experienced and managed by staff, and how accessing support can be a positive and detrimental experience in FMH. Across the papers it was noted how working in FMH settings evoked powerful feelings such as fear, distress, and trauma, yet concealing emotions from colleagues and patients appeared to be a standard part of practice. There was a notion that supervision and open communication with colleagues did not always feel safe or supportive. This has important implications for the development of individualised support systems which

enable staff to share their difficulties confidently, and thus be able to provide the best possible care for patients.

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Appendix 1-A: Journal Guidelines

Author guidelines for the submission of papers to *Legal and Criminological Psychology*:

The *Legal and Criminological Psychology* journal publishes theoretical, review and empirical studies which advance professional and scientific knowledge in the field of legal and criminological psychology, as defined in the Journal [Overview](#).

All papers published in *Legal and Criminological Psychology* are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

The word limit for papers submitted for consideration to LCP is 5000 words and any papers that are over this word limit will be returned to the authors. The word limit does not include the abstract, reference list, tables and figures. Appendices however are included in the word limit. In very exceptional cases, the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). The authors should contact the Editor first in such a case.

LCP frequently invites target articles that give readers access to the very latest in the field, particularly but not limited to new theoretical or methodological approaches. In those cases deemed appropriate, peer commentaries on these papers/reviews will be solicited from other researchers. These peer commentaries are published immediately after the target article, with the authors(s) of the article also on occasion being invited to write a response to the

commentaries. If you believe that your article should be considered for the basis of an invited article, please select the 'Target Article' article type on submission and justify your decision in an accompanying cover letter.

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All manuscripts must be submitted via [Editorial Manager](#). The Journal operate a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the [terms and conditions of submission](#) and the [declaration of competing interests](#). You may also like to use the [Submission Checklist](#) to help you prepare your paper.

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- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
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- All papers must include a structured abstract of up to 250 words with the following headings: Purpose, Methods, Results, Conclusions.
- The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and always refer to any previous work in the third person.

- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.

- Figures can be included at the end of the document or attached as separate files, carefully labelled with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.

- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide doi numbers where possible for journal articles. For example:

Author, A., Author, B., & Author, C. (1995). *Title of book*. City, Country: Publisher.

Author, A. (2013). Title of journal article. *Name of journal*, 1, 1-16. doi: 10.1111/bjep.12031

- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

- In normal circumstances, effect size should be incorporated.

- Authors are requested to avoid the use of sexist language.

- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

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If you need more information about submitting your manuscript for publication, please email Hannah Wakley, Managing Editor (lcrp@wiley.com) or phone +44 (0) 116 252 9504.

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Colour illustrations can be accepted for publication online. These would be reproduced in greyscale in the print version. If authors would like these figures to be reproduced in colour in print at their expense they should request this by completing a [Colour Work Agreement](#) form upon acceptance of the paper.

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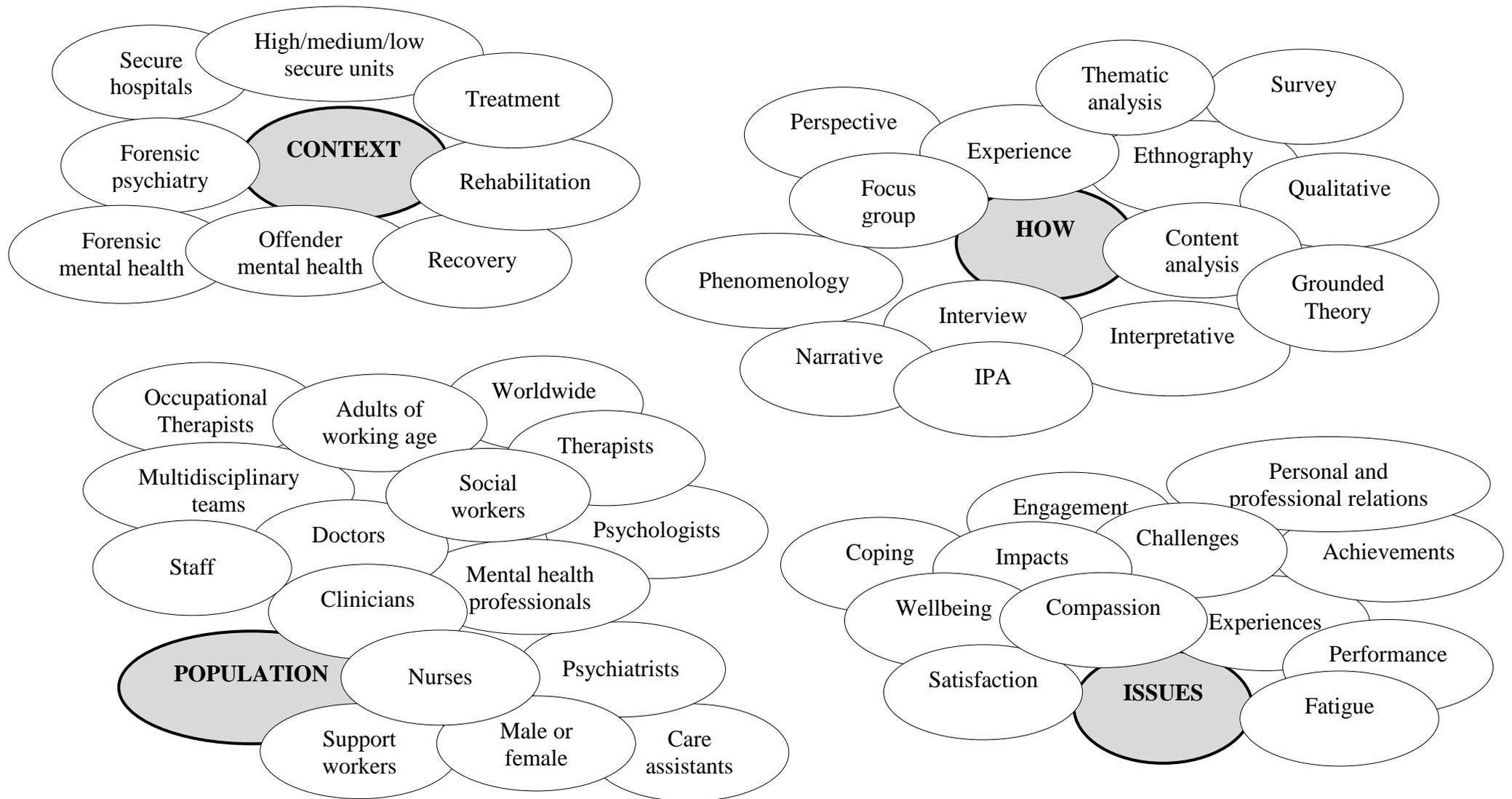
Appendix 1-B: CHIP Analysis

CONTEXT	<p>What contexts are of interest?</p> <p>Forensic mental health services / secure mental health settings / secure psychiatric hospitals.</p>
HOW	<p>What research methods are of importance/interest?</p> <p>Qualitative research methods.</p>
ISSUES	<p>What issues related to working in these settings are of interest?</p> <p>Personal experiences of working in forensic mental health settings.</p> <p>The impacts of this work on an individual level e.g. emotional wellbeing, cognitions, behaviour, mood, relations, beliefs.</p> <p>Ways to manage the experiences related to working in these settings.</p>
POPULATION	<p>Which groups are of main interest?</p> <p>Staff who are adults of working age.</p> <p>Staff working in forensic mental health settings, such as secure hospitals, forensic community mental health teams, forensic mental health inpatient wards etc.</p> <p>Staff who are defined as working in a clinical role e.g. nurses, support workers, psychiatrists, psychologists, social workers, occupational therapists etc.</p>

Identified research questions:

- What are the experiences and personal impacts of staff who work in forensic mental health settings?
- How do staff make sense of and manage these experiences?

Appendix 1-C: CHIP Mind Map



Appendix 1-D: Quality appraisal scores of the selected papers using the CASP tool.

Paper	Clear aims	Qualitative appropriate	Research design	Sample recruitment	Data collection	Researcher's reflexivity	Ethical considerations	Data analysis	Findings	Research value	Total	Percent achieved
S1	3	3	3	1	1	1	1	1	3	2	19	63.3%
S2	3	3	3	2	2	1	3	3	2	2	25	83.3%
S3	3	3	2	3	2	2	1	2	2	2	22	73.3%
S4	3	3	3	2	2	1	3	2	2	2	24	80%
S5	3	3	2	2	2	2	2	3	2	3	24	80%
S6	3	3	2	3	2	1	3	3	3	2	25	83.3%
S7	3	3	2	2	1	1	3	2	3	3	22	73.3%
S8	3	3	2	2	2	1	3	2	3	2	25	83.3%
S9	3	3	2	2	3	1	2	2	3	2	23	76.6%
S10	3	3	2	1	2	2	1	2	2	2	22	73.3%
S11	3	3	1	2	1	1	1	1	2	3	18	60%
S12	3	3	3	2	2	2	1	2	2	2	22	73.3%
S13	3	3	2	2	2	3	3	3	2	2	25	83.3%
S14	3	3	2	2	3	1	1	2	2	2	21	70%
S15	3	3	2	2	2	2	1	2	3	3	23	76.6%
S16	3	3	3	2	3	1	3	2	2	1	23	76.6%

Key: 1) "weak"; 2) "moderate"; or 3) "strong" justifications and explanations of the issue (Duggleby et al., 2010).

Appendix 1-E: Summary of Papers Included in Meta-synthesis

Author(s) and date	Research aims (of relevance)	Country	Participants	Methodology- Data collection	Methodology- Data analysis	Setting
Aiyegbusi & Kelly (2015)	<i>To establish primary nurses' experiences of the nurse-patient relationship with people who have PDs in therapeutic community (TC) and secure mental health settings.</i>	England	Purposive sample of primary nurses (n=13) from three specialist services.	In-depth qualitative interviews.	Framework analysis.	Specialist mental health services for the care and treatment of people diagnosed with PD.
Beryl, Davies & Völlm (2016)	<i>To understand the experience of providing nursing care to women patients in a high secure hospital.</i>	UK	Nursing staff. Male (n=2), female (n=5). Two were team leaders, two nursing assistants, three staff nurses.	Interviews guided by a schedule of open-ended, non-leading questions.	IPA	National High Secure Healthcare Service for Women (NHSWS).
Boyle, Kernohan & Rush (2009)	<i>To explore the role of feelings experienced by professionals in community forensic practice.</i>	Northern Ireland	CMHT members (n=5) purposively sampled.	Individual in-depth semi-structured interviews.	A modified hermeneutic version of grounded theory (Rennie, 2000; Strauss & Corbin, 1998).	Three MDTs containing nursing, psychiatry, psychology, occupational therapy and social work professions.

Clark (2013)	<i>To examine the difficulties faced and the needs of staff when working in a medium secure forensic environment with adolescents, highlighting concepts such as burnout, stress, control, and safety.</i>	UK	Male (n=5) and female (n=8) participants from nursing (qualified and unqualified), psychology, education, and OT.	Semi-structured interviews.	IPA.	A Forensic Child and Adolescent Mental Health (FCAMHS) unit.
Evans, Murray, Jellicoe-Jones, & Smith (2012)	<i>To explore how relationships are formed and developed between support staff and patients within secure mental health services via personal accounts of such relationships, drawing upon staff experiences, attitudes and feelings.</i>	UK	Unqualified support staff. Male (n=3) and female (n=7). Included nursing assistants and OT assistants.	Semi-structured interviews.	IPA.	Two medium secure establishments within the National Health Service (NHS) based in the North West of England.
Gustafsson & Salzmann-Erikson (2016)	<i>To describe nurses' thoughts on and experiences of exerting coercive measures in forensic psychiatric care.</i>	Sweden	Nurses. Male (n=3) and female (n=5)	Qualitative unstructured interviews.	Qualitative inductive content analysis (Elo & Kyngäs, 2008).	Forensic psychiatric clinic.

Harris, Happell, & Manias (2015)	<i>To examine the experiences of Forensic Mental Health (FHM) clinicians and their attitudes towards the Forensic Patients they were treating during a programme of rehabilitation.</i>	Australia	Male (n=12) and female (n=15) participants. Included psychiatrists, psychologists, social workers, OTs, personal care officers.	Three focus groups. All participants also offered an individual interview, 6 accepted.	Thematic analysis.	Hospital and community-based forensic clinicians from all professional groups.
Holmes, Murray, & Knack (2015)	<i>To obtain detailed information on the lived experiences of forensic psychiatric patients/nurses who have experienced/used seclusion rooms.</i>	Canada	Forensic psychiatric nurses (n=13) and patients (n=13) who had both experienced the seclusion process.	In-depth semi-structured interviews.	An adapted IPA method.	A mid-size forensic psychiatric facility.
Jacob & Holmes (2011)	<i>To describe and comprehend how fear influences nurse–patient interactions in a forensic psychiatric setting.</i>	Canada	Registered Nurses and Registered Practical Nurses. Male (n=5) and female (n=13).	Semi-structured interviews, direct observations, mute evidence (hospital documents), memos and a “field work journal.”	Grounded theory as adapted in a sequential fashion by Paillé (1994).	Medium-security facility called the Forensic Psychiatric Treatment Division (F.P.T.D)

Kumpula & Ekstrand (2013)	<i>To illuminate the experiences of male caregivers in providing care for patients in forensic psychiatric care.</i>	Sweden	Permanently employed male caregivers (n=6).	Interviews.	Latent content analysis.	A forensic psychiatric clinic in a town in central Sweden.
Kurtz & Jeffcote (2011)	<i>The exploration of the experiences of FMH staff in two contrasting services.</i>	UK.	Staff working in two NHS FMH services (n=25).	Semi-structured interviews.	Grounded Theory.	A mainstream NHS medium secure unit (MSU), and a Personality Disorder Unit (PDU) in an MSU.
Kurtz & Turner (2007)	<i>Does clinical work with offenders with a diagnosis of personality disorder have a negative psychological impact on staff?</i>	UK.	Male (n=6) and female (n=7) staff from a range of disciplines.	Semi-structured interviews.	Grounded Theory.	A 12-bedded medium secure unit for male offenders with a diagnosis of personality disorder.
Niebieszczanski, Dent & McGowan (2016)	<i>What are mental health nurses' beliefs about hope and their experiences of fostering hope with service users in a forensic mental health setting?</i>	England.	Qualified mental health nurses. Male (n=5) and female (n=5).	Semi-structured interviews.	Grounded Theory.	A male medium secure NHS hospital.

Rose, Peter, Gallop, Angus, & Liaschenko (2011)	<i>To analyze the concept of respect systematically, from a forensic psychiatric nurse's perspective.</i>	Canada	Registered Nurses and Registered Practical Nurses. Male (n=3) and female (n=8).	Two semi-structured interviews per participant. Attrition (n=6) at second interview.	Thomas' (2003) five step process for inductive analysis.	Two medium secure forensic rehabilitation units.
Sequeira & Halstead (2004)	<i>To examine the experiences of physical restraint procedures reported by nursing staff in a secure mental health service.</i>	UK	Nursing staff (n=17) who had restrained patients. Patients who were secluded (n=14) and who observed the seclusion process (n=5) were also interviewed.	Semi-structured interviews.	Thematic content analysis in accordance with grounded theory method.	A secure mental health hospital.
Tema, Poggenpoel, & Myburgh (2011)	<i>To explore and describe the psychiatric nurses' experiences of hostile behaviour by patients in a forensic ward and make recommendations for nurse managers to empower these psychiatric nurses to cope with the patients' aggression.</i>	South Africa	Psychiatric nurses. Male (n=2) and female (n=7).	In-depth, phenomenological interviews.	Tesch's open coding method (Creswell 2008).	A forensic ward.

Appendix 1-F: Extracts from Final Meta-Synthesis Table

Third order constructs (renamed themes) <i>with example notations from meta-synthesis</i>	Related papers	Examples of second order constructs (author interpretations)	Examples of first order constructs (participant quotes)
The impact of safety			
<p><i>Sudden realisation of risk</i></p> <p><i>Short staffed and unsafe</i></p> <p><i>Socialising students to be wary</i></p> <p><i>Wariness equals safeness</i></p> <p><i>Feeling comparatively safer than other services</i></p> <p><i>Victimised by assault</i></p> <p><i>Knowledge of patients enhances safety</i></p> <p><i>Benefits of patient rapport</i></p> <p><i>Perceived dangers of patients</i></p> <p><i>Restored sense of safety after seclusion</i></p> <p><i>Helpless due to gender (restraint)</i></p> <p><i>Male staff greater impacted (by restraint)</i></p> <p><i>Ignorance is bliss/better (refutation)</i></p> <p><i>Fear of injury/ hypervigilance</i></p> <p><i>Rumination of potential scenarios</i></p> <p><i>Potential to be assaulted</i></p> <p><i>Fearing for loved ones</i></p>	<p>Beryl et al. (2016)</p> <p>Clark (2013)</p> <p>Evans et al. (2012)</p> <p>Gustafsson et al. (2016)</p> <p>Harris et al. (2015)</p> <p>Holmes et al. (2015)</p> <p>Jacob & Holmes (2011)</p> <p>Kurtz & Turner (2011)</p> <p>Rose et al. (2011)</p> <p>Sequiera (2004)</p> <p>Tema et al. (2011)</p>	<p>Safety (Clark, 2013).</p> <p>Experiencing seclusion (Holmes et al., 2015).</p> <p>Fear (Jacob & Holmes, 2011).</p> <p>Staff's experience of the clinical task 3. Minimal sense of risk and anxiety at the centre (Overarching theme: 'Everything contradicts in your mind') (Kurtz & Turner, 2011).</p> <p>Reduction in anxiety through familiarity with restraint (Sequiera, 2004).</p>	<p>I found myself on Ward A on my own with 2 young people...it was an extremely stressful situation to be in. (Clark, 2013, p.220).</p> <p>I usually feel better when a person that needs to be locked is locked into seclusion. It just brings down the anxiety and tension level for staff and patients, and the safety is increased. (Holmes et al., 2015, p.209)</p>

Third order constructs (renamed themes) <i>with example notations from meta-synthesis</i>	Related papers	Examples of second order constructs (author interpretations)	Examples of first order constructs (participant quotes)
Psychological and emotional impacts			
<p><i>Breaking down and crying</i></p> <p><i>Inner disruption</i></p> <p><i>Despair and trauma</i></p> <p><i>Sleep disturbances</i></p> <p><i>Feeling contaminated by badness</i></p> <p><i>Repulsion at sexual offenses</i></p> <p><i>Absorbing patients' distress (with no outlet)</i></p> <p><i>Visual intrusions</i></p> <p><i>Repressing stressful memories</i></p> <p><i>Unable to forget</i></p> <p><i>Shaken by patient volatility</i></p> <p><i>Struggle to maintain hope</i></p> <p><i>Burdened by complaints</i></p> <p><i>Anticipatory anxiety</i></p> <p><i>Inevitability of patient self-harm</i></p> <p><i>Terror caused error</i></p> <p><i>Feeling threatened by patients</i></p> <p><i>Uneasy in expectation of violence</i></p> <p><i>Burden of constant alertness</i></p> <p><i>Apprehension of workload and risks</i></p>	<p>Aiyegbusi & Kelly (2015)</p> <p>Beryl et al. (2016)</p> <p>Boyle et al. (2009)</p> <p>Clark (2013)</p> <p>Harris et al. (2015)</p> <p>Holmes et al. (2011)</p> <p>Jacob & Holmes (2011)</p> <p>Kurtz & Turner (2011)</p> <p>Niebieszczanski et al. (2016)</p> <p>Sequiera (2004)</p> <p>Tema et al. (2011)</p>	<p>Pain: processing or passing on? The onslaught (Aiyegbusi & Kelly, 2015).</p> <p>Horror (Beryl et al., 2016).</p> <p>Trauma (Boyle et al., 2009).</p> <p>Vicarious traumatization (Harris et al., 2015).</p> <p>Distress and crying (Sequiera, 2004).</p> <p>Theme 4: psychiatric nurses experience emotional and physical distress related to interactions with patients- Emotional distress (Tema et al., 2011).</p>	<p>In fact it was very, very disturbing for me that evening, very, very disturbing and I felt that I needed some time out because I could feel it within me. (Aiyegbusi & Kelly, 2015, p.284).</p> <p>The image was really affecting me. What am I going to do with it? (Harris et al., 2015, p.134).</p> <p>...I was paralysed with fear, I even used the wrong drug book to enter drugs given to the patient. (Tema et al., 2011, p.920).</p>

Third order constructs (renamed themes) <i>with example notations from meta-synthesis</i>	Related papers	Examples of second order constructs (author interpretations)	Examples of first order constructs (participant quotes)
Trying to maintain control			
<p><i>Actively separate work/home life</i></p> <p><i>Learning to segregate home life</i></p> <p><i>Separate personal/professional identities</i></p> <p><i>Becoming skilled at segregating identities at the gate</i></p> <p><i>Moving forward- new beginning each day</i></p> <p><i>Desensitisation-potential to seep outside work</i></p> <p><i>Letting guard down at home</i></p> <p><i>Distress emerges later at home</i></p> <p><i>Labouring to switch off at home</i></p> <p><i>Feeling inevitable home life is affected</i></p> <p><i>Acceptance home life affected</i></p> <p><i>Keeping a 'controlled' front</i></p> <p><i>Not professional to be emotional</i></p> <p><i>Fighting natural instincts</i></p>	<p>Beryl et al. (2016)</p> <p>Boyle et al. (2009)</p> <p>Clark (2013)</p> <p>Evans et al. (2012)</p> <p>Jacob & Holmes (2011)</p> <p>Kumpula & Ekstrand (2013)</p> <p>Kurtz & Jeffcote (2007)</p> <p>Niebieszczanski et al. (2016)</p> <p>Rose et al. (2011)</p> <p>Sequiera (2004)</p> <p>Tema et al. (2011)</p>	<p>Balancing acts (Beryl t al., 2016).</p> <p>The professional is personal (Boyle et al., 2009).</p> <p>Control and structure (Clark, 2013).</p> <p>“Playing your cards close to our chest’’: maintaining boundaries (Evans et al., 2012).</p> <p>Feelings of powerlessness Kumpula & Ekstrand, 2013).</p> <p>Coping with strong emotional reactions- Inhibition of emotional distress (Sequiera, 2004).</p>	<p>If a patient’s right up in your face and they’re screaming and effing and jeffing or just wanting to punch you, your natural instinct on the street would be to retaliate but obviously you can’t do that here (Evans et al., 2012, p.111).</p> <p>It does sound cruel, but for my sanity I have to switch off...it’s the only way to do it...I was a victim of an assault on the ward...I did think about that a lot and it just brought me right down, couldn’t cope...I try not to think about it just get on and do it...(Sequiera, 2004, p.10).</p>

Third order constructs (renamed themes) <i>with example notations from meta-synthesis</i>	Related papers	Examples of second order constructs (author interpretations)	Examples of first order constructs (participant quotes)
The double edged-sword of support			
<i>Needing systemic support</i>	Aiyegbusi & Kelly	Team Dynamics (Clark, 2013).	You go along to the official reflective practice and you don't actually want to talk in that environment...you don't feel safe in that environment. (Clark, 2013, p.221).
<i>Insufficient to rely on own resources</i>	(2015)	The Need for Debriefing (Gustafsson et al., 2016).	
<i>Need to know frustrations are shared</i>	Beryl et al. (2016)		
<i>Needing validation</i>	Boyle et al. (2009)	Staff's experience of the organisation 5. Preoccupation with staff relationships (Overarching theme: 'Everything contradicts in your mind') (Kurtz & Turner, 2011).	It's about knowing that there are at least a few people in the same clinical team who share some of my angst and annoyance at certain things, which is very supportive and reassuring, because you know otherwise you'd think you're going mad... (Kurtz & Turner, p.253).
<i>Sharing feelings helped boost morale</i>	Clark (2013)		
<i>Seeking professional company to safeguard well-being</i>	Evans et al. (2012) Gustafsson et al. (2016)		
<i>Need to process feelings to protect patients</i>	Harris et al. (2015)		
<i>Pros and cons of debriefing-reliving pain</i>	Kurtz & Jeffcote (2007)		
<i>Reflection causes more distress</i>	Kurtz & Turner (2011)		
<i>Perils of open communication with colleagues</i>	Niebieszczanski et al. (2016)	Ambivalence about support (Sequiera, 2004).	
<i>Reluctance to share feelings openly</i>	Sequiera (2004)		
<i>Choosing what to share with colleagues</i>	Tema et al. (2011)	Theme 3: Experience of disempowerment related to a lack of recognition- De-motivation related to lack of support (Tema et al., 2011).	
<i>Contradiction of attending vs sharing in supervision</i>			
<i>Conceal fear from colleagues</i>			
<i>Further wounded by post-incident procedures</i>			

Third order constructs (renamed themes) <i>with example notations from meta-synthesis</i>	Related papers	Examples of second order constructs (author interpretations)	Examples of first order constructs (participant quotes)
A special insight into humanity			
<p><i>Empathy and compassion</i></p> <p><i>Humility over potential shared fate</i></p> <p><i>Seeing through the offense</i></p> <p><i>Tolerating aggression when patients are ‘ill’</i></p> <p><i>Working to see patients’ positives</i></p> <p><i>Recognising patient individuality</i></p> <p><i>Fearing similarities between self and patients</i></p> <p><i>Sympathy delivering painful injections</i></p> <p><i>‘Travelling’ with patients during their recovery</i></p> <p><i>Vexed by deliberate aggression when patients are ‘well’</i></p> <p><i>Miss having clinical contact</i></p> <p><i>Surprise at patient recovery</i></p> <p><i>Good outcomes override difficulties</i></p> <p><i>Rarity of patients helped</i></p> <p><i>Feeling honoured</i></p> <p><i>Part of something cherishable</i></p> <p><i>Fulfilment at patients’ progress</i></p>	<p>Aiyegsburi & Kelly (2015)</p> <p>Beryl et al. (2016)</p> <p>Boyle et al. (2009)</p> <p>Clark (2013)</p> <p>Evans et al. (2012)</p> <p>Gustafsson et al. (2016)</p> <p>Harris et al. (2015)</p> <p>Holmes et al. (2015)</p> <p>Jacob & Holmes (2011)</p> <p>Kumpula & Ekstrand (2013)</p> <p>Kurtz & Jeffcote (2007)</p> <p>Kurtz & Turner (2011)</p> <p>Niebieszczanski et al. (2016)</p> <p>Rose et al. (2011)</p> <p>Tema et al. (2011)</p>	<p>Meaningful contact (Clark, 2013).</p> <p>“‘You do forget what they’ve done’”: seeing the person and managing risk (Evans et al., 2012).</p> <p>Orientation and adjustment to FMH (Harris et al., 2015).</p> <p>Seeing the complete person (Kumpula & Ekstrand, 2013).</p> <p>Theme I: Emotive–cognitive reactions- Empathy (Rose et al., 2011).</p>	<p>...rather than look to the crime one tries to see the character, you don’t stick to shallowness or similar things, one put those things aside and try to find the human being instead...(Kumpula & Ekstrand, 2013, p.68).</p> <p>When I see them achieve their goal of getting out of here or getting into the community, whatever, that makes me feel good... (Rose et al., 2011, p.10).</p>

Section Two: Research Paper

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Compassion satisfaction and barriers to this in clinical psychologists working in forensic mental health settings.

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Prepared for *Legal and Criminological Psychology* (see Appendix 2-A)

Abstract

Purpose: Little research has explored compassion satisfaction even though this can buffer against the effects of fatigue, stress and burnout in a range of clinical workforces. In addition, little is known about the experiences of clinical psychologists working in forensic mental health, despite elevated levels of staff stress and burnout being reported in these settings. This study explored the lived experiences of clinical psychologists working in forensic mental health settings to develop an initial understanding of their experiences of compassion satisfaction. Method: Individual semi-structured interviews were conducted with eight clinical psychologists from a range of forensic mental health services in the UK. Data were analysed using Interpretative Phenomenological Analysis. Results: Five themes were identified: 1) The magnitude of trust; 2) Adjusting expectations; 3) Being both lock and key; 4) The impact of time and resources; and 5) Variety and complexity. Compassion satisfaction was influenced by feeling able to work in a challenging specialty and from the invigoration of connecting with patients who were hard to engage. High workloads, the restrictive nature of the environments, and the ‘stipulated’ approach to psychological therapy by other staff hindered the experiences of compassion satisfaction. Conclusion: The results highlight the important distinctions in how compassion satisfaction can be experienced by clinical psychologists in this specialty, and what factors can influence these experiences. Findings are discussed with reference to previous research and implications for future research, education and practice are identified.

Keywords: interpretative phenomenological analysis, qualitative, clinical psychologists, forensic mental health, compassion satisfaction.

The forensic mental health (FMH) specialty involves “the assessment and treatment of those who are both mentally disordered¹ and whose behaviour has led, or could lead, to offending” (Mullen, 2000, p.307). FMH services are often described as highly stressful and dangerous working environments which can cause staff across disciplines to experience elevated levels of occupational stress, burnout, and psychological distress (Elliott & Daley, 2013). Clinical psychologists (CPs) are considered an integral part of the multidisciplinary team (MDT) within FMH settings as the needs of patients² are complex; services are thus required to address all aspects of mental health, including psychological aspects (Joint Commissioning Panel for Mental Health, 2013).

Mental health professionals are generally believed to be at increased risk of experiencing psychological distress through their work (Edwards, Burnard, Coyle, Fothergill & Hannigan, 2000; Paris & Hoge, 2010; Turgoose & Maddox, 2017). Research within the FMH specialism indicates staff can face challenges such as patient aggression and violence (Bowers et al., 2011; Mason, 2000). Furthermore, staff in FMH encounter an occupational phenomenon referred to as the ‘custody-care tension’ (Peternelj-Taylor, 2000; Rask & Hallberg, 2000; Swinton & Boyd, 2000) which involves both managing security and providing therapeutic support to patients.

The available literature in FMH has tended to focus on the perspectives of nursing staff with a few studies involving CPs. Where CPs have been included in published FMH research, they have represented a minority of the samples; for instance, CPs comprised 6.7% of the sample in Elliott and Daley’s (2013) study. Though this may reflect the comparatively smaller ratio of CPs working in FMH, it also means that to date very little is understood about their experiences of working in these settings. In addition, previous research with staff has

¹ The term ‘mentally disordered offender’ is not used in this paper though this is used within the literature.

² The term “patient” will be used in this paper to reflect the terminology traditionally used in the FMH specialty.

largely focused on the negative aspects of working in this area, with only few studies identifying the positive and rewarding aspects.

Caring for others professionally can be inherently stressful and carry a personal cost (Figley, 2002) and again research has focused on the negative aspects of therapists' experiences generally (Linley & Joseph, 2007). The role of a CP involves psychological assessment, formulation and intervention with individual patients and via consultation with staff teams, thus spanning both direct and indirect ways of working, as well as leadership, supervisory, research and service development responsibilities (Division of Clinical Psychology, 2010). As CPs support the psychological wellbeing of patients both directly and via MDT staff, their roles are arguably distinct from other disciplines in FMH and therefore warrant separate investigation.

Previous research in the UK indicates working in the clinical psychology profession can be both satisfying (Walfish, Moritz, Stenmark & Delworth, 1991) and stressful (Cushway & Tyler, 1996). Hannigan, Edwards and Burnard (2015) found in a review of UK studies that many clinical psychologists were themselves experiencing significant levels of psychological distress; however, all seven papers reviewed were published in the 1990s, suggesting progress in research in this area has slowed down. An Australian study identified burnout in clinical psychologists was related to stress and perfectionism (D'Souza, Egan & Rees, 2011), and a survey of South African clinical and counselling psychologists concluded that poor management of personal emotional stress was a common issue (Jordaan, Spangenberg, Watson & Fouchè, 2007).

A key role of a CP is to develop therapeutic relationships with patients in order to support positive therapeutic change. This process could be challenging in FMH settings as patients present with high levels of risk in addition to complex mental health needs and attachment patterns. For instance, compared to the general population, research has identified

patients in FMH settings overall have higher levels of post-traumatic stress and experiences of neglect/abuse in early childhood and adolescence (Garieballa et al., 2006). These can potentially lead to insecure attachment patterns, thus impacting upon an individual's ability to form relationships as negative memories of early caregiving experiences may be recalled which can trigger attachment-related patterns of defence and affect regulation towards the therapist (Slade, 2016). In line with this, it has been identified that insecure attachment patterns are strongly correlated with all types of criminal behaviours (Oglivie, Newman, Todd & Peck, 2014) and with mental health difficulties (Mikulincer & Shaver, 2012). Furthermore, repeated exposure to traumatic recollections when patients do engage in therapy can lead to excessive stress levels (Coetzee & Klopper, 2010; Craig & Sprang, 2010). Therefore, CPs' therapeutic relationships with patients may be both difficult to establish and indirectly distressing in FMH contexts, which may influence their positive experiences.

Furthermore, CPs in FMH services collaborate with and support other MDT staff members; this may also impact on CPs' experiences and present considerable challenges, as research has identified some samples of staff in FMH have reported higher levels of burnout, fatigue and stress (Chadler & Nolan, 2000; Coffey & Coleman, 2001; Elliot & Daley, 2013; Kirby & Pollock, 1995). Interestingly, Bakker, Le Blanc, Pascale and Schaufeli (2005) found burnout appeared to be contagious across intensive care nurses. With this 'contagious' nature in mind, it could be assumed that CPs may also be prone to burnout contagion, as their roles require providing regular support for teams of FMH staff working on wards and secure units, who as a group may be at high risk of burnout. In addition, CPs' priorities are not solely determined by the needs of patients, but also by the expectations of the legal system regarding risk management and public protection. In turn, the positive experiences of working in FMH contexts may be affected by the specific tasks CPs undertake and in balancing the psychological needs of patients, staff, and wider society.

These numerous responsibilities may potentially impact on the CP's sense of compassion. As it stands, research activity into compassion is currently in its early stages (Matheiu, 2012). 'Compassion' is defined as "a basic kindness with a deep awareness of the suffering of oneself and of other living things, coupled with the wish and effort to relieve it" (Gilbert, 2008; p. xiii). Compassion is recognised as a "distinct emotion" (Goetz, Keltner & Simon-Thomas, 2013, p.351) which is usually conceptualised as pleasant (Condon & Feldman-Barrett, 2013). The Francis Report (2012) detailed how deficits in compassionate care had caused serious impacts on patient wellbeing, an issue which is reported across the world (Mannion, 2014) and can be worsened by organisational culture rather than staff values (Flynn & Mercer, 2013).

According to Stamm (2010), the 'professional quality of life' of those working in helping occupations has received increasing interest over the last few decades, and is influenced by both the positive and negative aspects of one's role. Negative aspects include 'compassion fatigue' which "reduces our capacity or our interest in bearing the suffering of others" (Figley, 2002, p.1434). Compassion fatigue is further divided into 'burnout', characterised by exhaustion, anger and depression, and 'secondary traumatic stress', which involves fear and work-related trauma (Stamm, 2010). Related to the CP's role, burnout is described as "the single most common personal consequence of practicing therapy" by Kottler (2001, p.158).

Alternatively, 'compassion satisfaction' is a positive aspect referring to "the sense of fulfilment or pleasure" therapists derive from doing their work well (Stamm, 2010, p.8). Compassion satisfaction is also described as a phenomenon which "addresses the ability to receive gratification from caregiving" (Simon, Pryce, Roff, & Klemmack, 2006, p.7). Recent research indicates compassion satisfaction can 'buffer' against the negative impacts of compassion fatigue, burnout and secondary traumatic stress in a range of clinical workers.

Such studies have included frontline mental healthcare professionals (Ray, Wong, White & Heaslip, 2013), therapists working with survivors of sexual violence (Samios, Abel & Rodzik, 2013), social workers (Wagaman, Geiger, Shockley & Segal, 2015) and hospice/palliative care staff (Slocum-Gori, Hensowrth, Chan, Carson & Kazanjian., 2011). Furthermore, a quantitative study in Israel found high levels of compassion satisfaction were related to marital quality in a sample of social workers (Finzi-Dottan & Kormosha, 2016), suggesting compassion satisfaction is linked to personal as well as professional quality of life.

As the consequences of compassion fatigue are believed to include staff turnover, decreased productivity and lower morale (Showalter, 2010), compassion satisfaction therefore has important implications for service delivery and patient care due to its protective function against fatigue and burnout. Previous explorations into compassion satisfaction such as work by Elliot and Daley (2013) have mostly used quantitative approaches. Quantitative measures of compassion satisfaction, compassion fatigue and burnout have been developed such as the 'Professional Quality of Life Scale' (ProQOL) (Stamm, 2010), whereby clinicians rate their experiences based on the last 30 days using a five-point Likert scale. Whilst quantitative measures are useful in gaining a standardised objective set of data at a particular time point, they are limited in eliciting the depth of information required to understand the lived experiences of a phenomenon by individuals in their own words.

The Current Study

At present there is a lack of research regarding the experiences of CPs working in FMH settings, especially in relation to the positive aspects of their work. As CPs have distinct roles within FMH services to other MDT members it is important to understand how compassion satisfaction may be experienced in this context.

As research suggests compassion satisfaction buffers against compassion fatigue and burnout in other clinical workforces and specialties, it could be speculated these experiences

may be indirectly related to compassionate care, since fatigue and burnout are characterised by exhaustion and diminished potential to tolerate others' distress. This therefore has implications for the wellbeing of CPs, quality of service delivery and patient treatment. Understanding the influences on compassion satisfaction in CPs may point to ways to enhance this in the workplace, and could provide trainee and qualified CPs with a useful insight into the positive aspects of working in FMH services when considering placement choices or career paths. As there have been no qualitative studies published to date exploring CPs' experiences of compassion satisfaction in FMH settings, this study is therefore of value as it will add to the research base relating to staff experiences in this area.

The research question for the current study was to understand CPs' experiences of compassion satisfaction in FMH settings, and what circumstances may influence or minimise these experiences for CPs.

Method

Study Design

A qualitative approach was chosen for this study to facilitate reflexivity and generate experiential richness and depth. Qualitative approaches provide participants with opportunities to describe their accounts in their own words with relevance to their context (Clarke & Jack, 1998) and are particularly suited to the exploration of issues that have had limited focus (Smith, 2008). Thus, data were collected from a sample of CPs via individual semi-structured interviews and analysed using interpretative phenomenological analysis (IPA) (Smith, Flowers & Larkin, 2009). This is a methodology which is increasingly used in psychological research and is characterised by its "ideographic, inductive and interrogative" features (Smith, 2004; p.41).

IPA was considered highly suitable for the current study as it permits the active role of the researcher in the process by acknowledging data is interpreted through the researcher's viewpoint (Smith, Flowers & Larkin, 2009). IPA was also congruent with the researcher's critical realist perspective of research, which proposes "the phenomena studied in scientific research...correspond to real entities or processes which exist independently of us" (Lund, 2005; p.118). This stance also acknowledges research is a social process carried out in the context of values (Sullivan, 2010).

Ethics

Ethical approval was granted by the Health Research Authority (HRA; see Section Four- Appendix 4-F) following an application to the Integrated Research Application System (IRAS project ID: 218436, REC reference: 16/HRA/5922; see Section Five- Appendix 5-A). Letters of access were obtained from the Research and Development (R&D) departments of three National Health Service (NHS) Trusts prior to recruiting CPs (see Section Five- Appendices 5-B, 5-C, and 5-D).

Participants

Purposive sampling was used to recruit qualified CPs working in FMH settings within the NHS. Though there is no consensus on sample size for IPA studies (Pietkiewicz & Smith, 2014; Smith & Osborn, 2008), the researcher aimed to recruit a sample of between five and 12 CPs to provide enough richness of accounts to conduct a meaningful analysis. This was also appropriate given the relatively small pool of CPs working in FMH and the short timeframe of the study.

In total eight CPs expressed an interest in the study, all of whom comprised the final sample. This included six females and two males, with between two and 19 years' experience of working in FMH. Types of services included high secure ($n=1$), medium secure ($n=5$), low

secure ($n=1$) and community FMH teams ($n=1$). The majority worked in male FMH services ($n=6$) and with adults ($n=7$). Five CPs worked full-time, three worked part-time.

Materials

Section Four provides details of the recruitment materials which included an email communication to potential CPs (Appendix 4-A), a Participant Information Sheet (Appendix 4-B), a consent form (Appendix 4-C), an interview schedule (Appendix 4-D), and a participant debrief sheet (Appendix 4-E).

Recruitment

The study details were circulated to potential CPs between December 2016 and May 2017. CPs were recruited using convenience sampling and snowball sampling. A short email communication containing two attachments (a Participant Information Sheet and a consent form) was distributed to CPs in FMH services via the field supervisor and key personnel within each Trust. This email invited CPs to opt in to the study by contacting the researcher directly.

The inclusion criteria stipulated CPs could participate if they were currently working in a FMH service within the NHS (with any age group), and had at least two years qualified experience in this field. CPs working solely in the private sector, charitable settings, forensic Learning Disability Services, or in prisons were excluded to preserve homogeneity of the sample.

Data Collection

Interviews were conducted by the researcher between January and May 2017. Informed consent to take part was obtained from all CPs once they had read and signed a copy of the consent form prior to their interview. Six interviews were completed face-to-face at CPs' workplaces in non-clinical areas, and two telephone interviews were conducted as

meeting the researcher in person was not practical. Interviews lasted between 61 to 85 minutes, with an average duration of 66 minutes.

Interviews were audio recorded in their entirety. The Participant Information Sheet was briefly recapped to CPs and the concept of compassion satisfaction was introduced prior to interviews. An interview schedule (see Appendix 4-D) was developed in collaboration with the study supervisors as a basis for broad questioning which enabled CPs to take more control of interview discussions. All interviews were transcribed verbatim by the researcher and all CPs were allocated pseudonyms to ensure anonymity.

Data Analysis

The study data were analysed using IPA. The researcher followed the process for IPA as outlined in Smith, Flowers & Larkin (2009) in order to explore the data and identify themes contained in each interview transcript and across the whole data set. This process is described in Table 1.

Table 1. The six stages of IPA.

Reading and re-reading	
1	The first interview transcript was read and re-read thoroughly in order to ‘immerse’ the researcher in the CP’s experience.
Making annotations	
2	Space was available to the left of each transcript to note key initial thoughts regarding the interview data line-by-line.
Identifying emergent themes	
3	Space was available to the right of the text to highlight data that were believed to be emergent themes pertinent to the research question.
Collating emergent themes	
4	Themes were grouped into one list; links were identified between emergent themes; superordinate/subordinate themes were developed by grouping themes together.
Analysis of remaining transcripts	
5	Each additional interview transcript was proceeded to and stages 1 to 4 were repeated, as detailed above.
Making connections across all transcripts	
6	Connections were searched for across the whole data set, emergent themes were clustered, and superordinate themes were identified across all transcripts.

Example materials from the data analysis process are provided, including an extract of an annotated transcript (Appendix 2-B) and an excerpt from the table of themes (Appendix 2-C). Several maps were developed throughout the analysis; an example is provided with explanatory notes on how one theme was revised and reduced (Appendix 2-D).

Reflexivity

Throughout the analysis the researcher reflected on their active role in the research, and considered how their beliefs may have shaped this process. It is acknowledged the

researcher's situation can considerably impact on the analysis so should be made transparent (Harper & Thompson, 2012). Below is a brief statement of the researcher's position:

I am a female trainee CP in my final year of training. Prior to training I worked full-time in a medium secure male FMH service for 10 months, and had found this role both challenging and rewarding.

I was interested in what CPs found fulfilling about working in FMH. From my brief experience, I anticipated CPs would identify positive and negative aspects of their work, and various influences on their sense of compassion satisfaction.

A reflective diary was utilised to note down the researcher's thoughts at key stages of data collection and analysis (Ortlipp, 2008) in order to 'bracket off' their experiences.

Engaging in reflexive tasks such as exploring dynamics between the researcher and participant is considered highly important yet subjective within qualitative research (Finlay, 2002). Appendix 2-E contains extracts from the reflective diary.

Furthermore, characteristics including gender, age and social class can influence the qualitative interview and themes which emerge from this (Manderson, Bennett & Andajani-Sutjahjo, 2006). Six CPs were the same gender as the researcher and all worked in a role consistent with the researcher's training. These similarities possibly led CPs to connect with the researcher and be less specific in their accounts due to the assumption that some mutual knowledge would be present. Conversely, the researcher was a trainee CP with no qualified experience of working in FMH, which may have led CPs to share more information in an 'educational' manner.

Credibility

To uphold the credibility and reliability of the research project several actions were undertaken. Firstly, the researcher sought supervisory feedback at key stages of data collection and analysis to ensure consistency and clarity of the process.

An audit trail was developed to check themes were rooted in the interview data and to ensure all CPs' accounts were incorporated in the analysis (Wolf, 2003). Using direct quotations from CPs further enhanced the trustworthiness of the findings (Thomas & Magilvy, 2011). Emergent themes were constantly compared with the original interview transcripts; a table of themes was created during the analysis and was developed continuously as themes had emerged (see Appendix 2-C for excerpt). The researcher's academic supervisor was consulted with and provided feedback on the analysis and interpretation of themes. Guidelines for examining the quality of qualitative studies were also followed in order to ensure the research conducted in the current study was of a high standard (Yardley, 2000).

Results

Five superordinate themes were developed during the analysis of data: 1) The magnitude of trust; 2) Adjusting expectations; 3) Being both lock and key; 4) The impact of time and resources; and 5) Variety and complexity. Themes are interpreted and illustrated with verbatim quotes. Final themes are displayed in Table 2.

Table 2: Final themes.

Final themes	Clustered emergent themes
<i>The magnitude of trust</i>	Harder to engage patients than in other settings Invigoration at being trusted Feeling privileged at disclosures
<i>Adjusting expectations</i>	The reality gap Slower pace of progress Salience of slight improvements
<i>Being both lock and key</i>	Psychology prescribed as the ‘way out’ Making the most with what you have
<i>The impact of time and resources</i>	There’s not enough time Too many demands
<i>Variety and complexity</i>	Always new and exciting The power of formulation Navigating multiple perspectives It’s not for everyone (yet I can do it?)

The Magnitude of Trust

This theme captured the sense of enormity CPs experienced at being trusted by the patients they worked with, which also included when working indirectly with patients via staff teams. There was an overall consensus that developing trusting relationships with patients in FMH services is inherently more difficult compared to other fields the CPs had worked in:

...at least [patients are] going to meet you at your session in the community, they’re turning up, so you sort of see that there’s already something there. We’re, I think

we're already starting off at a different and a more difficult position in forensics.

(Monica, p.14).

Building trust with patients was often a prolonged process, so when patients did engage meaningfully and of their own volition, CPs appeared to feel taken aback. The adversity of patients' upbringing and being detained often led CPs to feel more fulfilled at being entrusted with their stories, for instance:

...when you do feel like you've managed to reach someone or make a difference, then that's all the more rewarding because of the type of environment that they're in...people are usually coming from backgrounds where they've never ever felt able to trust someone or talk about some of the things that they then talk to us about, and that feels like quite an honour and quite a lot to hold... (Jessie, p.6).

This is emphasised by how three CPs referred to being trusted by patients as a "privilege" (Jessie, Lisa and Monica). There was a sense of being special in a patient's life once they engaged, given the previous lack of available support systems, "I guess maybe you feel all the more kind of honoured or privileged, unique in that sense in that person's life...that feels really important and really valuable..." (Jessie, p.6). This is echoed in the following quotation, "...being in a caring relationship with somebody can be so anxiety provoking and frightening [for patients], when people do let you in and do open up, it does feel a very privileged position to be in..." (Lisa, p.5). Furthermore, forming a therapeutic relationship was key to many CPs' experiences of making a positive impact, rather than specific psychological interventions:

I worked with someone who was really, really tricky, and we worked together for about two years...he struggled to just even be in the room with me...I worked in a

way that was just focused on the relationship...that was really positive, that I felt like I'd made a difference. (Mary, p.9).

Adjusting Expectations

All CPs described the transition to working in FMH settings as a qualified clinician as intense, irrespective of pre-training experience in the field. This theme captures how CPs soon adjusted their previous expectations of concepts such as 'outcomes', 'recovery' and 'change' to maintain a sense of being able to make a difference.

Upon first starting in post many CPs initially faced a gap between their aspirations and what could be achieved realistically in terms of resources and patient motivation:

I first came as a newly qualified psychologist all motivated and all 'I want to do groups on the ward!'...and [patients] weren't that bothered, they were like 'I don't want to speak to you' or like blanking me, and I was like 'gosh'... (Monica, p.9).

Martin similarly reflected "...when I started working with some of these men years ago I was maybe more hopeful that I'd be able to achieve greater changes than what has actually transpired" (Martin, p.6). The adjustment of expectations over time was conducive to maintaining compassion satisfaction and self-care, as Jessie stated, "...probably my expectations have changed, been lowered slightly in line with my experience that actually these things [staffing issues] don't change, and maybe there's a degree of self-preservation in that..." (Jessie, p.11). Likewise, CPs who were able to work in their preferred modality (either individual therapy or systemically with staff teams) described enhanced experiences of fulfilment in their roles.

All CPs compared the achievement of clinical outcomes in FMH as slower and less noticeable than other settings they had worked in:

...its very different to community psychology...ticking the box that you've had a successful outcome because your scores have gone down, that's not really on the cards in the same way, it could be years before you get that kind of change... (Jessie, p12).

This seemed to prompt CPs to reconsider what constitutes a 'successful' outcome, with very small changes being impressive, "...it might be a very throwaway comment and it just signifies to you [patients have] actually understood something, and you can see a glimmer or an increase in someone's insight...it might be very simple, that is hugely gratifying..."

(Carol, p.9).

Furthermore, there was a feeling that maintaining safety was implicitly rewarding, such as when transitioning a patient to another hospital, "...there are a lot of rewards in that [safe transition], there are no high fives and thank you cards that come with that kind of good work done, but it forms the foundation for what happens to that [patient] thereafter."

(Andrew, p.12).

Many CPs described adjusting their perceptions of 'recovery', again drawing comparisons to their experiences in community settings where recovery was generally viewed as a positive outcome. In FMH settings, CPs felt recovery was bittersweet; patients transitioning to a more independent life were often "treasured" (Andrew, p.16); however, recovery could be very disconcerting, "...a lot of women in here are really scared of leaving the one place where they've felt really safe in their life..." (Monica, p.2). This drawback at times marred the sense of rewards:

...because we're a forensic service, actually some [patients] if they recover might have to go back to prison, because that's the law. And that's really hard, because prisons [for patients] are horrible, and are not great places at all. I think most of them should be closed... (Andrew, p.9).

Being both Lock and Key

This theme was paradoxical in terms of compassion satisfaction and reflects the dilemmas CPs felt their roles encompassed, especially in providing therapeutic work in a restricted context. In one respect CPs described feeling part of the 'lock' in the overall system detaining patients, as part of their roles required contributing to MDT clinical decision making regarding risk assessment and patients' leave entitlement. Most CPs expressed uneasiness with the conditions of security that were placed on patients, though these were also accepted as necessary to maintain patient, staff and public safety. Furthermore, there was a sense that psychological therapy was stipulated by medical staff:

...yes, psychology is valued in forensic services, but it's often prescribed really from the psychiatrists...there's this sense of them wanting you to go off and do psychology to people and kind of fix people?... 'doing to' people instead of 'working with'?

(Mary, p.2).

For some CPs this impacted on their experiences of compassion satisfaction, as collaboration with patients was affected and caused patients to engage in psychological therapy in a tokenistic way:

... [patients have] been told they're going to have to do this work before they can be discharged, and obviously they want to be discharged, but [then] their idea of doing the work just means coming along, and just being there. (Monica, p.13).

Conversely, CPs conveyed a sense of fulfilment from being part of a sub-group within the FMH system (clinical psychology) which was comparable to the 'key' and could potentially facilitate patients to move along the treatment pathway and eventually out of services. This quote illustrates this issue, "...absolutely one of the pros is it can help you progress through your care pathway, and you're more likely to get stuck in the system if you don't engage in psychology..." (Lisa, p.12). Yet, being the 'key' out was still an uneasy experience, "... [but] that feels a really uncomfortable conversation to have with patients." (Lisa, p.13).

Given the discomfort of working in secure conditions, CPs appeared to gain satisfaction from attempting to make the most of the patient's restricted situation by working creatively and bringing as much person-centeredness to individual therapy as possible:

...it's trying to work with what we've got and kind of work around those restrictions I suppose a little bit. Because some of the restrictions, I understand why they're there, but they kind of are imposed on people, when they wouldn't choose them. So that's one of the things that I can struggle with here... (Carol, p.10).

...trying to emphasise, 'let's think about your personal goals? How would you like your life to be different?' The preferred futures stuff, good lives model stuff, motivational interviewing stuff, to try and make the work as meaningful as possible for the person. (Lisa, p.13).

Overall, this theme emphasises how maintaining a sense of compassion satisfaction can be complicated for CPs in FMH settings with reference to the dualism of their roles, but that strategies such as working with a sense of creativity helped with this.

The Impact of Time and Resources

This theme illustrated how sufficient time and resources were an important influence on compassion satisfaction in terms of having sufficient opportunities to reflect on positive achievements, making time for self-care and supervision, and preparing for therapy sessions. Conversely, the busy nature of FMH meant many CPs felt they were ‘firefighting’ daily, with more meaningful aspects of their roles taking less priority:

...if I was around more I would have more time, and I think I would be really quite present on the ward...I would make sure that we [MDT] were working together a bit better, but because I just don't have the time to do that...yeah, that sits quite uncomfortably with me. (Mary, p.6).

There was a notion that time passes quickly in FMH despite patient length of stay being relatively longer, and many CPs described the volume of work as demanding, "...this morning I was just writing out a list of things I needed to do by the end of next week because I'm off the week after that, and I was just thinking 'Christ!' you know, there's a hell of a lot to get done! So, that's a challenge." (Martin, p.10). Furthermore, lack of time meant the positive aspects of the role were harder to notice, "...you need time to reflect to be able to appreciate or see the positives, or to prepare so that you feel like you've done a good piece of work..." (Laura, p.14).

The CPs utilised methods to cope with time pressures, such as by prioritising their workload and trying to ensure time was taken in lieu of additional hours worked. In addition,

limited resources impacted on CPs' sense of fulfilment, both in terms of feeling stretched themselves and when working with staff teams:

...you can come up with great formulations and care plans, but in practice staff are incredibly stretched across the whole service and quite often its bank and agency staff, and they're just thrown in and they need to respond to incidents a lot, and the reality of trying to implement really good plans that come out of formulations is limited.

(Jessie, p.6).

Variety and Complexity

This theme related to how CPs found the complex nature of working in FMH to be a fulfilling and rewarding part of their role which enhanced their experiences of compassion satisfaction.

There was an overall sense that FMH settings offered a wider variety of work for CPs in comparison to other settings, which continuously brought something new and exciting, as noted by both Laura (p.2), "...everyday there is something different..." and Jessie (p.15), "...there's always something new...you're not going to stagnate in this role!" Interestingly, CPs who had worked at the same FMH service for many years also shared this view, "...you do get such a wide variety of stuff...even now I'd say every week you come across something in the hospital and you think 'Gosh, I've never come across that before!' so for me that's appealing." (Martin, p.12).

Linked to this, a sense of gratification was cultivated from being able to use a wide array of clinical skills and to assess and manage high levels of patient risk. The power of psychological formulation was noted by many CPs, who described satisfaction from mapping the events leading to a patient's offense, "...there's definitely that kind of intellectual

challenge, how to formulate a complex case, that is very dynamic and very changeable...”

(Andrew, p.12). CPs also valued the challenge of developing and sharing complex psychological formulations with patients and staff teams. Likewise, navigating the needs of various external systems was seen as an intellectually stimulating and challenging part of the work:

...you have the added legal component here and the fact that there's public protection as well and risk, so that can be quite difficult to manage. When you've got to think about who is your patient? Who is the person who you are working for? (Monica, p.12).

Similarly, mediating tensions between nursing staff and responsible clinicians also brought a sense of being able to make a positive difference, “It feels really good, especially I think when a member of staff on the ward has felt really criticised professionally and sometimes criticised as a person, and I've managed to sort of reframe the whole situation...” (Laura, p.7).

Finally, many CPs' experiences of compassion satisfaction were rooted in the belief that FMH is a unique and challenging specialty which is not suited to all, “...it's definitely not for everyone, but if you can do it, maybe you should, because there is such a big level of need...” (Jessie, p.16). This was mirrored by other CPs, for example, “...for some people they would find it really difficult to get past someone's offense...I don't think it is for everybody.” (Carole, p.17). Underpinning these assertions were unspoken messages that the CPs were able to manage this level of complexity and still derive fulfilment from this work, which itself generated a sense of pride and satisfaction.

Discussion

This study explored the experiences of compassion satisfaction in eight CPs working in FMH services. IPA was chosen to allow for experiential richness with regards to understanding these experiences and what may enhance or hinder compassion satisfaction. Analysis of the data led to the development of five superordinate themes: 1) The magnitude of trust; 2) Adjusting expectations; 3) Being both lock and key; 4) The impact of time and resources; and 5) Variety and complexity. Findings are discussed in relation to the available literature, and current policy. Clinical implications and areas for future research are then considered.

Across the interviews an initial theme emerged regarding how compassion satisfaction was derived from CPs being trusted by patients. CPs voiced that engaging with patients in FMH contexts was difficult. This is consistent with the literature that suggests the forensic population are more likely to have experienced higher levels of trauma, physical and sexual abuse (Garieballa et al., 2010) and insecure attachment patterns (Oglivie et al., 2014) which may impact on the formation of relationships with others. Research also indicates patients in FMH services may encounter difficulties in developing trusting therapeutic rapport as anxious or neglecting reactions can be re-enacted in relationships with staff (Ruszczynski, 2010). The notion of feeling 'privileged' by patient trust is supported by Hunter (2012) in an Australian grounded theory study of family and couples therapists when working with trauma, suggesting there are experiential similarities between clinicians working with a traumatized patient group.

Fostering trust with patients was described as a lengthy and difficult process. CPs were then surprised when patients did begin to open up and engage, with feelings of being 'privileged' and special in the patients' lives. This is consistent with compassion satisfaction including an element of feeling 'invigorated' at helping others (Stamm, 2010). However, the

finding that such invigoration at helping others may be experienced at an early stage of patient engagement in FMH is not reflected in the wider literature, indicating the trajectory of CPs' experiences of compassion satisfaction may differ in FMH compared to other clinical settings. For example, while Hunter (2012) reported therapists experienced compassion satisfaction within therapeutic relationships which were well-established, no references were made to the timeframe of this.

A second theme emerged regarding the adjusting of expectations, including CPs' goals and the meaning of various clinical concepts such as 'recovery'. CPs described working in FMH as intense, and all felt the first 12 months in their qualified post was a steep transitional period irrespective of their previous FMH experience. As such, a 'reality gap' often appeared between what could be achieved and what was expected in their work. Thus, CPs identified an important aspect of compassion satisfaction involved the realigning of their goals, expectations and definitions soon after starting to work in the field. This is theoretically consistent with the notion of 'service rationing' by Van Dernoote Lipsky and Burk (2009), a process staff complete in order to address the gap between how they would work ideally versus in reality. This enabled CPs to tailor such expectations in accordance with the realities of working in a FMH context, and thus maintain a sense of fulfilment. This theme is also supported by 'Goal Setting Theory' as proposed by Locke and Latham (2006; 2013); specifically, that self-set goals are key in self-regulation, and that goal-performance discrepancies can lead to choosing lower goals in the future. The slower pace of patient progress and salience of smaller improvements were also key components of compassion satisfaction; that is, small changes (or even maintenance and non-changes) were still hugely important. This is in keeping with suggestions that the application of a recovery approach in forensic services is complicated by patient, systemic and risk factors (Mann, Matias & Allen, 2014), and as such may require re-evaluation.

A third paradoxical theme emerged which conceptualised CPs' experiences to being the 'lock and key'. It was evident from CPs' discussions that working in FMH necessitated being part of a system that is essentially detaining patients, and part of a sub-system (clinical psychology) which can help patients to progress out of services. This theme is reflective of the role dualities staff working in FMH settings encounter in relation to balancing custodial and care duties (Ward, 2013). In one respect, CPs' sense of compassion satisfaction was impeded by being part of an organisational structure that restricted the choices and freedom of patients. However, many acknowledged the need to retain a holistic perspective, in that measures of security were necessary to fulfil wider responsibilities of public protection. In turn, compassion satisfaction ensued from being in a position within a detaining system to offer patients opportunities to engage in meaningful person-centred work which would potentially facilitate them being able to progress through the system and achieve more independence.

The fourth theme captured the importance of sufficient time and resources in the experiences of compassion satisfaction. All CPs described intense feelings of busyness, and some described feelings consistent with compassion fatigue; this is consistent with Iwamitsu et al. (2013) who found organisational pressures contributed to feelings of compassion fatigue in CPs working in cancer care in Japan. This finding is perhaps not surprising given the increasing pressure for NHS clinicians to provide both high quality and efficient care (Department of Health, 2013), a challenge which psychologists have been facing for decades (see Eckert & Delworth, 1994). The NHS at present is required to make a 3% 'efficiency saving' annually between 2016 and 2021 (NHS England, 2014), meaning clinicians including CPs are expected to do more with less in this current climate of cost-effectiveness. Having adequate time was key to CPs being able to notice positive achievements in FMH settings and gain fulfilment from these, especially as achievements were less visible than other

settings. However, time pressures and demanding workloads meant some CPs felt unable to either achieve what they desired or be able to notice achievements that did occur.

Fulfilment was also affected by wider organisational issues as the staff teams they collaborated with in FMH settings were often stretched, which impacted on the effective dissemination of psychological aspects of patients' care through other team members. Therefore, time constraints affected compassion satisfaction due to the impact on CP's personal reflective practice opportunities and time spent delivering care directly and via consultation. Considering Fredrickson's (2004) broaden-and-build theory purports positive emotions trigger an upward spiral of positive emotions in individuals and those around them, simply having sufficient time to acknowledge the positives of working as a CP in FMH is clearly paramount.

The final theme identified how the variety and complexity of working in FMH settings appeared to enhance CPs' experiences of compassion satisfaction. CPs appeared to gain fulfilment from the complex nature of working in FMH, which as a specialty continuously brought something new and exciting unlike other areas the CPs had worked or trained in. Similarly, the scope to utilise a range of clinical skills, especially psychological formulation and risk assessment, was gratifying to many CPs. This fits with literature that many areas of clinical and forensic psychology are complex, including ethical decision making (Swanepoel, 2010) and managing roles that interface between the criminal justice and mental health systems (Ward, 2013). Of salience was how CPs' expressed a belief that working in FMH is fundamentally challenging and 'not suited to all'; simply being able to work in this specialty thus generated a sense of pride and satisfaction. Given the literature that points to staff burnout in FMH (such as Elliot & Daley, 2013), this is contradictory and suggests the CPs in this study found the challenging aspects of FMH to be a positive influence in their experiences of compassion satisfaction.

Strengths and Limitations

The current study has provided an insight into the experiences of compassion satisfaction in a sample of CPs working in FMH services. To the researcher's knowledge, no similar studies have yet been conducted. Research involving staff in FMH settings has tended to focus on non-psychology professions, with a dominance on nursing staff perspectives. Gaining a deeper understanding of CPs' experiences is important as their roles often involve supporting other MDT staff in addition to patients within FMH contexts. Several CPs who were interviewed commented on the importance of this research, as the busy nature of FMH often limited their chances to reflect on the positive aspects of their roles.

A strength of the current study is that CPs were recruited from a range of FMH settings including high/medium/low secure hospitals, adolescent, and community services. This reflects the range of FMH services currently in operation and minimises the findings of the study becoming service-specific. Though IPA does not advocate for study findings to be generalised, the themes found in this study may relate to other CPs in FMH services and to CPs working in similar fields where conditions of security are required, such as locked inpatient wards. The exclusion of CPs with less than two years' FMH experience was a methodological strength as this ensured that CPs had acquired detailed knowledge and understanding of this specialty prior to interview, so were fully able to consider their experiences of compassion satisfaction when working in this area.

There was an under-representation of CPs working in high secure services, adolescent services, and community FMH teams ($n=1$ each), which may have influenced the findings. For instance, it is possible that CPs working in adolescent or community FMH services have more potential to experience compassion satisfaction given the younger age of the patients and lesser conditions of security respectively. The under-representation of CPs from women's FMH services ($n=1$) is also important to note, as research has suggested nurses experience

higher levels of emotional exhaustion in female services than male services (Nathan, Brown, Redhead, Holt, Hill, 2007). However, this study involved nursing staff, so the findings may not directly translate to CPs. Though CPs in non-NHS services were not included, and CPs in women's high secure services were not recruited due to geographical limits of the current study, a broad range of FHM services were still represented in the sample.

A limitation of the current study is the self-selecting nature of recruitment. This potentially means the CPs who participated may have been interested in the topic of compassion and felt more able to allocate the time to share their experiences in an in-depth 1:1 research interview, as opposed to CPs who felt fatigued or close to burnout. Finally, whilst only the principal researcher's understandings are represented in this paper, a strength of the current study is that several processes were completed to support the credibility and reliability of the research. Each theme which emerged reflected multiple CPs' perspectives, and choosing IPA methodology also allowed the flexibility to listen to the CPs' accounts without any hypotheses being set beforehand.

Clinical Implications

A number of clinical implications are drawn from the findings of this study. In England (the study location) qualifying as a CP requires the completion of a postgraduate Doctorate in Clinical Psychology (DClinPsy) course, which includes core training placements across child, adult, Learning Disability and older adult/health/neuropsychology settings (BPS, 2009). Training placements in FMH are not a core requirement. Therefore, unless trainee CPs select or are offered a placement in FMH (such as for their final year), or have worked in FMH settings prior to training, the majority will enter qualified life with no clinical experience in this specialty. As all CPs in the current study identified that FMH was in many ways distinct to other mental health settings they had worked in, the findings may be relevant

to informing the teaching content of DClInPsy programmes by enlightening trainee CPs on the experiential distinctions of working in FMH.

The findings also point to the importance of reflective space for CPs currently working in this field. The importance of adequate time and resources was key to compassion satisfaction, yet this was affected by the current time-pressured and cost-effective culture of the NHS. Implementing routine items on the agenda of supervision sessions regarding CPs' achievements could be one such way of ensuring time is allocated to identify the positives in their work, which may enhance their sense of compassion satisfaction. This is important given one review suggested lack of positive feedback was related to stress in mental health workers (Rössler, 2012). As CPs may experience personal and professional changes from listening to others' trauma (Large, 2013) FMH services also need to recognise the impact of this work and ensure CPs have sufficient opportunities to reflect on their work.

Recommendations for Future Research

Further research is needed to add to the findings of the current study and to the wider body of research in this area. Building more knowledge on what CPs find positive about working in FMH settings could contribute to the improvement of staff retention and work performance, and inform the teaching content of and raise interest in FMH training placements on DClInPsy training programmes.

As only CPs currently working in FMH settings were recruited, the experiences of CPs who had already left the FMH specialty were not captured; this may be another area for future research. Broadening the inclusion criteria to CPs who have left FMH would potentially shed more light on the barriers to compassion satisfaction if the reasons for leaving were related to fatigue/burnout.

Given the intense transitional period into FMH identified by CPs in this study, future research should explore the experiences of CPs with less than two years qualified experience.

This would illuminate what aspects of their roles are satisfying at different stages of working in this field. Longitudinal research with CPs would also be useful in identifying changes in individual experiences of compassion satisfaction over time, as the findings of the current study suggested this was a dynamic process and thus open to influence.

Lastly, consideration should be made as to how compassion satisfaction is conceptualised. While the ProQOL (Stamm, 2010) measures compassion satisfaction via a set of items containing terminology such as feeling ‘happy’ about aspects of one’s work, none of the CPs in the current study used this particular term. Some CPs stated this was primarily due to working with distressed people who are detained against their will, yet they still gained fulfilment from their roles. This suggests quantitative measures may not necessarily have captured this. Therefore, narrative studies exploring how the use of language can shape the experiences of compassion satisfaction would also be an interesting area of future research.

Conclusions

The present study has provided an initial insight into a sample of CPs’ experiences of compassion satisfaction and what may hinder these experiences when working in FMH services. These findings have important implications for future research, education, and clinical practice. Firstly, future research should continue to explore the experiences of CPs working in FMH services at different stages of their careers; given a number of newly qualified CPs expressed interest in the current study, but were not eligible to take part, longitudinal studies would provide a valuable insight into what issues are salient in CPs’ positive experiences at different career points. Secondly, the findings of this study may help to inform the teaching content of DClinPsy training programmes by providing an insight into the experiential challenges and rewards of working in FMH settings. For instance, the findings could provide a useful starting point for discussions in reflective learning groups or

placement planning sessions. Finally, the findings of this study highlight the importance of cultivating conditions which will facilitate the experiences of compassion satisfaction, the most prominent being regular protected space for CPs to recognise and reflect on the positive experiences of working in FMH settings, which are not always easy to notice.

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Appendix 2-A: Journal Guidelines

Author guidelines for the submission of papers to *Legal and Criminological Psychology*:

The Legal and Criminological Psychology journal publishes theoretical, review and empirical studies which advance professional and scientific knowledge in the field of legal and criminological psychology, as defined in the Journal [Overview](#).

All papers published in Legal and Criminological Psychology are eligible for Panel A: Psychology, Psychiatry and Neuroscience in the Research Excellence Framework (REF).

1. Circulation

The circulation of the Journal is worldwide. Papers are invited and encouraged from authors throughout the world.

2. Length

The word limit for papers submitted for consideration to LCP is 5000 words and any papers that are over this word limit will be returned to the authors. The word limit does not include the abstract, reference list, tables and figures. Appendices however are included in the word limit. In very exceptional cases, the Editor retains discretion to publish papers beyond this length where the clear and concise expression of the scientific content requires greater length (e.g., explanation of a new theory or a substantially new method). The authors should contact the Editor first in such a case.

LCP frequently invites target articles that give readers access to the very latest in the field, particularly but not limited to new theoretical or methodological approaches. In those cases deemed appropriate, peer commentaries on these papers/reviews will be solicited from other researchers. These peer commentaries are published immediately after the target article, with

the authors(s) of the article also on occasion being invited to write a response to the commentaries. If you believe that your article should be considered for the basis of an invited article, please select the 'Target Article' article type on submission and justify your decision in an accompanying cover letter.

3. Submission and reviewing

All manuscripts must be submitted via [Editorial Manager](#). The Journal operate a policy of anonymous (double blind) peer review. We also operate a triage process in which submissions that are out of scope or otherwise inappropriate will be rejected by the editors without external peer review to avoid unnecessary delays. Before submitting, please read the [terms and conditions of submission](#) and the [declaration of competing interests](#). You may also like to use the [Submission Checklist](#) to help you prepare your paper.

4. Manuscript requirements

- Contributions must be typed in double spacing with wide margins. All sheets must be numbered.
- Manuscripts should be preceded by a title page which includes a full list of authors and their affiliations, as well as the corresponding author's contact details. You may like to use [this](#) template. When entering the author names into Editorial Manager, the corresponding author will be asked to provide a CRediT contributor role to classify the role that each author played in creating the manuscript. Please see the [Project CRediT](#) website for a list of roles.
- All papers must include a structured abstract of up to 250 words with the following headings: Purpose, Methods, Results, Conclusions.
- The main document must be anonymous. Please do not mention the authors' names or affiliations (including in the Method section) and always refer to any previous work in the third person.

- Tables should be typed in double spacing, each on a separate page with a self-explanatory title. Tables should be comprehensible without reference to the text. They should be placed at the end of the manuscript but they must be mentioned in the text.

- Figures can be included at the end of the document or attached as separate files, carefully labelled with symbols in a form consistent with text use. Unnecessary background patterns, lines and shading should be avoided. Captions should be listed on a separate sheet. The resolution of digital images must be at least 300 dpi. All figures must be mentioned in the text.

- For reference citations, please use APA style. Particular care should be taken to ensure that references are accurate and complete. Give all journal titles in full and provide doi numbers where possible for journal articles. For example:

Author, A., Author, B., & Author, C. (1995). *Title of book*. City, Country: Publisher.

Author, A. (2013). Title of journal article. *Name of journal*, 1, 1-16. doi: 10.1111/bjep.12031

- SI units must be used for all measurements, rounded off to practical values if appropriate, with the imperial equivalent in parentheses.

- In normal circumstances, effect size should be incorporated.

- Authors are requested to avoid the use of sexist language.

- Authors are responsible for acquiring written permission to publish lengthy quotations, illustrations, etc. for which they do not own copyright.

- Manuscripts describing clinical trials are encouraged to submit in accordance with the [CONSORT statement](#) on reporting randomised controlled trials.

For guidelines on editorial style, please consult the [APA Publication Manual](#) published by the American Psychological Association.

If you need more information about submitting your manuscript for publication, please email Hannah Wakley, Managing Editor (lcrp@wiley.com) or phone +44 (0) 116 252 9504.

5. Supporting Information

Supporting Information can be a useful way for an author to include important but ancillary information with the online version of an article. Examples of Supporting Information include appendices, additional tables, data sets, figures, movie files, audio clips, and other related nonessential multimedia files. Supporting Information should be cited within the article text, and a descriptive legend should be included. Please indicate clearly on submission which material is for online only publication. It is published as supplied by the author, and a proof is not made available prior to publication; for these reasons, authors should provide any Supporting Information in the desired final format.

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9. Colour illustrations

Colour illustrations can be accepted for publication online. These would be reproduced in greyscale in the print version. If authors would like these figures to be reproduced in colour in print at their expense they should request this by completing a [Colour Work Agreement](#) form upon acceptance of the paper.

10. Pre-submission English-language editing

Authors for whom English is a second language may choose to have their manuscript professionally edited before submission to improve the English. A list of independent suppliers of editing services can be found in [Author Services](#). All services are paid for and arranged by the author, and use of one of these services does not guarantee acceptance or preference for publication.

11. The Later Stages

The corresponding author will receive an email alert containing a link to a web site. The proof can be downloaded as a PDF (portable document format) file from this site. Acrobat Reader will be required in order to read this file. This software can be downloaded (free of charge) from [Adobe's web site](#). This will enable the file to be opened, read on screen and annotated direct in the PDF. Corrections can also be supplied by hard copy if preferred.

Further instructions will be sent with the proof. Excessive changes made by the author in the proofs, excluding typesetting errors, will be charged separately.

12. Early View

Legal and Criminological Psychology is covered by the Early View service on Wiley Online Library. Early View articles are complete full-text articles published online in advance of their publication in a printed issue. Articles are therefore available as soon as they are ready, rather than having to wait for the next scheduled print issue. Early View articles are complete and final. They have been fully reviewed, revised and edited for publication, and the authors' final corrections have been incorporated. Because they are in final form, no changes can be made after online publication. The nature of Early View articles means that they do not yet have volume, issue or page numbers, so they cannot be cited in the traditional way. They are cited using their Digital Object Identifier (DOI) with no volume and issue or pagination information. E.g., Jones, A.B. (2010). Human rights Issues. *Human Rights Journal*. Advance online publication. doi:10.1111/j.1467-9299.2010.00300.x

Further information about the process of peer review and production can be found in this document. [What happens to my paper?](#) Appeals are handled according to [the procedure recommended by COPE](#).

Appendix 2-B: Extract of Annotated Interview Transcript (Jessie)

Initial annotations	Interview transcript (R=researcher, J=Jessie).	Emergent themes	Final theme
Rewards of challenges/ novelty	J:...I still enjoyed it and I think I enjoyed the challenge of doing something that was really different and just learning the complexities of working in a service like this where, rather than having people, which I've always worked in community services, so to have people come to you and who really want	Excitement and complexity	Variety and complexity
Engagement comparatively harder to achieve	help and are quite distressed and are also quite able to tell you about it generally, to greater or lesser extent, compared to going and knocking on someone's bedroom door and trying to get them to come to their psychology session, because if they don't they can't leave hospital, and that sense of being part	Harder to engage patients	The magnitude of trust
Psychology seen as the way out of hospital/ Stipulated- not patient choice	of the system that's locking them up and maybe being the key out*, you know, it's often kind of prescribed that they have psychological therapy, and if they don't engage in it then there not doing what we want them to do and they can't progress, and all of those kind of dynamics were really new to me, so trying to, coming from a background where psychological therapy is available and if you don't	Being both lock and key	Being both lock and key
Dilemma- balance pt. choice with realities of how to progress	want it that's fine, to being in a system that that's not quite always the case and its maybe not always fair to present it that way to people because actually that's not true, you know, and they're getting a very different message from other areas, and trying to hold that balance between trying to make it collaborative and making it something that's meaningful for them, and also sometimes ticking boxes	Balancing interests	Variety and complexity
Meeting needs of various systems/ Inject meaning to paperwork/ Trying to balance everyone	for the ministry of justice or probation, for the rest of the team, and still trying to make that meaningful as well as a paper exercise and something they need to do, is probably something that its different for each individual and I'm still learning and will continue learning forever, in terms of getting that balance right for people.	Bringing meaning to the work	Being both lock and key
		Balancing collaboration and stipulation	Being both lock and key

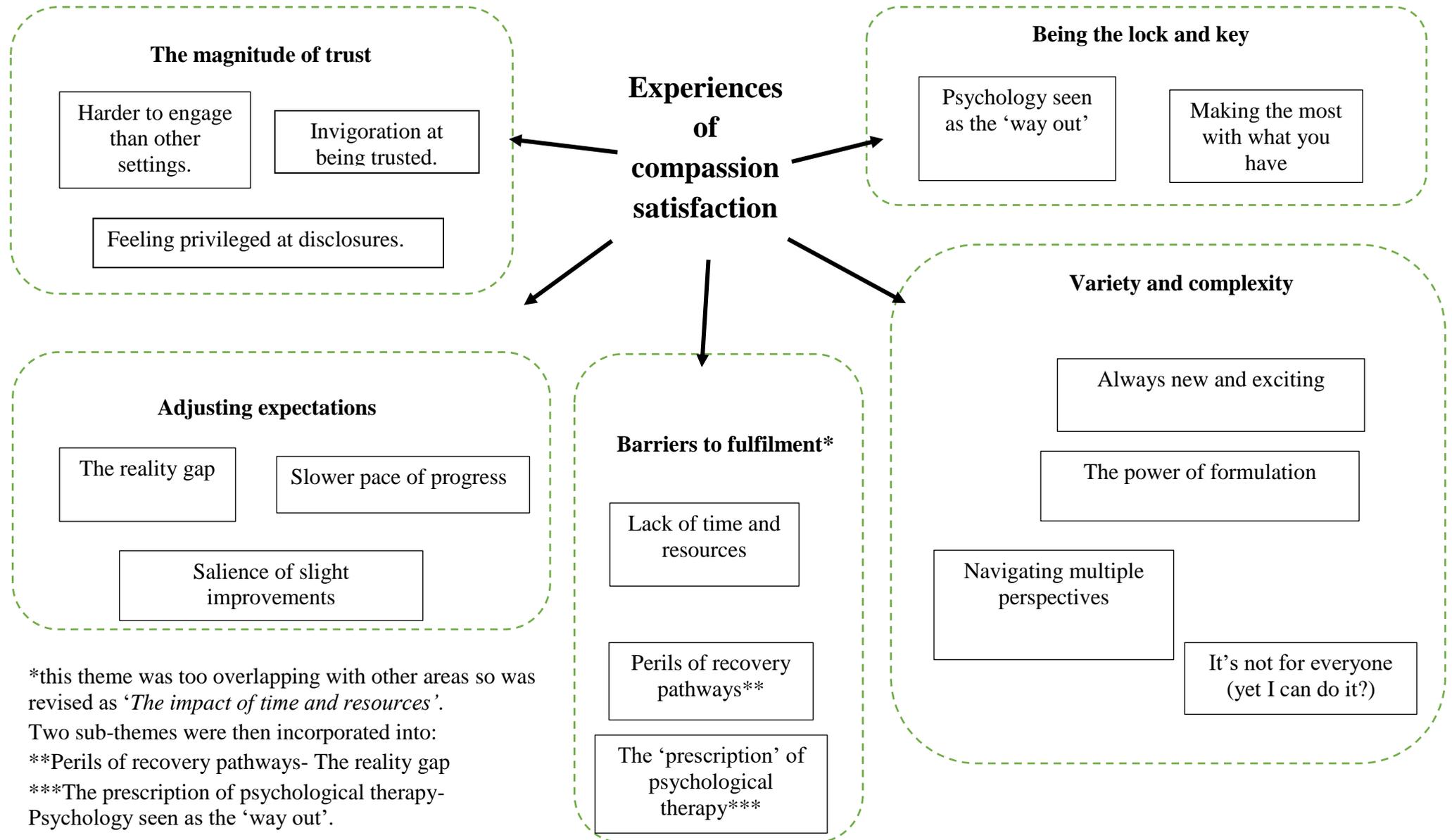
[*indicates key quote which has been used to name a theme]

Difficulties more prevalent/ accessible?	R: So you've been here three years, in terms of a typical day, what would a 'good day' be like?	Bad days more common	<i>Variety and complexity</i>
	J: Ha. Erm...I think it's probably easier for me to say what a bad day is like here!		
Challenge of regular meetings- impacts on week	R: Yes, what would a bad day be like?	Clusters of difficult times	<i>Variety and complexity</i>
	J: So we have our care team meeting or ward round on the high dependency ward first thing on a Monday morning. That typically doesn't always start the week off on a wonderful foot, because of the reason people are on that wards is because their needs are very high and they're often quite distressed and quite angry, it might be one of the first wards that they come into in hospital, so there's a lot of frustration and a lot of anger about being detained, so we can spend a good part of the morning being		
Faced with pt. distress/aggression	shouted at, and doors slammed, threats, and to start the week off like that is not always great! And it's not always like that, but there have been periods of time where you seem to go through times where	Clusters of difficult times	<i>Variety and complexity</i>
	quite a few people are feeling particularly distressed or angry and then it can be quite draining to know that you've got that on Monday morning, week after week for period of time. I guess, personally		
Clusters of difficult weeks	there's also times when I feel like the people on my caseload that I'm working with individually are quite engaged and actually do want therapeutic input, and that's more rewarding for me and we have sessions where it feel as bit more therapeutic rather than sort of 'doing to' or, I don't know, dragging them along because they've been told they have to be there, so maybe a good day is one where, there's maybe some element of that, so feeling like the individual work is meaningful and helpful to people.	Rewards when patients engage of own volition	<i>Being both lock and key</i>
Draining- predict future difficult weeks/			
Pockets of time when pts engage			
Rewarding when collaborative not 'enforced'			
Small tangible signs of progress are important/ Slow pace of change	Or, where just collectively as a team there's, if we do have people coming in who are very distressed very confused, and they start to be able to engage more with the team, so speak to us a little bit more when the distress is reducing, they feel a bit safer, they might have come into seclusion and they're able to start coming out of that, that kind of progress that's very tangible is very rewarding,...	Salience of small steps	<i>Adjusting expectations</i>

Appendix 2-C: Excerpt from Table of Themes

Title of theme and description		
<p>The magnitude of trust</p> <p>This theme referred to the sense of enormity psychologists’ felt at being entrusted by the patients they worked with, including when working indirectly with patients via staff teams. There was an overall consensus that developing trusting relationships with patients in forensic services is inherently more difficult compared to general mental health services, which was attributed to high levels of past trauma and because patients are usually detained against their will. Engaging with patients was often experienced as prolonged process, so when patients did engage meaningfully and of their own volition, participants appeared taken aback and surprised, and felt a real sense of achievement. It seemed the complexity of patients’ backgrounds and lack of previous support systems meant psychologists felt all the more honoured at being entrusted with patients’ stories, with this being all the more rewarding given the adversity underpinning their lives.</p>		
Examples of emergent themes:	Examples of initial annotations:	Examples of verbatim quotations:
<p>Harder to engage than other settings</p>	<p>Engagement and trust comparatively harder to achieve in forensics (Jessie).</p>	<p>“...I’ve always worked in community services...people come to you and who really want help and are quite distressed and are also quite able to tell you about it generally...compared to [here] going and knocking on someone’s bedroom door and trying to get them to come to their psychology session...” (Jessie).</p>
<p>Invigoration at being trusted</p>	<p>Engagement is surprising and impressive (Monica).</p>	<p>“...actually when that happens it’s really ‘wow!’...” (Monica).</p>
<p>Feeling privileged at disclosures</p>	<p>Honoured to be entrusted, special to be able to support patients (Lisa).</p>	<p>“...being in a caring relationship with somebody can be so anxiety provoking and frightening [for patients], when people do let you in and do open up, it does feel a very privileged position to be in really.” (Lisa).</p>

Appendix 2-D: Example Map of Key Findings



*this theme was too overlapping with other areas so was revised as 'The impact of time and resources'.
 Two sub-themes were then incorporated into:
 **Perils of recovery pathways- The reality gap
 ***The prescription of psychological therapy- Psychology seen as the 'way out'.

Appendix 2-E: Extracts from Reflective Diary

Thoughts after the first interview:

“Just completed the first interview which coincidentally was at the service I worked in before I started training, also the psychologist covered the same ward I had worked on, though I had not met them before as they started after I had left. Revisiting the site brought back lots of memories. I found myself inwardly agreeing with a lot of the participant’s experiences; almost everything they shared strongly resonated with me, and at first I felt the urge to ‘normalise’ their experiences and share some of my own. I remained mindful of being in a researcher role, so tried to suspend the position of ‘former employee’ and listen to them without interjecting or agreeing. This was difficult but became much easier as the interview progressed. The psychologist was very warm and friendly, which made the interview easier as I was quite worried about asking the ‘right’ questions, which may have led me to stick a bit rigidly to the interview schedule. I was also worried the recorder was not recording for some reason, which was increasingly distracting. It was a big relief at the end to find it had successfully recorded the interview. Interestingly the participant talked lots about the challenges of their work, even when questioned about the positives and rewards. For the next interview I will try to follow the ‘flow’ of the discussion more.”

(Taken from field diary: 13/01/2017).

Thoughts after the second interview:

“Just completed my second interview this morning. It was in a location quite far from my home so I didn’t want to be late as I had never visited the site before, but I arrived an hour early which was good. As I approached I was struck by the physical security such as high fences and CCTV cameras. The psychologist was incredibly friendly and warm, I instantly felt at ease, and the interview was much easier than the first one- I only occasionally looked at the interview schedule, and afterwards the participant commented on how it had felt really conversational and natural. I felt more able to check the audio recorder was working so this did not disrupt my thoughts during the interview. However, the room was quite echoic and there was lots of noise from outside building work; also an alarm went off for a good few minutes. But I still feel concerned about if I had asked the ‘right’ questions. I found the

psychologist fascinating and could have listened to them for longer had they not needed to go to a session. They offered to be interviewed again if needed which was lovely, and to help with recruitment. I am going to listen back to the recording and reflect on the balance between asking the ‘right’ questions, and allowing the discussion to develop more naturally.” (Taken from field diary- 27/01/2017).

Thoughts after a difficult interview:

“This was a hard interview. The psychologist was very negative about their role, the service, and even questioned if psychology was for them. This had been communicated with (dark?) humour but felt serious. I was then uncomfortable asking about compassion satisfaction and found myself apologising and explaining why I was asking the questions, to be sure the psychologist didn’t feel like I’d not been listening to their difficulties. A lot of their responses tailed off with them saying ‘...I don’t know...’ which gave a sense of their hopelessness. During the debrief they said they felt quite ‘flat’ and that they were aware they had been very negative. I tried to improve their mood by highlighting some of the support systems available (on the debrief sheet) which seemed to help as the psychologist said they felt better and that talking to me had been ‘cathartic’.

I picked up on themes of high workload, busyness and lack of time. There was an awful level of distortion and crackling on the research mobile. I am anticipating that transcribing and analysing this interview will be very hard in terms of navigating the background noise and revisiting the psychologist’s struggles and my own discomfort. We will see. It worries me that one day I too may be in a similar situation, where the only good point of the working day is ‘when it ends’.”

(Taken from field diary- 27/02/2017).

Section Three: Critical Appraisal

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Critical reflections on carrying out qualitative research in forensic mental health services.

Word Count:

3, 168 (excluding References and Appendices)

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Critical Reflections on Carrying out Research in Forensic Mental Health Services

This paper will discuss critical reflections related to the process of conducting research within forensic mental health (FMH) contexts. To reflect on their experiences fully, the researcher has written this paper using the first person. A summary of the research paper and main findings will be provided, followed by an account of how the project idea was developed. The process of gaining ethical approval and barriers to this will be explored in detail. Key stages of the research will then be discussed including recruitment, data collection, data analysis, and the plan for dissemination of the research findings. Finally, the researcher will consider the personal impact of conducting this study.

Research Summary

This study explored the lived experiences of clinical psychologists (CPs) working in the FMH settings with reference to compassion satisfaction. Eight CPs were interviewed and data were analysed using interpretative phenomenological analysis (IPA). Five main themes were identified: 1) The magnitude of trust; 2) Adjusting expectations; 3) Being both lock and key; 4) Needing time and resources; and 5) Variety and complexity.

Developing the Project

Before starting the doctorate in clinical psychology (DClinPsy) I had worked full-time in a medium secure FMH service on a male assessment ward for 10 months. My role was split between being a ward-based healthcare support worker and an Assistant Psychologist for the clinical psychology service. During this time I became aware of differences between these roles, in that I had found supporting patients on the ward was more ‘instantly’ fulfilling compared to completing psychological assessment work, which frequently involved working away from the ward to write reports. On reflection, the psychological work was more challenging in terms of feeling able to make a difference to patients.

In my second year of the DClinPsy I became interested in the theory of compassionate mind (Gilbert, 2009). Upon exploring the literature I learnt about ‘compassion satisfaction’ (Stamm, 2010); whereas I was familiar with compassion fatigue, compassion satisfaction was an entirely new concept to me. I was curious to explore what qualified CPs found satisfying about the work they do in a FMH context, based on my own prior experiences.

I discussed the project idea with a CP who had supervised me during my role in secure services. They were enthusiastic about the relevance of this research in recognising some of the opportunities and the challenges of a psychological role within FMH settings, and how CPs may maintain a commitment to working in FMH. The CP kindly agreed to act as my thesis field supervisor and have provided valuable input into this project. Given this was an innovative topic of research a qualitative design was chosen in order to facilitate an initial detailed exploration of CPs’ personal experiences (Willig, 2001).

Connected to the research project idea I was interested in the experiences of wider staff as services in FMH are provided by multidisciplinary teams (MDT). After an initial scope of the literature and discussions with my supervisors, I decided a literature review of studies regarding FMH staff experiences across disciplines would complement the research project. This had the potential to reveal broader issues related to the experiences of working in FMH, and in turn identify how CPs’ experiences of compassion satisfaction may be influenced when supporting staff teams in FMH settings.

Gaining Ethical Approvals

At the time of writing the research proposal in early 2016 projects involving staff only required approval from the University Faculty of Health and Medicine Research Ethics Committee (FHMREC). I applied to the FHMREC in June 2016 and approval was granted

after minor amendments in early October 2016, over a month prior to my thesis study block starting (see Appendix 3-A for FHMREC approval letter¹).

I felt well-organised as I could start recruitment as originally planned via an advert circulated in the Psychology Professions Network (PPN) email newsletter and via the British Psychological Society (BPS) Faculty of Forensic Clinical Psychologists (FFCP) members' email list. Within two days I had four responses from CPs via the PPN newsletter, and was hopeful that I could arrange interviews before my thesis study block started to maximise the time I had available.

I soon discovered that due to changes implemented in spring earlier in 2016 (the time when I was developing and writing the thesis project proposal), recruiting and interviewing NHS staff was no longer permitted without approvals from the Health Research Authority (HRA) and Research and Development (R&D) departments of each NHS Trust. It was clarified that HRA approval was needed for my project via an application to the online Integrated Research Application System (IRAS). This was very disappointing news; I was aware of fellow trainee CPs in my cohort who had waited substantial amounts of time to gain HRA approval due to a bottleneck in processing applications since the new system had been introduced.

In total it took over ten weeks from starting the IRAS application to gaining approvals from the HRA and three local R&D departments, which delayed the timescale of the project considerably. The new IRAS system appeared to be poorly implemented as I was provided conflicting advice, and some University staff and R&D personnel I had liaised with said they

¹ A copy of the approved FHMREC application is available upon request.

were also unclear on the process. I personally found the new 'Statement of Activities' and 'Activity Schedule' forms to be overly complicated and loaded with jargon.

Overall, gaining ethical approvals for the research project seemed straightforward but transpired to be complicated and caused significant delay to starting recruitment. Though problems inevitably arise in the early stages of introducing a new process, how the new IRAS system was disseminated to relevant stakeholders could clearly have been improved.

The bureaucracy of gaining ethical approvals to conduct research in the NHS is an issue that is widely reported in the medical literature that causes negative impacts such as considerable delays to project timeframes and increased research-related costs (Snooks et al., 2012). These hindrances may especially thwart the enterprise of qualitative research (Pollock, 2012). I provided constructive comments to the HRA via the feedback forms at the end of the IRAS application, and hope that some improvements have been made since I underwent this process. Going forward, this experience has highlighted to me the importance of staying up-to-date with developments in any future research ethical approval processes I undertake.

The Recruitment Process

A further barrier to recruitment arose when the FFCP informed me the study advert and recruitment materials could not be emailed to members on my behalf as this contradicted their communications policy. Despite this I was hopeful that recruitment would be a simpler process and enough CPs would be interested in the study to fulfil the target sample size (between 5 and 12). Though I was aware there was no consensus on sample size in IPA research (Pietkiewicz & Smith, 2014), I was ideally hoping to interview eight CPs. This was to ensure the data were rich enough to generate themes regarding the experiences of compassion satisfaction, in line with recommendations relating to sample size in IPA (Smith & Osborn, 2008).

In contrast, recruitment was much slower and more difficult than expected, with only two responses in the first month. In terms of sampling, I had perhaps underestimated the time pressures of senior CPs with at least two years' experience of working in FMH services. Interestingly, one CP I interviewed believed research in FMH is lacking as staff working in this specialty are so busy. Furthermore, another CP had chosen to be interviewed whilst on annual leave via telephone, stating they were interested in the research but there was simply not enough time in their regular working hours to complete a one-hour interview.

Some CPs may have been unfamiliar with compassion satisfaction, which may have discouraged them from engaging in this research. It is also possible that experiences of compassion satisfaction were much rarer than feelings indicative of compassion fatigue and burnout. In addition, the qualitative nature of the project required CPs to allocate a larger amount of time than some quantitative approaches, such as online surveys.

I regularly requested the help of my field supervisor, FMH service managers and R&D staff to email the study details to CPs and disseminate the study advert in business meetings. I encouraged CPs I interviewed to share the study details with colleagues once they had taken part in the essence of snowball sampling. Though I finished recruiting two months later than initially planned, I was pleased with the level of detail gathered across the final eight interviews.

Data Collection

Data were collected from CPs working in FMH services within the North West England region via semi-structured interviews; these are comprised of open-ended pre-determined questions which aim to encourage responses which are related to the research topic under question (Rubin & Rubin, 2010). Compared to other qualitative methods of data collection, using semi-structured interviews was considered the most suitable method of

enquiry due its scope for flexibility and its ability to elicit rich experiential data. Furthermore, administering semi-structured interviews was an approach that also complemented IPA, which was the chosen method of data analysis for this study. Telephone interviews were offered where meeting the researcher in person was not possible. Indeed, research suggests the quality of data gathered using telecommunication is comparable with face-to-face techniques (Carr & Worth, 2001; Vogl, 2013), and I found this method to be just as useful in eliciting information as meeting CPs in person.

Data Analysis

As IPA is an idiographic mode of inquiry (a study of a small sample size) it is possible to make specific statements about individuals because the data has been derived from examination of individual case studies (Smith & Osborn, 2008). It was hoped this approach would enable a deeper understanding of CP's individual experiences of compassion satisfaction to be reached than other qualitative approaches such as thematic analysis (Braun & Clark, 2006).

Essentially, I had chosen IPA as it allows for in-depth exploration of subjective experiences which are meaningful and important to the person being interviewed without trying to determine an objective truth. Indeed, IPA respects that individuals are immersed in the world they inhabit and commits to both 'giving voice' to individuals (the phenomenological aspect) and 'making sense' of their accounts (the interpretative aspect) (Larkin, Watts, & Clifton, 2006). As this study was exploring a novel area of research involving CPs in FMH settings, a qualitative approach such as IPA would identify unanticipated issues and themes as pre-set hypotheses associated with quantitative approaches are not applied.

According to Smith, Larkin & Flowers (2009), IPA assumes a realist ontological position which purports an individual's inner experiences can be accessed through their own explanations, yet also acknowledges the researcher's views influence the constructing of this knowledge. This is known as 'double hermeneutics', a process whereby an individual's interpretations of their own experiences are then interpreted by the researcher (Giddens, 1990). Therefore, in IPA the researcher must assume a reflexive stance by remaining mindful of their own feelings and expectations when interpreting the results; by recognising and 'bracketing' these responses during the analysis, the perspectives of participants are prioritised (Alvesson & Skoldberg, 2009). I kept a reflective diary to note my assumptions during key stages of the data collection and analysis process in order to minimise the potential impact of these on the findings.

This study was my first experience of using IPA, and as such I followed the stages outlined in Smith, Flowers and Larkin (2008). Drawing on other trainee CPs' experiences in my cohort, I planned at least one full study day to analyse each interview transcript, and at least a further day to analyse the whole data set. In addition, I used different coloured stationery to visually distinguish each CP's data. This technique had helped me organise the themes which had emerged from synthesising papers for the literature review. In deciding what order to analyse the eight transcripts, I enquired how other trainee CPs and supervisors had approached this and read the guidance by Smith, Flowers and Larkin (2008). It seemed there was no 'right way', and after supervisory discussions I decided to analyse the transcripts in chronological order. In one way this helped to familiarise myself with the data by mentally placing the transcripts in a timeline of when I had interviewed each CP. I also believe this was a more neutral approach which allowed themes to emerge as I went along, rather than selecting transcripts that resonated with me as a researcher for their richness or relevance to the research question.

Whereas Smith, Flowers and Larkin (2008) note that analysing data directly onto electronic files is possible, I found analysing hardcopies of data was an easier and clearer approach. I wrote emergent themes/initial notations from each annotated transcript onto sticky notes and grouped these onto A1 size flipchart paper, which allowed me to continually reflect on the location of each notation and easily reposition them. I grouped the themes for the first transcript then repeated these steps for each subsequent transcript. I then studied the eight flipcharts as a whole to identify the themes across dataset, and later scanned photographs of each flipchart and copies of each annotated transcript into a secure electronic format. Overall, some of the findings resonated with me, such as adjusting expectations, whereas others such as being the lock and key were in some ways surprising.

Dissemination of the Findings

A number of strategies have been identified with a view to disseminate the findings of the current project. Firstly, as per my training course requirements, I have presented a brief summary of the project at Lancaster University to an audience of staff, fellow trainees, stakeholders and members of the Lancaster University Public Involvement Network (LUPIN). This presentation will be available on the Lancaster University Doctorate in Clinical Psychology programme website.

Secondly, I aim to submit the current study for publication in *Legal and Criminological Psychology* in order to disseminate the findings to as wide an audience as possible. This peer-reviewed journal is circulated worldwide and “publishes theoretical, review and empirical studies which advance professional and scientific knowledge in the field of legal and criminological psychology”².

² [http://onlinelibrary.wiley.com/journal/10.1111/\(ISSN\)2044-8333/homepage/ProductInformation.html](http://onlinelibrary.wiley.com/journal/10.1111/(ISSN)2044-8333/homepage/ProductInformation.html)

Finally, I will share a summary paper of the project with the NHS Trusts involved and with the CPs who participated should they request a copy of this. Due to the particularly small and specific pool of CPs the study recruited from, it was not appropriate to share study findings directly with CPs via special interest groups or conferences, a process known as ‘member-check’, as maintaining anonymity of the data could have been compromised (Goldblatt, Karnieli-Miller & Neumann, 2011). This was an important issue given some CPs shared negative experiences consistent with compassion fatigue and burnout, and emphasised they wished to remain anonymous.

The Personal Impact of the Research

During the study I became aware that conducting research in FMH settings had influenced me in several ways. Firstly, as I had not worked in or visited an FMH environment for a number of years, the dominance of the physical security of the sites had struck me when visiting to conduct interviews. I had found the high fencing, CCTV cameras and gates conveyed an implicit sense of dangerousness and power. This made me reflect on my role in the medium secure service I worked in prior to training; though I had worked in this context full-time for almost a year, interestingly I cannot recall feeling as affected by the presence of such measures of physical security. This suggested to me that entering secure FMH settings as a patient, visitor or researcher is a very different experience to entering as a paid employee.

Throughout the project, several items reported in the media caused me to reflect on the findings. The most notable was the death of Ian Brady at Ashworth Hospital in May 2017, who’s criminal convictions and character had for a long time been widely covered by the press in a very negative tone, and some tabloid headlines contained language such as ‘twisted’ and ‘sickening’³. The following day I overheard discussions in the office which had

³ <http://www.mirror.co.uk/news/uk-news/ian-brady-dead-79-twisted-10430284>

a similar stance, which emphasised to me how media portrayals can seep into the public mind-set. I thought about how multifaceted it could be to work as a CP in FMH (or any clinical role), regarding balancing public protection and the influence of media portrayals with patients' therapeutic needs, and how interesting it was the CPs had referred to working with complexity as a satisfying part of the role.

Finally, the study findings also captured the notion that working as a CP in FMH is 'not for everyone'. Three CPs had asked me if I wanted to work in FMH after the DCLinPsy; my response was that I was uncertain. My route into this specialty had been rapid as I was redeployed into this field from community Learning Disability Services due to NHS cost-improvements. Six months later I had secured a place on the DCLinPsy, therefore, my time working in an FMH context was both unexpected and short-lived. Whilst I had overall found my role in FMH rewarding, I feel unclear about what my experience would have been like had I been in the post longer-term. The impact of the research and listening to some of the challenges CPs described in interviews along with my own uncertainty may have led to an unconscious gravitation away from this specialty, as since finishing training I have accepted a permanent post in a clinical psychology cancer service. I have great respect for the CPs who are motivated to work in FMH, and still believe sharing the findings of this study will be useful to other CPs considering a career in this field.

Conclusions

This project has explored the experiences that staff working in FMH settings and identified the challenges and rewards of this work. The findings clearly indicate that all staff working in FMH need to be supported effectively, including CPs. The themes that emerged from this study emphasised that whilst it may be assumed CPs should be inherently satisfied with their roles of therapeutically helping others, the experiences of compassion satisfaction may be influenced by the distinct aspects of working in a FMH setting. The positive aspects

may be particularly influenced by the restrictive nature of FMH services and meanings that patients and other MDT staff assign to psychology. The experiences of working in the FMH specialty should be further researched, shared and normalised amongst the professional community to enlighten service managers to the experiential differences and challenges staff may face compared to other settings.

To conclude, I hope taking part in this research afforded the CPs a space outside of their busy schedules to reflect upon and notice the positive and fulfilling aspects of their roles in FMH, and the chance to consider how they could maintain or improve a sense of compassion satisfaction in their work now and in going forward.

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Appendix 3-A: FHMREC Approval Letter

Applicant: Rosie Kirkham
Supervisor: Ian Fletcher
Department: Health Research
FHMREC Reference: FHMREC15117

03 October 2016

Dear Rosie

Re: Compassion satisfaction in clinical psychologists working in forensic settings: an interpretative phenomenological analysis

Thank you for submitting your research ethics application for the above project for review by the **Faculty of Health and Medicine Research Ethics Committee (FHMREC)**. The application was recommended for approval by FHMREC, and on behalf of the Chair of the Committee, I can confirm that approval has been granted for this research project.

As principal investigator your responsibilities include:

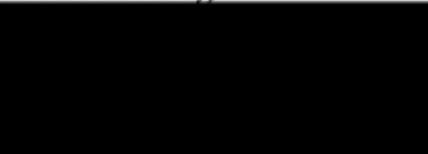
- ensuring that (where applicable) all the necessary legal and regulatory requirements in order to conduct the research are met, and the necessary licenses and approvals have been obtained;
- reporting any ethics-related issues that occur during the course of the research or arising from the research to the Research Ethics Officer at the email address below (e.g. unforeseen ethical issues, complaints about the conduct of the research, adverse reactions such as extreme distress);
- submitting details of proposed substantive amendments to the protocol to the Research Ethics Officer for approval.

Please contact me if you have any queries or require further information.

Tel:- 01542 592838

Email:- fhmresearchsupport@lancaster.ac.uk

Yours sincerely,



Dr 

Research Integrity and Governance Officer. Secretary to FHMREC.

Section Four: Ethics Section

Rosie Kirkham

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Division of Health Research, Lancaster University

Word Count:

5, 134 (excluding References and Appendices)

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Thesis Protocol**Version 1, 17.11.2016**

Title: Compassion satisfaction in clinical psychologists working in forensic settings:
an interpretative phenomenological analysis.

Principle Investigator: Rosie Kirkham, Trainee Clinical Psychologist,

Doctorate in Clinical Psychology (DClinPsy),

Lancaster University.

Academic supervisor: Dr Ian Fletcher, Senior Lecturer in Research Methods,

Division of Health Research,

Lancaster University.

Field supervisor: Dr Jo Hearne, Senior Clinical Psychologist,

Forensic Outreach Service,

Lancashire Care NHS Foundation Trust.

Summary

Forensic services in the UK are often described as highly stressful and dangerous working environments, which can cause staff to experience elevated levels of occupational stress, burnout, and psychological distress (Elliott & Daley, 2013). Similarly, in the prison workforce a recent psychologist-led survey reported staff felt unable to seek psychological

help themselves and many described feeling pressurised to work when sick (Kinman, Clements & Hart, 2015).

Compassion is a “distinct emotion” that arises when witnessing another’s suffering and drives a desire to help (Goetz, Keltner & Simon-Thomas, 2013). As an emotion, compassion can be experienced as pleasant or unpleasant, but it is usually conceptualised as pleasant (Condon & Feldman-Barrett, 2011). Compassion satisfaction is defined by Samios, Abel & Rodzik (2013) as the “sense of fulfilment or pleasure therapists derive from doing their work well”. A number of theories can be seen as underpinning the components of compassion, such as emotion regulation. For example, self-compassion was related with reduced emotional difficulties in a sample of psychologists (Finlay-Jone, Rees & Kane, 2015) and increased emotional regulation abilities have been positively associated with job satisfaction in a sample of British secondary school teachers (Brackett et al., 2010). Theories of emotion regulation strategies are also clinically important, as one study found doctors with higher levels of emotion regulation reappraisal were associated with higher levels of patient satisfaction (Kafetsios et al., 2014).

There is research to suggest compassion satisfaction reduces the negative impacts of burnout, compassion fatigue and secondary traumatic stress in a range of workforces such as frontline mental healthcare professionals (Ray et al, 2013), therapists working with survivors of sexual violence (Samios et al, 2013), social workers (Wagaman et al., 2015) and in hospice/palliative care staff (Slocum-Gori et al, 2011). Therefore, gaining a deeper understanding of this in clinical psychologists will be important, for example, in staff retention and identifying what may drive them to continue working in the field, and what strategies they may find useful in maintaining levels of compassion satisfaction.

Whilst research has been conducted into the negative aspects of working in forensic settings, such as burnout and compassion fatigue, few studies have looked at what drives staff to work in forensic settings, such as compassion satisfaction. In addition, while there has been some research into this phenomenon from a quantitative approach in terms of levels of satisfaction, few studies have explored compassion satisfaction qualitatively. Furthermore, even fewer studies have specifically explored the experiences of clinical psychologists in these settings; for example, clinical psychologists made up only 6.7% of the sample in Elliott and Daley (2013).

This study will aim to explore what keeps clinical psychologists involved in the field, and what they think is positive about their experiences at work. Related to this, it is also of interest to try to identify what may increase/maintain or inhibit/diminish compassion within a forensic setting, mechanisms for achieving compassion satisfaction, and if there are links between compassion satisfaction, nature of role, length of service, and type of setting.

The findings of this study may be of direct interest to some people who have had contact with clinical psychologists as part of their treatment within forensic services. In addition, the findings of this study may also be of interest to wider health professionals such as nursing staff, psychiatrists, OTs and social workers, given that clinical psychologists are frequently part of multidisciplinary teams (MDTs) within forensic settings. The findings could also provide future/current trainees or newly qualified clinical psychologists with a useful insight into the lived experiences of working in forensic services when considering placement choices or career paths.

Method

Design

This project will aim to explore clinical psychologists' experiences of compassion satisfaction related to working in forensic settings. The exploration of these experiences lends itself to a qualitative approach to provide participants the opportunity to describe their accounts in their own words, which will generate more richness and depth as opposed to quantitative data (e.g. using questionnaire scores). With this in mind, data will be collected from a small sample of participants via individual semi-structured interviews and analysed using interpretative phenomenological analysis (IPA) (Smith, Flowers & Larkin, 2009).

Participants

A target sample of qualified clinical psychologists who currently work in NHS forensic services in England will be identified via consulting with the BPS DCP Faculty of Forensic Clinical Psychology (FFCP) and Psychology Professions Network (PPN) Northwest. A mailshot communication will be sent by the leader or coordinator of the FFCP and PPN Northwest (on behalf of the trainee) to current members on the FFCP and PPN Northwest email lists regarding the study. The trainee will also arrange to attend SIG meetings and distribute materials to suitable services if needed. Participants will be recruited using both convenience sampling and snowball sampling.

The aim is to recruit a sample of up to 12 participants on a first-come first-served basis; this will be made clear on the Participant Information Sheet. In applying the chosen method (IPA), up to 12 participants should provide enough divergence and convergence of accounts in order to conduct a meaningful analysis. This will increase the possibilities for publication, and should provide more options for the analysis as there will be more data to work with. Should more than 12 participants opt in to the study, those who responded first and meet the inclusion criteria will be prioritised for interview. Reasons for initially only

including clinical psychologists within the sample, and not other MDT members, include 1) clinical psychologists have specific roles within forensic services that differ to other MDT members (such as offence-focussed work, formulation), and 2) these roles may present specific challenges in relation to compassion satisfaction.

Materials

Recruitment materials will include an email communication to FFCP members, a Participant Information Sheet, a consent form, an interview schedule, and a participant debrief sheet (see appendices for materials). An audio recording device will be used to record the interviews which is not encrypted. After the interview the digital audio files will be transferred on to the trainee's password protected H: drive on the University computer network, and deleted from the audio recorder. All transcription and analysis will be conducted via the H: drive, which will be accessed using a virtual private network (VPN) that is secure and only accessible to the trainee.

Recruitment

Participants will initially be recruited via a mailshot communication to members of the FFCP. The leader or administrator of the FFCP mailing list will be asked to assist with recruitment by sending a short email communication containing two attachments (a Participant Information Sheet and a copy of the consent form) to current members. The email will invite potential participants to opt in to the study by contacting the trainee directly. The trainee will also arrange to attend upcoming SIG meetings in order to publicise the study by introducing themselves to potential psychologists and circulating the recruitment materials on a face-to-face basis. The field supervisor will also be able to highlight the study to potential

participants who currently practice within the field. The trainee will liaise with their field supervisor on additional points of contact e.g. secure services, community forensic mental health teams, forensic in-reach teams, regional forensic Heads of Services etc. if needed. The trainee will then contact team admin/secretarial staff who routinely have details of potential participants, and request for them to send an email and attachment (as described above) on the trainee's behalf to clinical psychologists working within their service in order to assist with recruitment.

Snowball sampling will be used to recruit further participants, as the Participant Information Sheet will encourage psychologists to share details of the study with others who may be interested and who meet the inclusion criteria. To be considered for the project the participant needs to contact the trainee by email or by post (freepost address will be provided). Should more than 12 participants express an interest in taking part in the study, those who responded first will be interviewed; participants who will not be interviewed will be informed as such, and thanked for their interest.

The following inclusion criteria will be applied during the recruitment process: participants should be clinical psychologists currently working in a forensic service within the NHS in England (which may be attached to or based in HMPs), and should have at least two years post-qualification experience of working in the field. This is important as participants will be asked about their experiences of and influences on compassion satisfaction, so need to have had sufficient post-qualification experience in order to have lived it. The project will exclude clinical psychologists who work solely in private or charitable settings, or in forensic Learning Disability Services, in order to preserve homogeneity of the sample. Clinical psychologists who have less than two years post-

qualification experience working in forensic services will also be excluded due to the rationale outlined in the inclusion criteria (see above).

Arranging Interviews

When a potential participant contacts the trainee an initial conversation will be arranged about the project, either in person or over the telephone, and the trainee will also confirm that the participant has read the Participant Information Sheet and meets the inclusion criteria. The trainee will ensure the participant has had at least 24 hours to reflect on the Participant Information Sheet before agreeing to take part.

Interviews will be arranged at a mutually convenient time and location at the participants' home, workplace, Lancaster University, or over the telephone if face-to-face meeting is not practical. The trainee will adhere to their employer's Lone Working Policy (████████████████████) by informing a nominated colleague ('buddy') of their whereabouts when conducting interviews at participants' homes, workplaces and at Lancaster University. The trainee will agree a time to call their buddy following the interview to confirm they are safe; if the trainee does not call by the agreed time, the buddy will firstly attempt to contact the trainee. If the buddy cannot contact the trainee, they will escalate this to their line manager with relevant details (time/place of trainee's planned interview). The trainee's line manager will then attempt to track their whereabouts and, if there is genuine concern over their safety, will involve the police if deemed necessary as outlined in the Policy.

If participants wish their interview to take place at their place of work and within their working hours, the trainee will inform them it is the participant's responsibility to seek out and adhere to their individual NHS employer's research and development (R&D) policy and

procedure. For example, participants may need to inform their NHS organisation's R&D office that they have arranged to be interviewed for research purposes at their place of work within their working hours; completing such actions will be the responsibility of the participant.

For practical reasons, participants working in HMPs will be interviewed at a location outside of their workplace due to security restrictions relating to the use of recording devices. Should the participant request to be interviewed at a location away from their home or usual place of work (i.e. at Lancaster University), the trainee will ask the participant whether they wish to be reimbursed for any anticipated travel expenses for attending the interview, and will ask them to estimate this cost. The trainee will then arrange to collect funds following the programme's policy on reimbursement of travel expenses incurred by research participants (for more details see http://www.lancaster.ac.uk/shm/study/doctoral_study/dclinpsy/onlinehandbook/research_expenses/).

Gaining Informed Consent

At the start of each interview the participant will be provided with two hard copies of the consent form to read and sign. Once they have read and signed these forms, the trainee will also sign the forms, and provide the participant with a copy to keep for future reference (on request). Where interviews are scheduled to take place over the telephone, the trainee will email the participant an electronic copy of the consent form at least one week prior to an arranged interview date; the participant will be asked to read, print and sign two hard copies of these and return them via the trainee's freepost address prior to the interview taking place. Scanned electronic copies of consent forms relating to participants who took part in the study

will be kept for 10 years after the project has been submitted. If a participant wishes to withdraw from the project, they can do so up to two weeks after providing their informed consent. The trainee will allow at least two weeks after each interview before starting to analyse their data, thereby enabling participants to withdraw their data from the project up to the point of analysis. Following this point, it will not be possible to extract a participant's data from the study.

Data collection

Agreement to take part in the interviews will be on a completely voluntary basis. Interviews are expected to last for approximately 45 minutes to 1 hour in person with the trainee either at the participant's home, place of work or Lancaster University. Telephone interviews will be arranged if meeting face-to-face is not practical or convenient (e.g. the participant does not live within the North West of England area). Interviews will take place during weekdays, that is, Monday to Friday 9am to 5pm. If this is not convenient for participants, the trainee will endeavour to arrange a more convenient time in the early evening.

The trainee will first allow participants the opportunity to ask any questions and will provide their contact details should they think of any questions at a later time. Confidentiality and its limitations will be explained to participants prior to each interview commencing and written informed consent will be obtained (see above). All interviews will be audio recorded in their entirety. The trainee will refer to the interview schedule, which has been developed in collaboration with their supervisors, and contains a list of general topic areas and questions for guidance. The interview schedule will be used as a basis for broad questioning, which will enable participants to take control of the interview discussions.

After the interview the trainee will thank the participant for their time and again offer the opportunity for any questions. The participant will be provided with a hardcopy of the debrief sheet to keep.

Data handling

All documentation (e.g. email correspondence) containing participants' personal details necessary for arranging interviews will be kept confidential and separately to their consent forms, and all details except paper consent forms will be destroyed once the participant has taken part in the project. For participants who responded after 12 participants were recruited, emails regarding interest will be destroyed once all data have been gathered and no further participants are needed to be contacted. If a participant wishes to withdraw from the project prior to an arranged interview taking place, all personal data related to the project such as emails and consent forms will be destroyed as soon as possible.

All interview data will be recorded on a portable digital audio recording device, which is not encrypted. The device will be stored in a locked cabinet and the audio recordings will be transferred to a secure electronic format (Lancaster University's encrypted server) as soon as possible. The trainee will allocate each participant a pseudonym, thus all research documents will not contain any personally identifiable data. The trainee will share at least the first audio recording or transcribed interview with their academic/field supervisor to enable their supervisors to check the interviews are conducted appropriately, and to provide advice and feedback as necessary for future interviews. Once each interview has been transcribed, stored in a secure electronic format, and checked for accuracy, the audio recording will be deleted from the device. The data will then be analysed by the trainee with support from their academic supervisor two weeks after the participant provided informed consent. The trainee

will analyse the data whilst working on their secure personal file space (H: drive) both at Lancaster University and via the VPN when working at their home.

Only the trainee and their supervisors (academic and field) will have access to the audio files and interview transcripts. To support the identification of clinical implications of the findings, the field supervisor will have access to the codes developed during the early stages of analysis and of the analysis draft write-ups, which will be anonymised.

Short-term data storage

During the course of the project any paper files of personally identifiable information and anonymised research data will be securely stored separately in a locked cabinet. That is, participants' signed consent forms will be stored separately to anonymised raw data (interview transcripts) and coded data (analysed interview transcripts). All electronic data, such as transcribed interviews and the project write-up, will be password protected and stored securely on the trainee's personal file space on the H: drive of Lancaster University's server via their VPN. Any electronic data stored on portable devices during the thesis, such as USB drives or laptops, will be encrypted in addition to being password protected.

Long-term data storage

After the project has been submitted, all paper consent forms will be scanned and saved into electronic format for long-term storage. Paper consent forms will then be destroyed. These will then be encrypted and securely transferred (via file transfer software that is supported by the University) to the DClinPsy programme Research Coordinator, who will save the files on the University server in a password-protected file space. Data will be stored for 10 years after the thesis is submitted then destroyed by the Research Coordinator.

Data Analysis

Data will be analysed using IPA by following the process outlined in Smith, Flowers & Larkin (2009) and the trainee will discuss all stages with the academic supervisor to ensure consistency and trustworthiness of the data analysis. The trainee will read and re-read each transcript thoroughly in order to 'immerse' themselves in the data and allow detailed exploration of the participants' experiences and the meaning they attach to these. The trainee will then aim to identify themes across participants' accounts regarding their experiences of compassion satisfaction when working in forensic settings. Interview transcripts will be coded either directly onto the electronic file, or by hand and then transferred to an electronic file for further analysis. The codes will be analysed further to provide overarching themes across the interview data.

A summary of the themes will be created and specific quotations will be marked with the participant's pseudonym and the transcript page number. This will create an audit trail and facilitate retrieving the location of where quotes have been identified in the interview data. Where direct quotes are reported, the trainee will consider whether the content of the quote makes it possible to identify the participant; if a quote is deemed to make it possible to identify a participant, it will be removed. Throughout the data analysis, the trainee will reflect on their active role in the research, and will consider how their beliefs and assumptions may have shaped the process.

Ethical Issues

The trainee will prepare and submit an application for this project to be reviewed by Lancaster University's Faculty of Health and Medicine Research Ethics Committee (FHMREC) for ethical approval. The proposal of this project was also anonymously peer-

reviewed by the research team within the DClinPsy programme at Lancaster University, and was approved by the Research Director as suitable to submit for ethical review.

While it is not expected that the interviews will cause participants any distress, if a participant does show signs of distress or becomes upset during the interview, the trainee will pause the interview and check how the participant is. The trainee will allow the participant sufficient time to recover and an opportunity to discuss their feelings, before checking if they wish to continue with the interview. The trainee will only resume the interview if they feel the participant is able to continue. Participants will be provided contact details of support agencies (Mind, Samaritans) in the Participant Information Sheet and Debrief Sheet, and the trainee will encourage them to seek a consultation with their GP for advice where needed. Should the trainee become distressed due to the content of an interview, they will seek support from their supervisors or GP as necessary.

Confidentiality

Confidentiality will be explained to participants via the Participant Information Sheet and Debrief Sheet, and also verbally prior to the start of each interview.

Confidentiality will firstly be ensured by sending recruitment materials to the leader or administrator of the FFCP and PPN Northwest for distribution to the mailing lists for current members. This will make sure that personal details are not accessed by the trainee prior to participants expressing an interest in the study. In addition, where recruitment materials are distributed to identified services (e.g. forensic CMHTs) these will be initially sent to a named staff member (such as a team administrator/team secretary) who routinely has access to the details of potential clinical psychologists, thus again ensuring the trainee does not have sight of participants' details before they consider to take part.

Interview rooms should ideally preserve confidentiality, although participants will be informed this cannot be totally guaranteed if interviews take place on work premises during the working day. The limits to confidentiality will be explained to each participant prior to the interview starting. Breaking confidentiality will be required when a participant has indicated that they are at risk of causing harm to themselves or others, or are at risk of harm from others; the trainee will explain they will need to break confidentiality and inform their supervisor in these circumstances.

During and after the interview, the trainee will take steps to address confidentiality issues. Examples of these steps include storing any paperwork containing participant's details in an opaque document wallet, displaying 'do not disturb' signs on the doors of rooms used for interviews if available, and pausing the interview should an outside person interrupt or enter the room. The trainee will ensure they are in possession of the audio recording devices at all times, and will not leave these unattended at any point. All interview transcripts will be anonymised and participants will be allocated numbers or pseudonyms. Personal information (e.g. consent forms) will be kept confidential and separately to the participants' research information.

Informed consent

Participants will only be interviewed when they have provided informed consent to take part in the project. Informed consent to participate in the project is gained once the participant reads, completes and signs the consent forms. It is the trainee's responsibility to ensure informed consent is gained for each participant prior to each individual interview commencing.

Right to withdraw

Participants will be informed they may withdraw from the study, without providing a reason, up to two weeks after providing informed consent (including during the interview) as per current FHMREC advice. Again, the trainee will wait for a two week period after each interview before starting to analyse data in order to enable participants' to withdraw their data up to the point of analysis. If consent is withdrawn after this point, data may have been pooled and the data analysis process may have started, meaning it would not be possible to extract their data from the study. However, every effort will be made to do so up to the point of publication.

Complaints

Details regarding how to make a complaint will be provided on the Participant Information Sheet, explaining complaints can be directed to Professor Bill Selwood, Programme Director, or Professor Roger Pickup, Chair of the FHMREC, both c/o Lancaster University.

Location of interviews

At this stage the trainee cannot guarantee these locations will maintain confidentiality / be soundproof or will be free from interruptions. The trainee will work with participants to make queries in advance and endeavour to book the most suitable room(s) available, if at their place of work. Local procedures regarding electronic devices and restricted items will be adhered to for interviews being conducted within forensic services.

Risk

No risk issues are anticipated for the trainee conducting the interviews. The trainee has experience of working in clinical environments (including forensic NHS services) with

people who are distressed and in conducting risk assessments. They have practical training in communication, breakaway techniques, and in de-escalation. In the event that a disclosure is made that warrants concern, the trainee will seek advice from their academic and field supervisors in a timely way, and will ensure they have a mobile phone with relevant contact numbers stored in case they need to make any urgent enquiries.

The trainee will comply with their employer's Lone Working Policy ([REDACTED]

[REDACTED]) to ensure health and safety requirements are followed.

Examples of the steps the researcher will take in relation to this include informing colleagues or a nominated 'buddy' of their whereabouts, having their ID badge on their person, carrying a fully charged mobile phone, and ensuring their vehicle has enough fuel when travelling to and from interviews. The trainee will also adhere to local security policies and procedures when conducting interviews within forensic environments.

Breaking confidentiality

If during the interview the trainee learns about aspects of practice which cause concern, or believes the participant or another person is at risk of harm, the trainee will explain their concerns to the participant during the interview (if deemed appropriate to do so) and clarify the potential for confidentiality to be broken in this instance. The trainee will consult with their supervisors in a timely way and necessary policies will be followed, including [REDACTED] safeguarding policies. The limits to confidentiality will be explained to participants before each interview starting, and will be included in the Participant Information Sheet and Debrief Sheet.

Practical Issues

Costs related to the printing of recruitment and interview materials, photocopying, envelopes and postage will be covered by Lancaster University. Travel expenses may be incurred and will be covered by the University in line with the programme's travel expenses policy for research participants and trainees. Where face-to-face interviews are not practical in terms of high travel costs and time (e.g. a participant lives outside of the North West of England) telephone interviews will be arranged instead.

If interviews are held at the participant's usual place of work, room bookings will be made in advance by the trainee or the participant. Where participants choose to be interviewed at their usual place of work, the trainee will make it clear when arranging the interview that confidentiality cannot be fully ensured in these circumstances, due to interviews being conducted on work premises and during the working day. The room should ideally maintain confidentiality, although this cannot be guaranteed.

Storage of data

After the project has been conducted all research material will be securely stored electronically by the DClinPsy administration team for 10 years after the trainee has submitted the project as per Lancaster University and DClinPsy programme policies.

Changes to the project

The trainee will conduct the project in the manner detailed in the approved ethical application and thesis research protocol. In all instances where changes need to be made to the project, the trainee will contact the FHMREC and await a response before continuing.

Recruitment difficulties

Insufficient numbers of participants may be recruited for several reasons:

- Not enough participants consent to take part who meet the inclusion criteria, therefore limiting the likelihood of conducting a meaningful analysis of the interview data.
- Participants may choose to withdraw from the project up to two weeks after providing informed consent.
- Participants may wish to take part but do not meet the inclusion criteria.

If during the course of the project insufficient participants opt in, for example, less than 5 participants have been interviewed by the end of the thesis study block (i.e. by the end of February 2017), the trainee will consider alternative avenues for the study as outlined below. In this instance, the trainee will contact the FHMREC ethics committee to inform them of change(s) they wish to make, and submit an amendment to the original application with revised versions of any of the project documents. The following changes to the study could be considered to increase participation rates:

1. widening the pool of potential participants by recruiting clinical psychologists from non-NHS settings e.g. third sector, private/charitable organisations etc.
2. broadening the inclusion criteria to include more potential clinical psychologists, such as those with less post-qualified clinical experience of working in forensic services (such as 1 year before the interview) or who are newly qualified.

Project management

The trainee will have regular formal supervisory meetings with both the academic and field supervisors, on at least a monthly basis (either in person or by email/telephone), and as needed at key milestones of the project.

Dissemination strategy

The findings of the project will aim to be disseminated by submitting for publication in an appropriate peer-reviewed journal, and a summary of the project will be presented to an audience of course staff, stakeholders, fellow trainees, and members of the Lancaster University Public Involvement Network (LUPIN). The Debrief Sheet will state that if participants would like to receive a summary of the research once it has finished, they should request this from the trainee using the contact details provided.

Timescale

The project is proposed to start around September 2016, depending on the status of FHMREC ethical approval, and will finish in June 2017. The trainee will complete and submit the ethics application forms prior to the deadline at 12 noon on Wednesday 29th June 2016 for review in the next FHMREC meeting on 14th July 2016. The trainee will respond to advice and make any amendments, and resubmit their application if needed. Once ethical approval is gained from the FMHREC the trainee will start recruitment (from September 2016 depending on the status of ethical approval).

Interviews are planned to take place from the point that ethical approval is gained up to the start of the trainee's thesis study block (December 2016) though interviews could take place up to March 2017 depending on recruitment success. This will be followed by transcribing and analysing the collected data and writing up the first draft for feedback. The final write-up is scheduled to be submitted in June 2017. The findings will be disseminated via a summary paper after the project has been submitted to participants who contact the trainee requesting this.

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Appendix 4-A:

Email communication to be sent on behalf of the trainee to members of FFCP and PPN Northwest via the group mailing list coordinators, and by team secretaries/administrators of identified services to potential participants:

Re: exploring compassion satisfaction in clinical forensic psychologists.

Hello

This email is being circulated on my behalf to FFCP members/ PPN Northwest members/ potential participants regarding my doctoral thesis study. I am a Trainee Clinical Psychologist at Lancaster University.

As part of this course I am looking to individually interview clinical psychologists to explore their experiences of compassion satisfaction when working in forensic NHS settings.

The findings of this research will be useful in identifying what drives clinical psychologists to work in this field, and what may increase or diminish compassion satisfaction when working in forensic settings.

You are welcome to take part if you are a clinical psychologist currently working in an NHS forensic service, and have at least two years qualified experience of working in this field.

The study will involve an interview that will last approximately one hour and will be audio recorded. The interview can be arranged at a time and place convenient to you, either in person or over the telephone.

An information sheet and copy of the consent form is attached with more details to help you choose whether or not to participate.

The study has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

If you are interested in taking part in the study or have any other questions, please contact me via one of the methods below:

Email: r.kirkham@lancaster.ac.uk

Post: Rosie Kirkham
FREEPOST: RTAU-SYXU-YCZZ
Clinical Psychology
Furness College
Bailrigg
LANCASTER
LA1 4YG

Finally, please feel free to circulate this email and the attached information to other clinical psychologists who you feel may be interested in taking part.

Thanks and kind regards

Rosie Kirkham

Trainee Clinical Psychologist

Lancaster University

Appendix 4-B:**Participant Information Sheet****Compassion satisfaction in clinical psychologists working in forensic settings: an interpretative phenomenological analysis.****What is the study about?**

The purpose of this study is to conduct a qualitative exploration into qualified clinical psychologists' experiences of compassion satisfaction when working in forensic settings and services. This is important as some research suggests compassion satisfaction reduces the negative impact of work-related stress, such as burnout and fatigue, across a range of workforces. However, few studies have qualitatively explored this specifically in clinical psychologists working in forensic services.

Before deciding to take part, please read the information on this sheet and feel free to ask any further questions.

Why have I been approached?

I would like to interview clinical psychologists with at least two years qualified experience of working in forensic services within the NHS. Please note, this study does not include those working in forensic Learning Disability Services. Up to 12 participants are hoped to be interviewed on a first-come first-served basis.

Do I have to take part?

No. It is completely your choice to decide whether or not you take part. Not taking part in the project will have no negative repercussions. If you do take part, you can stop the interview at any point. You may also choose to withdraw your consent and your data up to two weeks after the interview. After this time, the analysis of your data will have begun, so it will not be possible to extract your data from the study.

Will I definitely be interviewed if I agree to take part?

Hopefully you will be, however should more than 12 participants wish to take part, those who opted in first will be interviewed. If you are not in the first 12 to be interviewed, I will let you know.

What will I be asked to do if I take part?

You will be asked to read and sign a consent form, and to take place in an interview regarding your experiences of compassion satisfaction when working in forensic settings. This will last about 1 hour, and can be arranged to take place at your home, your place of work, or at Lancaster University. If meeting in person is not convenient, the interview can be arranged to take place over the telephone.

You can say as much or as little as you feel comfortable with, and can request to stop the recording or the interview at any point. You can also ask to have words or phrases removed or replaced.

Will taking part be confidential?

Yes. If you choose to take part, your information will be kept confidential and the content of your interview will be anonymised. Your name will not be stated in the research. Anonymised quotes from your interview may be used in the report write-up.

Whilst every effort will be made, unfortunately it is not possible to ensure total confidentiality of participation if the interview takes place on work premises during the working day.

There are some limits to confidentiality: if what is said in the interview causes me concern that you or someone else is at significant risk of harm, I will have to speak to a member of staff (my supervisor). Where possible, I will try to tell you if I have to do this.

Will my data be identifiable?

The information you provide is confidential. However, direct quotes are intended to be used to illustrate key themes across the data. In all cases, direct quotes will be anonymised.

How will my data be stored?

The data collected for this project will be stored securely and only the researchers conducting this project will have access to this data:

- Personal details gathered in order to arrange interviews will be kept confidential and separate to your interview responses, and will be destroyed after you have taken part in the project.
- Audio recordings will be kept in a locked cabinet and deleted once the data have been stored in a secure electronic location.
- The transcript of your interview will be made anonymous by removing all identifying information, including your name.
- Electronic files will be stored on the trainee's secure file space on the University's server.
- After the project is submitted, scanned electronic copies of research documents will be kept securely for 10 years. At the end of this period, they will be deleted.
- All personal data will remain strictly confidential and will be kept separately from your interview responses.

What will happen to the results?

The results will be summarised, reported and written up as a formal piece of research. An overview of the project will be presented at a University presentation day. The project write-up may also be submitted for publication in a peer-reviewed journal at a later date.

Are there any risks?

There are no risks anticipated with participating in this project. However, should you feel distressed either as a direct result of reading this information sheet, from taking part in this project, or at some point in the future, the following resources may be of assistance: The Samaritans (www.samaritans.org tel: 116 123) or Mind (www.mind.org.uk tel: 0300 123 3393).

Are there any benefits to taking part?

Although you may find the topics discussed in the interview interesting, there are no direct benefits in taking part.

Who has reviewed the project?

This project has been reviewed and approved by the Faculty of Health and Medicine Research Ethics Committee at Lancaster University.

Where can I obtain further information about the study?

If you have any questions about the project, please feel free to contact myself in any of the following ways:

Email: r.kirkham@lancaster.ac.uk
Post: Rosie Kirkham
FREEPOST: RTAU-SYXU-YCZZ
Clinical Psychology
Furness College
Bailrigg
LANCASTER
LA1 4YG

Alternatively, you may contact my supervisors:

Dr Ian Fletcher i.j.fletcher@lancaster.ac.uk tel: 01524 593301
Dr Jo Hearne joanna.hearne@lancashirecare.nhs.uk tel: 01772 406796

Complaints

If you wish to raise concerns about any aspect of this project and do not want to speak to myself or my supervisors, you may contact:

Professor Bill Selwood
Programme Director
Doctorate in Clinical Psychology
Lancaster University
LA1 4YG
Email: b.sellwood@lancaster.ac.uk
Tel: 01524 593998

Alternatively, to talk to someone outside of the course you may also contact:

Professor Roger Pickup
Chair of the FHMREC
Lancaster University
Lancaster

LA1 4YG

Email: r.pickup@lancaster.ac.uk

Tel: 01524 593746

If you decide you would like to take part, you would need to contact myself by email or by post to indicate your interest. I will then contact you to discuss the study in more detail and answer any queries. If you still wish to take part, you will then be asked to meet with myself for an individual interview at an agreed location. If it is not convenient to meet in person, you can choose to be interviewed by telephone instead.

Following the interview you will be provided with a copy of your signed consent form and a debrief sheet with sources of support listed should you wish to seek help with any issues that may have been raised.

Thank you for your time in reading this sheet.

Please feel welcome to share this information with other clinical psychologists who may be interested.

**Rosie Kirkham
Trainee Clinical Psychologist
Lancaster University**

Appendix 4-C: Consent Form

Project Title: Compassion satisfaction in clinical psychologists working in forensic settings: an interpretative phenomenological analysis.

You are invited to take part in a qualitative thesis research project which aims to explore clinical psychologists’ experiences of compassion satisfaction when working in forensic services.

Before you consent to participate in the project please read the Participant Information Sheet. Read and mark each statement below with your **initials** if you agree. If you have any queries before signing this consent form please contact the principal investigator Rosie Kirkham: r.kirkham@lancaster.ac.uk.

Please **initial**
each statement

1. I confirm that I have read the Participant Information Sheet and fully understand what is expected of me within this project.
2. I confirm that I have had the opportunity to ask any questions and to have them answered.
3. I understand that my interview will be audio recorded and then made into an anonymised written transcript.
4. I understand that audio recordings will be transcribed then deleted. Interview transcripts will be kept electronically for 10 years after the research project has been submitted.
5. I understand that my participation is voluntary and that I am free to withdraw up to 2 weeks after signing this form, without giving any reason and without my legal rights being affected.
6. I understand that the researcher will share and discuss the collected data with their supervisors.
7. I understand the information from my interview will be pooled with other participants’ responses, anonymised, and may be published.
8. I consent to anonymised information and quotations from my interview being used in reports, conferences and training events.
9. I understand that any information I give will remain strictly confidential and anonymous unless it is thought that there is a risk of harm to myself or others, in which case the principal investigator will need to share this information with their research supervisor.
10. I consent to Lancaster University keeping this consent form and interview transcripts in electronic format for 10 years after the project has finished.
11. I give my informed consent to take part in this project.

Name of Participant _____ **Signature** _____ **Date** _____

Name of Researcher _____ **Signature** _____ **Date** _____

Appendix 4-D:**Thesis interview schedule:**

Compassion satisfaction in clinical psychologists working in forensic settings: an interpretative phenomenological analysis.

Before interview

- Introductions
- Display 'do not disturb' sign on door if available
- Outline aims of the study
- Outline confidentiality, limits, issues around risk, and right to withdraw
- If at participant's workplace, check they have notified their R&D department and complied with their organisation's R&D policy and procedure.
- Ensure participant has read the information sheet and had 7 days to consider the content
- Explain the participant can share as much as they want to, ask for questions to be clarified, and ask for breaks during the interview or for the interview to be stopped
- Ensure participant has read and signed two copies of consent form (if telephone interview, ensure signed consent form is received prior to starting).
- Remind the participant they may change their mind and choose to withdraw from the study up to two weeks after the interview
- Answer any questions

Interview

- Start audio recording device
- Pause the recording at the participant's request or if the interview is interrupted by an outside person
- Consider the following questions as potential avenues for discussion (in no particular order):
 - Participant's role and how long they have been in the field/service
 - What attracted them to working in the service
 - What their service is like to work in
 - What is the nature of their role/ tasks involved i.e. 1:1 work, team working, consultation
 - What was it like during the initial stages of their role i.e. first 12 months
 - What feelings they have about their work setting
 - What feelings they have about the people they work with- colleagues, clients
 - Good and bad aspects of their work

- Have aspects of their role become easier or harder with time
- Do they feel like they have ever achieved something in their role
- What satisfaction or rewards they derive from their role
- What are the most satisfying aspects of the work they do
- What challenges they encounter at work
- What are the least satisfying aspects of their role
- How responsible do they see clients for the offence(s) they have committed
- Do their responses to clients differ according to the type of offence
- How distant do they feel from the clients they work with/ does this relate to type of offence
- Do they feel desensitised in any way to aspects of the work/ setting
- How do they deal with shifts during the working day i.e. moving between different clients/ staff teams/ tasks
- How their role affects their personal life/wellbeing
- How do they generally feel when they leave work
- What they would advise others when starting in this field
- *Also consider prompting for each response: changes in responses / compassion over time and perceived influences on any change over time (give a specific timeframe to focus reflection on, such as the last 12 months).*

After interview

- Stop the recording device
- Check the participant is not distressed
- If the participant is distressed, provide space to discuss this and advice on useful sources of support
- If any risk issues are identified, the trainee will discuss this if appropriate with the participant and seek advice from their supervisors
- Provide the participant with a signed copy of the consent form and the debrief sheet- if telephone interview, send a signed copy by post and email debrief sheet
- Answer any questions
- Reimburse participant for travel expenses if necessary- obtain receipt
- Thank the participant for taking part

Appendix 4-E:

Participant Debrief Sheet:

Compassion satisfaction in clinical psychologists working in forensic settings: an interpretative phenomenological analysis.

Thank you for taking part in an interview regarding the above study.

What will happen to my interview data?

The recording of the interview you have just taken part in will be stored on the audio recording device until it has been securely transferred to a secure electronic location on Lancaster University's server. It will then be deleted from the device. The data from the study will be written into a report and may be published in a journal. The data will be stored electronically for 10 years, then deleted.

Can I have a summary of the findings?

Yes. If you would like to receive a summary of the research once it has finished, please contact me via the details listed below.

Can I withdraw from the study?

You are able to withdraw from the study without giving a reason up to two weeks after the interview. Please feel free to contact me using the details below should you wish to do so. If you wish to withdraw after two weeks since the interview took place, your data may have been pooled and the analysis may have begun, so it may not be possible to remove your data from the study.

What if the interview upset me?

If the content of the interviews have upset you or left you distressed in any way, you could seek support from Mind on 0300 123 3393 or The Samaritans on 116 123. Please seek further support from your GP if needed.

How can I raise concerns?

If you wish to make a complaint about this project and do not wish to speak to the researcher or their supervisors, you can contact:

Professor Bill Selwood

Programme Director
Doctorate in Clinical Psychology
Lancaster University
LA1 4YG
Email: b.sellwood@lancaster.ac.uk
Tel: 01524 593998

Alternatively, to talk to someone outside of the course you may also contact:

Professor Roger Pickup
Chair of the FHMREC
Lancaster University
Lancaster
LA1 4YG
Email: r.pickup@lancaster.ac.uk
Tel: 01524 593746

If you would like more information please feel welcome to contact myself, Rosie Kirkham,
Trainee Clinical Psychologist on r.kirkham@lancaster.ac.uk at any point.

Thank you again for taking part in this study.



Health Research Authority

Mrs Rosie Kirkham
 Trainee Clinical Psychologist
 Lancashire Care NHS Foundation Trust
 Doctorate in Clinical Psychology
 Faculty of Health and Medicine
 Furness College, Lancaster University
 LA1 4YG

Email: hra.approval@nhs.net

07 December 2016

Dear Rosie

Letter of HRA Approval

Study title: **Compassion satisfaction in clinical psychologists working in forensic settings: an interpretative phenomenological analysis.**

IRAS project ID: **218436**

REC reference: **16/HRA/5922**

Sponsor **Lancaster University**

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.

IRAS project ID	218436
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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 attached document “*After HRA Approval – guidance for sponsors and investigators*” gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- 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.

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 procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

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/>

IRAS project ID	218436
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Your IRAS project ID is **218436**. Please quote this on all correspondence.

Yours sincerely

[REDACTED]

Senior Assessor

Email: hra.approval@nhs.net

Copy to: *Dr Diane Hopkins – sponsor contact*

[REDACTED] *NHS Foundation Trust – R&D contact*

Section Five: Appendices

Rosie Kirkham

Doctorate in Clinical Psychology

Division of Health Research, Lancaster University

Word Count:

6, 796

All correspondence should be forwarded to:

Rosie Kirkham

Doctorate in Clinical Psychology

Division of Health Research

Lancaster University

LA1 4YG

Email: r.kirkham@lancaster.ac.uk

Welcome to the Integrated Research Application System

IRAS Project Filter

The integrated dataset required for your project will be created from the answers you give to the following questions. The system will generate only those questions and sections which (a) apply to your study type and (b) are required by the bodies reviewing your study. Please ensure you answer all the questions before proceeding with your applications.

Please complete the questions in order. If you change the response to a question, please select 'Save' and review all the questions as your change may have affected subsequent questions.

Please enter a short title for this project (maximum 70 characters)
Compassion satisfaction in clinical forensic psychologists.

1. Is your project research?

Yes No

2. Select one category from the list below:

- Clinical trial of an investigational medicinal product
- Clinical investigation or other study of a medical device
- Combined trial of an investigational medicinal product and an investigational medical device
- Other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice
- Basic science study involving procedures with human participants
- Study administering questionnaires/interviews for quantitative analysis, or using mixed quantitative/qualitative methodology
- Study involving qualitative methods only
- Study limited to working with human tissue samples (or other human biological samples) and data (specific project only)
- Study limited to working with data (specific project only)
- Research tissue bank
- Research database

If your work does not fit any of these categories, select the option below:

Other study

2a. Please answer the following question(s):

- a) Does the study involve the use of any ionising radiation? Yes No
- b) Will you be taking new human tissue samples (or other human biological samples)? Yes No
- c) Will you be using existing human tissue samples (or other human biological samples)? Yes No

3. In which countries of the UK will the research sites be located? (Tick all that apply)

- England
 Scotland

- Wales
 Northern Ireland

3a. In which country of the UK will the lead NHS R&D office be located:

- England
 Scotland
 Wales
 Northern Ireland
 This study does not involve the NHS

4. Which applications do you require?

IMPORTANT: If your project is taking place in the NHS and is led from England select 'IRAS Form'. If your project is led from Northern Ireland, Scotland or Wales select 'NHS/HSC Research and Development Offices' and/or relevant Research Ethics Committee applications, as appropriate.

- IRAS Form
 Confidentiality Advisory Group (CAG)
 National Offender Management Service (NOMS) (Prisons & Probation)

For NHS/HSC R&D Offices in Northern Ireland, Scotland and Wales the CI must create NHS/HSC Site Specific Information forms, for each site, in addition to the study wide forms, and transfer them to the PIs or local collaborators.

For participating NHS organisations in England different arrangements apply for the provision of site specific information. Refer to IRAS Help for more information.

Most research projects require review by a REC within the UK Health Departments' Research Ethics Service. Is your study exempt from REC review?

- Yes No

4b. Please confirm the reason(s) why the project does not require review by a REC within the UK Health Departments Research Ethics Service:

- Projects limited to the use of samples/data samples provided by a Research Tissue Bank (RTB) with generic ethical approval from a REC, in accordance with the conditions of approval.
 Projects limited to the use of data provided by a Research Database with generic ethical approval from a REC, in accordance with the conditions of approval.
 Research limited to use of previously collected, non-identifiable information
 Research limited to use of previously collected, non-identifiable tissue samples within terms of donor consent
 Research limited to use of acellular material
 Research limited to use of the premises or facilities of care organisations (no involvement of patients/service users as participants)
 Research limited to involvement of staff as participants (no involvement of patients/service users as participants)

5. Will any research sites in this study be NHS organisations?

- Yes No

5a. Are all the research costs and infrastructure costs (funding for the support and facilities needed to carry out research e.g. NHS Support costs) for this study provided by a NIHR Biomedical Research Centre, NIHR Biomedical Research Unit, NIHR Collaboration for Leadership in Health Research and Care (CLAHRC), NIHR Patient Safety Translational Research Centre or a Diagnostic Evidence Co-operative in all study sites?

Please see information button for further details.

Yes No

Please see information button for further details.

5b. Do you wish to make an application for the study to be considered for NIHR Clinical Research Network (CRN) Support and inclusion in the NIHR Clinical Research Network Portfolio?

Please see information button for further details.

Yes No

The NIHR Clinical Research Network provides researchers with the practical support they need to make clinical studies happen in the NHS e.g. by providing access to the people and facilities needed to carry out research "on the ground".

If you select yes to this question, you must complete a NIHR Clinical Research Network (CRN) Portfolio Application Form (PAF) immediately after completing this project filter question and before submitting other applications. Failing to complete the PAF ahead of other applications e.g. HRA Approval, may mean that you will be unable to access NIHR CRN Support for your study.

6. Do you plan to include any participants who are children?

Yes No

7. Do you plan at any stage of the project to undertake intrusive research involving adults lacking capacity to consent for themselves?

Yes No

Answer Yes if you plan to recruit living participants aged 16 or over who lack capacity, or to retain them in the study following loss of capacity. Intrusive research means any research with the living requiring consent in law. This includes use of identifiable tissue samples or personal information, except where application is being made to the Confidentiality Advisory Group to set aside the common law duty of confidentiality in England and Wales. Please consult the guidance notes for further information on the legal frameworks for research involving adults lacking capacity in the UK.

8. Do you plan to include any participants who are prisoners or young offenders in the custody of HM Prison Service or who are offenders supervised by the probation service in England or Wales?

Yes No

9. Is the study or any part of it being undertaken as an educational project?

Yes No

Please describe briefly the involvement of the student(s):
Chief Investigator

9a. Is the project being undertaken in part fulfilment of a PhD or other doctorate?

Yes No

10. Will this research be financially supported by the United States Department of Health and Human Services or any of its divisions, agencies or programs?

Yes No

11. Will identifiable patient data be accessed outside the care team without prior consent at any stage of the project (including identification of potential participants)?

Yes No

Integrated Research Application System
Application Form for Research involving qualitative methods only

IRAS Form (project information)

Please refer to the E-Submission and Checklist tabs for instructions on submitting this application.

The Chief Investigator should complete this form. Guidance on the questions is available wherever you see this symbol displayed. We recommend reading the guidance first. The complete guidance and a glossary are available by selecting [Help](#).

Please define any terms or acronyms that might not be familiar to lay reviewers of the application.

Short title and version number: (maximum 70 characters - this will be inserted as header on all forms)
Compassion satisfaction in clinical forensic psychologists.

Please complete these details after you have booked the REC application for review.

REC Name:
None REC study.

REC Reference Number:
16/HRA/5922

Submission date:
10/11/2016

PART A: Core study information

1. ADMINISTRATIVE DETAILS

A1. Full title of the research:

Compassion satisfaction in clinical psychologists working in forensic settings: an interpretative phenomenological analysis.

A2-1. Educational projects

Name and contact details of student(s):

Student 1

	Title Forename/Initials Surname
	Mrs Rosie Kirkham
Address	Doctorate in Clinical Psychology Faculty of Health and Medicine Furness College, Lancaster University
Post Code	LA1 4YG
E-mail	r.kirkham@lancaster.ac.uk
Telephone	01524593378
Fax	

Give details of the educational course or degree for which this research is being undertaken:
Name and level of course/ degree:

Doctorate in Clinical Psychology

Name of educational establishment:
Lancaster University

Name and contact details of academic supervisor(s):

Academic supervisor 1

	Title	Forename/Initials	Surname
	Dr	Ian	Fletcher
Address	Doctorate in Clinical Psychology Faculty of Health and Medicine Furness College, Lancaster University		
Post Code	LA1 4YG		
E-mail	i.j.fletcher@lancaster.ac.uk		
Telephone	01524593301		
Fax			

Please state which academic supervisor(s) has responsibility for which student(s):

Please click "Save now" before completing this table. This will ensure that all of the student and academic supervisor details are shown correctly.

Student(s)

Academic supervisor(s)

Student 1 Mrs Rosie Kirkham

Dr Ian Fletcher

A copy of a current CV for the student and the academic supervisor (maximum 2 pages of A4) must be submitted with the application.

A2-2. Who will act as Chief Investigator for this study?

- Student
- Academic supervisor
- Other

A3-1. Chief Investigator:

	Title	Forename/Initials	Surname
	Mrs	Rosie	Kirkham
Post	Trainee Clinical Psychologist BSc Hons Neuropsychology- First Class A Level English Literature-B		
Qualifications	A Level Psychology- B A Level Law- B 11 GCSEs grades A* to B, including English and Maths		
Employer	Lancashire Care NHS Foundation Trust		
Work Address	Doctorate in Clinical Psychology Faculty of Health and Medicine Furness College, Lancaster University		

Post Code LA1 4YG
 Work E-mail r.kirkham@lancaster.ac.uk
 * Personal E-mail [REDACTED]
 Work Telephone 01524593378
 * Personal Telephone/Mobile [REDACTED]
 Fax

** This information is optional. It will not be placed in the public domain or disclosed to any other third party without prior consent.
 A copy of a current CV (maximum 2 pages of A4) for the Chief Investigator must be submitted with the application.*

A4. Who is the contact on behalf of the sponsor for all correspondence relating to applications for this project?
This contact will receive copies of all correspondence from REC and HRA/R&D reviewers that is sent to the CI.

Title Forename/Initials Surname
 Dr [REDACTED] [REDACTED]
 Address Research Integrity and Governance Officer
 Research Services, Room B14
 Furness College, Lancaster University
 Post Code LA1 4YG
 E-mail ethics@lancaster.ac.uk
 Telephone 01524592838
 Fax

A5-1. Research reference numbers. *Please give any relevant references for your study:*

Applicant's/organisation's own reference number, e.g. R & D (if available):
 Sponsor's/protocol number:
 Protocol Version:
 Protocol Date:
 Funder's reference number:
 Project website:

Additional reference number(s):

Ref.Number Description	Reference Number
------------------------	------------------

Registration of research studies is encouraged wherever possible. You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you have registered your study please give details in the "Additional reference number(s)" section.

A5-2. Is this application linked to a previous study or another current application?

Yes No

Please give brief details and reference numbers.

2. OVERVIEW OF THE RESEARCH

To provide all the information required by review bodies and research information systems, we ask a number of specific questions. This section invites you to give an overview using language comprehensible to lay reviewers and members of the public. Please read the guidance notes for advice on this section.

A6-1. Summary of the study. *Please provide a brief summary of the research (maximum 300 words) using language easily understood by lay reviewers and members of the public. Where the research is reviewed by a REC within the UK Health Departments' Research Ethics Service, this summary will be published on the Health Research Authority (HRA) website following the ethical review. Please refer to the question specific guidance for this question.*

This study will aim to qualitatively explore clinical psychologists' experiences of compassion satisfaction when working in forensic NHS settings.

Forensic services in the UK are often described as highly stressful working environments which can cause staff to experience elevated levels of occupational stress, burnout, and psychological distress (Elliott & Daley, 2013). Compassion satisfaction is the "sense of fulfilment or pleasure therapists derive from doing their work well" (Samios, Abel & Rodzik, 2013). Research suggests compassion satisfaction reduces the negative impacts of burnout, fatigue and secondary traumatic stress across a range of workforces. However, few studies have looked qualitatively at what drives staff to work in forensic settings, and even fewer studies have studied the experiences of clinical psychologists in these settings.

This study will explore what drives clinical psychologists to stay involved in the field, and what they perceive as positive about their work experiences. This could help identify what inhibits/diminishes compassion within forensic settings, mechanisms for achieving compassion satisfaction, and possible links between compassion satisfaction, role, and setting.

A6-2. Summary of main issues. *Please summarise the main ethical, legal, or management issues arising from your study and say how you have addressed them.*

Not all studies raise significant issues. Some studies may have straightforward ethical or other issues that can be identified and managed routinely. Others may present significant issues requiring further consideration by a REC, HRA, or other review body (as appropriate to the issue). Studies that present a minimal risk to participants may raise complex organisational or legal issues. You should try to consider all the types of issues that the different reviewers may need to consider.

Confidentiality

Participant confidentiality will firstly be ensured by sending recruitment materials to the leader or administrator of the FFCP and PPN Northwest email lists for distribution to current members. This will ensure personal details are not accessed by the chief investigator prior to participants expressing an interest in the study. Confidentiality and its limitations will be included in the Participant Information Sheet and Debrief Sheet, and will be explained to participants prior to each interview commencing. All interview transcripts will be anonymised and participants will be allocated pseudonyms. Personal information (e.g. consent forms) will be kept confidential and separately to the participants' anonymised research information. Where direct quotes are reported, the chief investigator will consider whether the content of the quote makes it possible to identify the participant; if a quote is deemed to make it possible to identify a participant, it will be removed.

Limits to confidentiality

The limits to confidentiality will be explained to participants before each interview starting, and will be included in the Participant Information Sheet and Debrief Sheet. If during the interview the chief investigator learns about aspects of practice which cause concern, or believes the participant or another person is at risk of harm, the chief investigator will explain their concerns to the participant during the interview (if deemed appropriate to do so) and clarify the potential for confidentiality to be broken in this instance. The chief investigator will consult with their supervisors in a timely way and necessary policies will be followed, including [REDACTED] safeguarding policies.

Informed consent

Participants will only be interviewed when they have provided informed consent to take part in the project. Informed consent to participate in the project is gained once the participant reads, completes and signs the consent forms. It is the chief investigator's responsibility to ensure informed consent is gained for each participant prior to each individual interview commencing.

Right to withdraw

Participants will be informed they may withdraw from the study, without providing a reason, up to two weeks after providing informed consent and being interviewed (including during the interview) as per current FHMREC advice. The chief investigator will wait for a two week period after each interview before starting to analyse data in order to enable participants' to withdraw their data up to the point of analysis. If consent is withdrawn after this point, data may have

been pooled and the data analysis process may have started, meaning it would not be possible to extract their data from the study. However, every effort will be made to do so up to the point of publication.

Location of interviews

Interviews will take place either at participants' homes, by telephone, or in a pre-booked room if they wish to be interviewed during their working hours either at their place of work or at Lancaster University. However, at this stage the chief investigator cannot guarantee these locations will maintain confidentiality / be soundproof or will be free from interruptions. The chief investigator will work with participants to make queries in advance and endeavour to book the most suitable room(s) available, if at their place of work. For practical reasons, participants working in HMPs will be interviewed at a location outside of their workplace due to security restrictions relating to the use of recording devices. Local procedures regarding electronic devices and restricted items will be adhered to for interviews being conducted within forensic services.

Complaints

Details regarding how to make a complaint will be provided on the participant information sheet and the debrief sheet, explaining that complaints or concerns can be directed to Professor Bill Selwood, Programme Director, or Professor Roger Pickup, Chair of the FHMREC, both c/o Lancaster University.

3. PURPOSE AND DESIGN OF THE RESEARCH

A7. Select the appropriate methodology description for this research. Please tick all that apply.

- Case series/ case note review
- Case control
- Cohort observation
- Controlled trial without randomisation
- Cross-sectional study
- Database analysis
- Epidemiology
- Feasibility/ pilot study
- Laboratory study
- Metanalysis
- Qualitative research
- Questionnaire, interview or observation study
- Randomised controlled trial
- Other (please specify)

A10. What is the principal research question/objective? Please put this in language comprehensible to a lay person.

What are the experiences of compassion satisfaction in clinical psychologists working in NHS forensic settings, and what meanings do they attach to these experiences?

A11. What are the secondary research questions/objectives if applicable? Please put this in language comprehensible to a lay person.

Not applicable.

A12. What is the scientific justification for the research? Please put this in language comprehensible to a lay person.

Forensic services in the UK are often described as highly stressful and dangerous working environments, which can cause staff to experience elevated levels of occupational stress, burnout, and psychological distress (Elliott & Daley, 2013). Similarly, in the prison workforce a recent psychologist-led survey reported staff felt unable to seek psychological help themselves and many described feeling pressurised to work when sick (Kinman, Clements & Hart, 2015).

Compassion is a "distinct emotion" that arises when witnessing another's suffering and drives a desire to help (Goetz, Keltner & Simon-Thomas, 2013). As an emotion, compassion can be experienced as pleasant or unpleasant, but it is usually conceptualised as pleasant (Condon & Feldman-Barrett, 2011). Compassion satisfaction is defined by Samios, Abel & Rodzik (2013) as the "sense of fulfilment or pleasure therapists derive from doing their work well". A number of theories can be seen as underpinning the components of compassion, such as emotion regulation. For example, self-compassion was related with reduced emotional difficulties in a sample of psychologists (Finlay-Jone, Rees & Kane, 2015) and increased emotion regulation abilities have been positively associated with job satisfaction in a sample of British secondary school teachers (Brackett et al., 2010). Theories of emotion regulation strategies are also clinically important, as one study found doctors with higher levels of emotion regulation reappraisal were associated with higher levels of patient satisfaction (Kafetsios et al., 2014).

There is research to suggest compassion satisfaction reduces the negative impacts of burnout, compassion fatigue and secondary traumatic stress in a range of workforces such as frontline mental healthcare professionals (Ray et al, 2013), therapists working with survivors of sexual violence (Samios et al, 2013), social workers (Wagaman et al., 2015) and in hospice/palliative care staff (Slocum-Gori et al, 2011). Therefore, gaining a deeper understanding of this in clinical psychologists will be important, for example, in staff retention and identifying what may drive them to continue working in the field, and what strategies they may find useful in maintaining levels of compassion satisfaction.

Whilst research has been conducted into the negative aspects of working in forensic settings, such as burnout and compassion fatigue, few studies have looked at what drives staff to work in forensic settings, such as compassion satisfaction. In addition, while there has been some research into this phenomenon from a quantitative approach in terms of levels of satisfaction, few studies have explored compassion satisfaction qualitatively. Furthermore, even fewer studies have specifically explored the experiences of clinical psychologists in these settings; for example, clinical psychologists made up only 6.7% of the sample in Elliott and Daley (2013).

This study will aim to explore what keeps clinical psychologists involved in the field, and what they think is positive about their experiences at work. Related to this, it is also of interest to try to identify what may increase/maintain or inhibit/diminish compassion within a forensic setting, mechanisms for achieving compassion satisfaction, and if there are links between compassion satisfaction, nature of role, length of service, and type of setting.

The findings of this study may be of direct interest to some people who have had contact with clinical psychologists as part of their treatment within forensic services. In addition, the findings of this study may also be of interest to wider health professionals such as nursing staff, psychiatrists, OTs and social workers, given that clinical psychologists are frequently part of multidisciplinary teams (MDTs) within forensic settings. The findings could also provide future/current trainees or newly qualified clinical psychologists with a useful insight into the lived experiences of working in forensic services when considering placement choices or career paths.

A13. Please summarise your design and methodology. *It should be clear exactly what will happen to the research participant, how many times and in what order. Please complete this section in language comprehensible to the lay person. Do not simply reproduce or refer to the protocol. Further guidance is available in the guidance notes.*

This project will aim to explore clinical psychologists' experiences of compassion satisfaction related to working in forensic settings. The exploration of these experiences lends itself to a qualitative approach to provide participants the opportunity to describe their accounts in their own words, which will generate more richness and depth as opposed to quantitative data (e.g. using questionnaire scores). With this in mind, data will be collected from a small sample of participants via individual semi-structured interviews and analysed using interpretative phenomenological analysis (IPA) (Smith, Flowers & Larkin, 2009). Each participant will be interviewed once (in person or by telephone) which may last between 45 minutes and up to 1 hour.

A target sample of qualified clinical psychologists who currently work in NHS forensic services in England will be identified via consulting with the BPS DCP Faculty of Forensic Clinical Psychology (FFCP) and Psychology Professions Network (PPN) Northwest. A mailshot communication will be sent by the leader or coordinator of the FFCP and PPN Northwest (on behalf of the trainee) to current members on the FFCP and PPN Northwest email lists regarding the study. The trainee will also arrange to attend SIG meetings and distribute materials to suitable services if needed. Participants will be recruited using both convenience sampling and snowball sampling.

The aim is to recruit a sample of up to 12 participants on a first-come first-served basis; this will be made clear on the Participant Information Sheet. In applying the chosen method (IPA), up to 12 participants should provide enough divergence and convergence of accounts in order to conduct a meaningful analysis. This will increase the possibilities for publication, and should provide more options for the analysis as there will be more data to work with. Should more than 12 participants opt in to the study, those who responded first and meet the inclusion criteria will be prioritised for interview. Reasons for initially only including clinical psychologists within the sample, and not other MDT members,

include 1) clinical psychologists have specific roles within forensic services that differ to other MDT members (such as offence-focussed work, formulation), and 2) these roles may present specific challenges in relation to compassion satisfaction.

A14-1. In which aspects of the research process have you actively involved, or will you involve, patients, service users, and/or their carers, or members of the public?

- Design of the research
- Management of the research
- Undertaking the research
- Analysis of results
- Dissemination of findings
- None of the above

Give details of involvement, or if none please justify the absence of involvement.

A principle clinical psychologist (field supervisor) working in a forensic NHS service has been involved in the decision making processes regarding the design and proposed analysis of the research. They are representative of the target population.

The field supervisor has provided valuable consultation on the design of the research. They have provided detailed feedback on the thesis proposal, method of recruitment, the interview schedule and proposed method of analysis for the study. The field supervisor has agreed to provide assistance with identifying important clinical implications throughout the study and to provide feedback on draft report write-ups.

4. RISKS AND ETHICAL ISSUES

RESEARCH PARTICIPANTS

A15. What is the sample group or cohort to be studied in this research?

Select all that apply:

- Blood
- Cancer
- Cardiovascular
- Congenital Disorders
- Dementias and Neurodegenerative Diseases
- Diabetes
- Ear
- Eye
- Generic Health Relevance
- Infection
- Inflammatory and Immune System
- Injuries and Accidents
- Mental Health
- Metabolic and Endocrine
- Musculoskeletal
- Neurological
- Oral and Gastrointestinal

- Paediatrics
- Renal and Urogenital
- Reproductive Health and Childbirth
- Respiratory
- Skin
- Stroke

Gender: Male and female participants
 Lower age limit: 27 Years
 Upper age limit: 85 Years

A17-1. Please list the principal inclusion criteria (list the most important, max 5000 characters).

Participants should be clinical psychologists currently working in a forensic service within the NHS in England (which may be attached to or based in HMPs), and should have at least two years post-qualification experience of working in the field. This is important as participants will be asked about their experiences of and influences on compassion satisfaction, so need to have had sufficient post-qualification experience in order to have lived it.

A17-2. Please list the principal exclusion criteria (list the most important, max 5000 characters).

The project will exclude clinical psychologists who work solely in private or charitable settings, or in forensic Learning Disability Services, in order to preserve homogeneity of the sample. Clinical psychologists who have less than two years post-qualification experience working in forensic services will also be excluded.

RESEARCH PROCEDURES, RISKS AND BENEFITS

A18. Give details of all non-clinical intervention(s) or procedure(s) that will be received by participants as part of the research protocol. These include seeking consent, interviews, non-clinical observations and use of questionnaires.

Please complete the columns for each intervention/procedure as follows:

1. Total number of interventions/procedures to be received by each participant as part of the research protocol.
2. If this intervention/procedure would be routinely given to participants as part of their care outside the research, how many of the total would be routine?
3. Average time taken per intervention/procedure (minutes, hours or days)
4. Details of who will conduct the intervention/procedure, and where it will take place.

Intervention or procedure	1	2	3	4
Eligibility check (exclusion criteria).	One	One	Approx. 5 minutes.	Chief Investigator, by email/telephone prior to arranging interview.
Seeking consent.	One	One	Approx. 5 minutes.	Chief Investigator, at location of interview if in person (NHS workplace, participant's home or Lancaster University) or by email/post if telephone interview.
1:1 interview.	One	One	Up to 60 minutes.	Chief Investigator, at location of interview (NHS workplace, participant's home or Lancaster University) or by telephone.
Debriefing.	One	One	Approx. 5 minutes.	Chief Investigator, at location of interview (NHS workplace, participant's home or Lancaster University) or by telephone.

A21. How long do you expect each participant to be in the study in total?

Between 45 minutes and 1 hour 30 minutes maximum (from gaining consent to completion of individual interview).

A22. What are the potential risks and burdens for research participants and how will you minimise them?

For all studies, describe any potential adverse effects, pain, discomfort, distress, intrusion, inconvenience or changes to lifestyle. Only describe risks or burdens that could occur as a result of participation in the research. Say what steps would be taken to minimise risks and burdens as far as possible.

While it is not expected that the interviews will cause participants any distress, if a participant does show signs of distress or becomes upset during the interview, the chief investigator will pause the interview and check how the participant is. The chief investigator will allow the participant sufficient time to recover and an opportunity to discuss their feelings, before checking if they wish to continue with the interview. The chief investigator will only resume the interview if they feel the participant is able to continue. Participants will be provided contact details of support agencies (Mind, Samaritans) in the Participant Information Sheet and Debrief Sheet, and the chief investigator will encourage them to seek a consultation with their GP for advice where needed.

A23. Will interviews/ questionnaires or group discussions include topics that might be sensitive, embarrassing or upsetting, or is it possible that criminal or other disclosures requiring action could occur during the study?

Yes No

A24. What is the potential for benefit to research participants?

No direct benefits may arise from taking part in the study. However, participants may find taking part in the interview process interesting, and may enjoy the opportunity to engage in a reflective discussion regarding their experiences.

A26. What are the potential risks for the researchers themselves? (if any)

No risk issues are anticipated for the chief investigator conducting the interviews. The chief investigator has experience of working in clinical environments (including forensic NHS services) with people who are distressed and in conducting risk assessments. They have practical training in communication, breakaway techniques, and in de-escalation. In the event that a disclosure is made that warrants concern, the chief investigator will seek advice from their academic and field supervisors in a timely way, and will ensure they have a mobile phone with relevant contact numbers stored in case they need to make any urgent enquiries.

The chief investigator will comply with their employer's Lone Working Policy [REDACTED] to ensure health and safety requirements are followed. Examples of the steps the chief investigator will take in relation to this include informing a nominated 'buddy' of their whereabouts, having their ID badge on their person, carrying a fully charged mobile phone, and ensuring their vehicle has enough fuel when travelling to and from interviews. The trainee will also adhere to local security policies and procedures when conducting interviews within forensic environments.

Prior to each interview, the chief investigator will agree a time to call their buddy following the interview to confirm they are safe; if the chief investigator does not call by the agreed time, the buddy will firstly attempt to contact the chief investigator. If the buddy cannot contact the chief investigator, they will escalate this to their line manager with relevant details (time/place of chief investigator's planned interview). The chief investigator's line manager will then attempt to track their whereabouts and, if there is genuine concern over their safety, will involve the police if deemed necessary as outlined in the Policy.

RECRUITMENT AND INFORMED CONSENT

In this section we ask you to describe the recruitment procedures for the study. Please give separate details for different study groups where appropriate.

A27-1. How will potential participants, records or samples be identified? Who will carry this out and what resources will be used? *For example, identification may involve a disease register, computerised search of GP records, or review of medical records. Indicate whether this will be done by the direct healthcare team or by researchers acting under arrangements with the responsible care organisation(s).*

Participants will initially be recruited via a mailshot communication to members of the BPS Faculty of Forensic Clinical Psychology (FFCP) and members of the Psychology Professions Network (PPN) Northwest. This will be sent on the chief investigator's behalf by the administrators of the FFCP and PPN mailing lists. The chief investigator will also arrange to attend upcoming SIG meetings in order to publicise the study by introducing themselves to potential psychologists and circulating the recruitment materials on a face-to-face basis. The field supervisor will also be able to highlight the study to potential participants who currently practice within the field.

Snowball sampling will be used to recruit further participants, as the Participant Information Sheet will encourage psychologists to share details of the study with others who may be interested and who meet the inclusion criteria. To be considered for the project the participant needs to contact the chief investigator by email or by post (freepost address will be provided). Should more than 12 participants express an interest in taking part in the study, those who responded first will be interviewed; participants who will not be interviewed will be informed as such, and thanked for their interest.

A27-2. Will the identification of potential participants involve reviewing or screening the identifiable personal information of patients, service users or any other person?

Yes No

Please give details below:

A28. Will any participants be recruited by publicity through posters, leaflets, adverts or websites?

Yes No

If Yes, please give details of how and where publicity will be conducted, and enclose copy of all advertising material (with version numbers and dates).

The administrator of the FFCP and PPN mailing lists will be asked to assist with recruitment by sending a short email communication containing two attachments (a Participant Information Sheet and a copy of the consent form) to current members. The email will invite potential participants to opt in to the study by contacting the chief investigator directly. A copy of the email communication is enclosed.

A29. How and by whom will potential participants first be approached?

Participants who agree to take part in the interviews will do so on a completely voluntary basis. Participants will be approached via email communications sent by the FFCP and PPN Northwest as described above. The chief investigator will liaise with their field supervisor on potential points of contact e.g. secure services, community forensic mental health teams, forensic in-reach teams, regional forensic Heads of Services etc. if needed. The chief investigator and/or field supervisor will then contact team admin/secretarial staff who routinely have details of potential participants, and request for them to send an email communication and attachment (as described above) on the chief investigator's behalf to clinical psychologists working within their service in order to assist with recruitment.

A30-1. Will you obtain informed consent from or on behalf of research participants?

Yes No

If you will be obtaining consent from adult participants, please give details of who will take consent and how it will be done, with details of any steps to provide information (a written information sheet, videos, or interactive material). Arrangements for adults unable to consent for themselves should be described separately in Part B Section 6, and for children in Part B Section 7.

If you plan to seek informed consent from vulnerable groups, say how you will ensure that consent is voluntary and fully informed.

At the start of each interview the participant will be provided with two hard copies of the consent form to read and sign. Once they have read and signed these forms, the chief investigator will also sign the forms, and provide the participant with a copy to keep for future reference (on request).

Where interviews are scheduled to take place over the telephone, the chief investigator will email the participant an electronic copy of the consent form at least one week prior to an arranged interview date; the participant will be asked to read, print and sign two hard copies of these and return them via the chief investigator's freepost address prior to

the interview taking place. The chief investigator will sign both hard copies upon receiving them, and will provide the participant with a copy should they request this. Scanned electronic copies of consent forms relating to participants who took part in the study will be kept for 10 years after the project has been submitted.

If a participant wishes to withdraw from the project, they can do so up to two weeks after providing their informed consent. The chief investigator will allow at least two weeks after each interview before starting to analyse their data, thereby enabling participants to withdraw their data from the project up to the point of analysis. Following this point, it will not be possible to extract a participant's data from the study.

If you are not obtaining consent, please explain why not.

Not applicable.

Please enclose a copy of the information sheet(s) and consent form(s).

A30-2. Will you record informed consent (or advice from consultees) in writing?

Yes No

A31. How long will you allow potential participants to decide whether or not to take part?

Participants will be allowed at least 24 hours after reading the Participant Information Sheet to decide whether or not to take part in the study.

A33-1. What arrangements have been made for persons who might not adequately understand verbal explanations or written information given in English, or who have special communication needs?(e.g. translation, use of interpreters)

Translators will not be applicable, as all participants will already be required to speak English as per their role as a clinical psychologist in the NHS.

A35. What steps would you take if a participant, who has given informed consent, loses capacity to consent during the study? Tick one option only.

- The participant and all identifiable data or tissue collected would be withdrawn from the study. Data or tissue which is not identifiable to the research team may be retained.
- The participant would be withdrawn from the study. Identifiable data or tissue already collected with consent would be retained and used in the study. No further data or tissue would be collected or any other research procedures carried out on or in relation to the participant.
- The participant would continue to be included in the study.
- Not applicable – informed consent will not be sought from any participants in this research.
- Not applicable – it is not practicable for the research team to monitor capacity and continued capacity will be assumed.

Further details:

CONFIDENTIALITY

In this section, personal data means any data relating to a participant who could potentially be identified. It includes pseudonymised data capable of being linked to a participant through a unique code number.

Storage and use of personal data during the study

A36. Will you be undertaking any of the following activities at any stage (including in the identification of potential participants)?(Tick as appropriate)

- Access to medical records by those outside the direct healthcare team
- Access to social care records by those outside the direct social care team
- Electronic transfer by magnetic or optical media, email or computer networks
- Sharing of personal data with other organisations
- Export of personal data outside the EEA
- Use of personal addresses, postcodes, faxes, emails or telephone numbers
- Publication of direct quotations from respondents
- Publication of data that might allow identification of individuals
- Use of audio/visual recording devices
- Storage of personal data on any of the following:
 - Manual files (includes paper or film)
 - NHS computers
 - Social Care Service computers
 - Home or other personal computers
 - University computers
 - Private company computers
 - Laptop computers

Further details:

Participants' quotations will be used in the report write-up and in presentation to stakeholders, these will be anonymised.

All interview data will be recorded on a portable digital audio recording device, which is not encrypted. The device will be stored in a locked cabinet and the audio recordings will be transferred to a secure electronic format (Lancaster University's encrypted server) as soon as possible. Once each interview has been transcribed, stored in a secure electronic format, and checked for accuracy, the audio recording will be deleted from the device.

Personal information detailed on 'consent forms' will be stored in hard copy form in a locked cabinet (separately to any hard copies of research data) and will later be scanned into electronic form and stored in a secure file space.

A37. Please describe the physical security arrangements for storage of personal data during the study?

Arranging Interviews

All documentation (e.g. email correspondence) containing participants' personal details necessary for arranging interviews will be kept confidential and separately to their consent forms, and all details (except paper consent forms) will be destroyed once the participant has taken part in the project. For participants who responded after 12 participants were recruited, emails regarding interest will be destroyed once all data have been gathered and no further participants are needed to be contacted. If a participant wishes to withdraw from the project prior to an arranged interview taking place, all personal data related to the project such as emails and consent forms will be destroyed as soon as possible. Data on portable devices will be encrypted; if it cannot be encrypted, any identifiable data (including audio recordings of participants' voices) will be deleted from the recorder as quickly as possible (once it has been transferred to a secure medium, such as a password protected PC) and in the meantime the recorder will be stored securely.

Short-term data storage

During the course of the project any paper files of personally identifiable information and anonymised research data will be securely stored separately in a locked cabinet. That is, participants' signed consent forms will be stored separately to anonymised raw data (interview transcripts) and coded data (analysed interview transcripts). All electronic data, such as transcribed interviews and the project write-up, will be password protected and stored securely on the trainee's personal file space on the H: drive of Lancaster University's server via their VPN. Any electronic data stored on portable devices during the thesis, such as USB drives or laptops, will be encrypted in addition to being password protected.

Long-term data storage

After the project has been submitted, all paper consent forms will be scanned and saved into electronic format for long-term storage. Paper consent forms will then be destroyed. These will then be encrypted and securely transferred (via file transfer software that is supported by the University) to the DClinPsy programme Research Coordinator, who will save the files on the University server in a password-protected file space. Data will be stored for 10 years after the thesis is submitted then destroyed by the Research Coordinator.

A38. How will you ensure the confidentiality of personal data? *Please provide a general statement of the policy and procedures for ensuring confidentiality, e.g. anonymisation or pseudonymisation of data.*

Confidentiality will be explained to participants via the Participant Information Sheet and Debrief Sheet, and also verbally prior to the start of each interview.

Confidentiality will firstly be ensured by sending recruitment materials to the leader or administrator of the FFCP and PPN Northwest for distribution to the mailing lists for current members. This will make sure that personal details are not accessed by the chief investigator prior to participants expressing an interest in the study. In addition, where recruitment materials are distributed to identified services (e.g. forensic CMHTs) these will be initially sent to a named staff member (such as a team administrator/team secretary) who routinely has access to the details of potential clinical psychologists, thus again ensuring the chief investigator does not have sight of participants' details before they consider to take part.

Interview rooms should ideally preserve confidentiality, although participants will be informed this cannot be totally guaranteed if interviews take place on work premises during the working day. The limits to confidentiality will be explained to each participant prior to the interview starting. Breaking confidentiality will be required when a participant has indicated that they are at risk of causing harm to themselves or others, or are at risk of harm from others; the chief investigator will explain they will need to break confidentiality and inform their supervisor in these circumstances.

During and after the interview, the chief investigator will take steps to address confidentiality issues. Examples of these steps include storing any paperwork containing participant's details in an opaque document wallet, displaying 'do not disturb' signs on the doors of rooms used for interviews if available, and pausing the interview should an outside person interrupt or enter the room. The trainee will ensure they are in possession of the audio recording devices at all times, and will not leave these unattended at any point.

The chief investigator will allocate each participant a pseudonym, thus all research documents such as interview transcripts will not contain any personally identifiable data. Personal information (e.g. consent forms) will be kept confidential and separately to the participants' research information.

A40. Who will have access to participants' personal data during the study? *Where access is by individuals outside the direct care team, please justify and say whether consent will be sought.*

Only the chief investigator will have access to participants' personal data in order to arrange and conduct interviews. No personal details will be shared with their academic or field supervisors, unless during an interview a participant indicates that they are at risk of causing harm to themselves or others, or are at risk of harm from others; in this instance the chief investigator will potentially share personal details with their supervisors.

Storage and use of data after the end of the study

A41. Where will the data generated by the study be analysed and by whom?

The chief investigator will have primary responsibility for transcribing and analysing the data, will input and support from their supervisor(s) where necessary. The chief investigator will analyse the data two weeks after participants' have provided their informed consent.

All transcription and analysis will be conducted by the chief investigator whilst working on their secure personal file space (H: drive) which only they can access. Data will be analysed both at Lancaster University, and via the Virtual Private Network (VPN) when working at their home. When at home the chief investigator will ensure all data is kept secure, such as keeping paper files in locked cabinets and storing electronic data on their password protected filespace (H: drive) on the University server.

A42. Who will have control of and act as the custodian for the data generated by the study?

	Title Forename/Initials Surname
	Dr Jane Simpson
Post	Research Director, Doctorate in Clinical Psychology, Lancaster University
Qualifications	PhD
Work Address	Division of Health Research Furness College, Lancaster University Lancaster
Post Code	LA1 4YG
Work Email	j.simpson2@lancaster.ac.uk
Work Telephone	01524592858
Fax	01524592401

A43. How long will personal data be stored or accessed after the study has ended?

Less than 3 months
 3 – 6 months
 6 – 12 months
 12 months – 3 years
 Over 3 years

A44. For how long will you store research data generated by the study?

Years: 10
 Months: 0

A45. Please give details of the long term arrangements for storage of research data after the study has ended. Say where data will be stored, who will have access and the arrangements to ensure security.

After the project has been submitted, all paper consent forms will be scanned and saved into electronic format for long-term storage. Paper consent forms will then be destroyed. These will then be encrypted and securely transferred (via file transfer software that is supported by the University) to the DClinPsy programme Research Coordinator, who will save the files on the University server in a password-protected file space. Data will be stored for 10 years after the thesis is submitted then destroyed by the Research Coordinator.

INCENTIVES AND PAYMENTS

A46. Will research participants receive any payments, reimbursement of expenses or any other benefits or incentives for taking part in this research?

Yes No

If Yes, please give details. For monetary payments, indicate how much and on what basis this has been determined.

Though interviews are anticipated to take place at participants' usual place of work, travel expenses will be offered should participants need to travel to agreed locations away from their place of work for their interview.

Should the participant request to be interviewed at a location away from their home or usual place of work (i.e. at Lancaster University), the chief investigator will ask the participant whether they wish to be reimbursed for any anticipated travel expenses for attending the interview, and will ask them to estimate this cost. The chief investigator will then arrange to collect funds following the Lancaster DClinPsy programme's policy on reimbursement of travel expenses incurred by research participants (for more details see http://www.lancaster.ac.uk/shm/study/doctoral_study/dclinpsy/onlinhandbook/research_expenses/).

A47. Will individual researchers receive any personal payment over and above normal salary, or any other benefits or incentives, for taking part in this research?

Yes No

A48. Does the Chief Investigator or any other investigator/collaborator have any direct personal involvement (e.g. financial, share holding, personal relationship etc.) in the organisations sponsoring or funding the research that may give rise to a possible conflict of interest?

Yes No

NOTIFICATION OF OTHER PROFESSIONALS

A49-1. Will you inform the participants' General Practitioners (and/or any other health or care professional responsible for their care) that they are taking part in the study?

Yes No

If Yes, please enclose a copy of the information sheet/letter for the GP/health professional with a version number and date.

PUBLICATION AND DISSEMINATION

A50. Will the research be registered on a public database?

Yes No

*Please give details, or justify if not registering the research.
No suitable register exists.*

*Registration of research studies is encouraged wherever possible.
You may be able to register your study through your NHS organisation or a register run by a medical research charity, or publish your protocol through an open access publisher. If you are aware of a suitable register or other method of publication, please give details. If not, you may indicate that no suitable register exists. Please ensure that you have entered registry reference number(s) in question A5-1.*

A51. How do you intend to report and disseminate the results of the study? Tick as appropriate:

- Peer reviewed scientific journals
- Internal report
- Conference presentation
- Publication on website
- Other publication
- Submission to regulatory authorities
- Access to raw data and right to publish freely by all investigators in study or by Independent Steering Committee on behalf of all investigators
- No plans to report or disseminate the results
- Other (please specify)

A52. If you will be using identifiable personal data, how will you ensure that anonymity will be maintained when

publishing the results?

All participants will be allocated a pseudonym during the study. Quotations that are used in the project write-up to illustrate key findings will be anonymised, but may be identifiable by the chief investigator and the participant who provided the quotation. Where direct quotes are reported, the chief investigator will consider whether the content of the quote makes it possible to identify the participant; if a quote is deemed to make it possible to identify a participant, it will be removed. Information that directly identifies any NHS organisations involved in the project will not be included in the write-up or subsequent dissemination.

A53. Will you inform participants of the results?

Yes No

Please give details of how you will inform participants or justify if not doing so.

The Debrief Sheet will state that if participants would like to receive a summary of the research once the study has finished, they should request this from the chief investigator using the contact details provided.

5. Scientific and Statistical Review

A54. How has the scientific quality of the research been assessed? Tick as appropriate:

- Independent external review
- Review within a company
- Review within a multi-centre research group
- Review within the Chief Investigator's institution or host organisation
- Review within the research team
- Review by educational supervisor
- Other

Justify and describe the review process and outcome. If the review has been undertaken but not seen by the researcher, give details of the body which has undertaken the review:

The research proposal was reviewed by the chief investigator's academic and field supervisors who provided written and verbal feedback. The research proposal was then anonymously peer reviewed by the research team within the Doctorate in Clinical Psychology programme, Lancaster University. It was stated that the study was an interesting and worthwhile, and the Research Director agreed that the proposed study was suitable to proceed and to submit for ethical review.

For all studies except non-doctoral student research, please enclose a copy of any available scientific critique reports, together with any related correspondence.

For non-doctoral student research, please enclose a copy of the assessment from your educational supervisor/ institution.

A59. What is the sample size for the research? How many participants/samples/data records do you plan to study in total? If there is more than one group, please give further details below.

Total UK sample size: 12
 Total international sample size (including UK): 12
 Total in European Economic Area: 12

Further details:

A sample of up to 12 participants is hoped to be recruited, though this may be smaller (minimum of 5).

A60. How was the sample size decided upon? If a formal sample size calculation was used, indicate how this was done, giving sufficient information to justify and reproduce the calculation.

In applying the chosen method (IPA), up to 12 participants should provide enough divergence and convergence of accounts in order to conduct a meaningful analysis. This will increase the possibilities for publication, and should

provide more options for the analysis as there will be more data to work with.

A62. Please describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative research) by which the data will be evaluated to meet the study objectives.

Data will be analysed using IPA by following the process outlined in Smith, Flowers & Larkin (2009) and the chief investigator will discuss all stages with the academic supervisor to ensure consistency and trustworthiness of the data analysis.

The chief investigator will read and re-read each transcript thoroughly in order to 'immerse' themselves in the data and allow detailed exploration of the participants' experiences and the meaning they attach to these. The chief investigator will then aim to identify themes across participants' accounts regarding their experiences of compassion satisfaction when working in forensic settings. Interview transcripts will be coded either directly onto the electronic file, or by hand and then transferred to an electronic file for further analysis. The codes will be analysed further to provide overarching themes across the interview data.

A summary of the themes will be created and specific quotations will be marked with the participant's pseudonym and the transcript page number. This will create an audit trail and facilitate retrieving the location of where quotes have been identified in the interview data. Throughout the data analysis, the chief investigator will reflect on their active role in the research, and will consider how their beliefs and assumptions may have shaped the process.

6. MANAGEMENT OF THE RESEARCH

A63. Other key investigators/collaborators. Please include all grant co-applicants, protocol co-authors and other key members of the Chief Investigator's team, including non-doctoral student researchers.

	Title Forename/Initials Surname
	Dr Ian Fletcher
Post	Senior Research Lecturer, ACADEMIC SUPERVISOR
Qualifications	PhD
Employer	Lancaster University
Work Address	Doctorate in Clinical Psychology Faculty of Health and Medicine Furness College, Lancaster University
Post Code	LA1 4YG
Telephone	01524593301
Fax	
Mobile	
Work Email	i.j.fletcher@lancaster.ac.uk

	Title Forename/Initials Surname
	Dr Jo Hearne
Post	Principle Clinical Psychologist, FIELD SUPERVISOR
Qualifications	Doctorate in Clinical Psychology
Employer	Lancashire Care NHS Foundation Trust
Work Address	Forensic Outreach Service Parlick Centre, Guild Lodge Whittingham Lane, Goosnargh
Post Code	PR3 2JH
Telephone	01772406796
Fax	
Mobile	

Work Email joanna.hearne@lancashirecare.nhs.uk

A64. Details of research sponsor(s)

A64-1. Sponsor

Lead Sponsor

Status: NHS or HSC care organisation

Commercial status:

Academic

Pharmaceutical industry

Medical device industry

Local Authority

Other social care provider (including voluntary sector or private organisation)

Other

If Other, please specify:

Contact person

Name of organisation Lancaster University

Given name

Family name

Address Research Services, Room B14, Furness College

Town/city Lancaster

Post code LA1 4YT

Country UNITED KINGDOM

Telephone 01524592838

Fax

E-mail ethics@lancaster.ac.uk

Is the sponsor based outside the UK?

Yes No

Under the Research Governance Framework for Health and Social Care, a sponsor outside the UK must appoint a legal representative established in the UK. Please consult the guidance notes.

A65. Has external funding for the research been secured?

Funding secured from one or more funders

External funding application to one or more funders in progress

No application for external funding will be made

What type of research project is this?

- Standalone project
- Project that is part of a programme grant
- Project that is part of a Centre grant
- Project that is part of a fellowship/ personal award/ research training award
- Other

Other – please state:

A66. Has responsibility for any specific research activities or procedures been delegated to a subcontractor (other than a co-sponsor listed in A64-1) ? Please give details of subcontractors if applicable.

- Yes No

A67. Has this or a similar application been previously rejected by a Research Ethics Committee in the UK or another country?

- Yes No

Please provide a copy of the unfavourable opinion letter(s). You should explain in your answer to question A6-2 how the reasons for the unfavourable opinion have been addressed in this application.

A68-1. Give details of the lead NHS R&D contact for this research:

	Title Forename/Initials Surname
Organisation	
Address	
Post Code	
Work Email	
Telephone	
Fax	
Mobile	

Details can be obtained from the NHS R&D Forum website: <http://www.rdforum.nhs.uk>

A69-1. How long do you expect the study to last in the UK?

Planned start date: 30/11/2016
Planned end date: 30/06/2017
Total duration:
Years: 0 Months: 6 Days: 1

A71-1. Is this study?

- Single centre
 Multicentre

If yes, details should be given in Part C.

A74. What arrangements are in place for monitoring and auditing the conduct of the research?

The chief investigator will share at least their first anonymised audio recording or transcribed interview with their academic/field supervisor to enable their supervisors to check the interviews were conducted properly and provide advice and feedback as necessary for future interviews. The chief investigator will have regular formal supervisory meetings with both the academic and field supervisors, on at least a monthly basis (either in person or by email/telephone), and as needed at key milestones of the project.

A76. Insurance/ Indemnity to meet potential legal liabilities

Note: In this question to NHS indemnity schemes include equivalent schemes provided by Health and Social Care (HSC) in Northern Ireland

A76-1. What arrangements will be made for insurance and/or indemnity to meet the potential legal liability of the sponsor(s) for harm to participants arising from the management of the research? Please tick box(es) as applicable.

Note: Where a NHS organisation has agreed to act as sponsor or co-sponsor, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For all other sponsors, please describe the arrangements and provide evidence.

- NHS indemnity scheme will apply (NHS sponsors only)
 Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-2. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of the sponsor(s) or employer(s) for harm to participants arising from the design of the research? Please tick box(es) as applicable.

Note: Where researchers with substantive NHS employment contracts have designed the research, indemnity is provided through NHS schemes. Indicate if this applies (there is no need to provide documentary evidence). For other protocol authors (e.g. company employees, university members), please describe the arrangements and provide evidence.

- NHS indemnity scheme will apply (protocol authors with NHS contracts only)
 Other insurance or indemnity arrangements will apply (give details below)

Lancaster University legal liability cover will apply.

Please enclose a copy of relevant documents.

A76-3. What arrangements will be made for insurance and/ or indemnity to meet the potential legal liability of investigators/collaborators arising from harm to participants in the conduct of the research?

Note: Where the participants are NHS patients, indemnity is provided through the NHS schemes or through professional indemnity. Indicate if this applies to the whole study (there is no need to provide documentary evidence). Where non-NHS sites are to be included in the research, including private practices, please describe the arrangements which will be made at these sites and provide evidence.

- NHS indemnity scheme or professional indemnity will apply (participants recruited at NHS sites only)
 Research includes non-NHS sites (give details of insurance/ indemnity arrangements for these sites below)

Please enclose a copy of relevant documents.

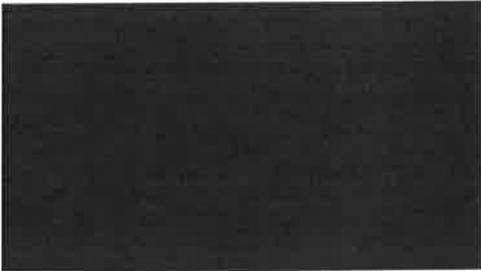
A78. Could the research lead to the development of a new product/process or the generation of intellectual property?

Yes No Not sure

PART C: Overview of research sites

Please enter details of the host organisations (Local Authority, NHS or other) in the UK that will be responsible for the research sites. For NHS sites, the host organisation is the Trust or Health Board. Where the research site is a primary care site, e.g. GP practice, please insert the host organisation (PCT or Health Board) in the Institution row and insert the research site (e.g. GP practice) in the Department row.

Investigator identifier	Research site	Investigator Name
IN1	<input checked="" type="radio"/> NHS site <input type="radio"/> Non-NHS site Country: England Organisation name Address Post Code	Forename Rosie Middle name Family name Kirkham Email r.kirkham@lancaster.ac.uk Qualification (MD...) BSc Hons Neuropsychology Country UNITED KINGDOM
IN2	<input checked="" type="radio"/> NHS site <input type="radio"/> Non-NHS site Country: England Organisation name Address Post Code	Forename Rosie Middle name Family name Kirkham Email r.kirkham@lancaster.ac.uk Qualification (MD...) BSc Hons Neuropsychology Country UNITED KINGDOM
IN3	<input checked="" type="radio"/> NHS site <input type="radio"/> Non-NHS site Country: England	Forename Rosie Middle name Family name Kirkham

Organisation name		Email	r.kirkham@lancaster.ac.uk
Address		Qualification (MD...)	BSc Hons Neuropsychology
Post Code		Country	UNITED KINGDOM

PART D: Declarations**D1. Declaration by Chief Investigator**

1. The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
2. I undertake to abide by the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research.
3. If the research is approved I undertake to adhere to the study protocol, the terms of the full application as approved and any conditions set out by review bodies in giving approval.
4. I undertake to notify review bodies of substantial amendments to the protocol or the terms of the approved application, and to seek a favourable opinion from the main REC before implementing the amendment.
5. I undertake to submit annual progress reports setting out the progress of the research, as required by review bodies.
6. I am aware of my responsibility to be up to date and comply with the requirements of the law and relevant guidelines relating to security and confidentiality of patient or other personal data, including the need to register when necessary with the appropriate Data Protection Officer. I understand that I am not permitted to disclose identifiable data to third parties unless the disclosure has the consent of the data subject or, in the case of patient data in England and Wales, the disclosure is covered by the terms of an approval under Section 251 of the NHS Act 2006.
7. I understand that research records/data may be subject to inspection by review bodies for audit purposes if required.
8. I understand that any personal data in this application will be held by review bodies and their operational managers and that this will be managed according to the principles established in the Data Protection Act 1998.
9. I understand that the information contained in this application, any supporting documentation and all correspondence with review bodies or their operational managers relating to the application:
 - Will be held by the REC (where applicable) until at least 3 years after the end of the study; and by NHS R&D offices (where the research requires NHS management permission) in accordance with the NHS Code of Practice on Records Management.
 - May be disclosed to the operational managers of review bodies, or the appointing authority for the REC (where applicable), in order to check that the application has been processed correctly or to investigate any complaint.
 - May be seen by auditors appointed to undertake accreditation of RECs (where applicable).
 - Will be subject to the provisions of the Freedom of Information Acts and may be disclosed in response to requests made under the Acts except where statutory exemptions apply.
 - May be sent by email to REC members.
10. I understand that information relating to this research, including the contact details on this application, may be held on national research information systems, and that this will be managed according to the principles established in the Data Protection Act 1998.
11. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named below. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.

Contact point for publication*(Not applicable for R&D Forms)*

NRES would like to include a contact point with the published summary of the study for those wishing to seek further information. We would be grateful if you would indicate one of the contact points below.

Chief Investigator

- Sponsor
- Study co-ordinator
- Student
- Other – please give details
- None

Access to application for training purposes *(Not applicable for R&D Forms)*

Optional – please tick as appropriate:

I would be content for members of other RECs to have access to the information in the application in confidence for training purposes. All personal identifiers and references to sponsors, funders and research units would be removed.

This section was signed electronically by Mrs Rosie Kirkham on 09/11/2016 11:30.

Job Title/Post: Trainee Clinical Psychologist
Organisation: Lancaster University
Email: r.kirkham@lancaster.ac.uk

D2. Declaration by the sponsor's representative

If there is more than one sponsor, this declaration should be signed on behalf of the co-sponsors by a representative of the lead sponsor named at A64-1.

I confirm that:

1. This research proposal has been discussed with the Chief Investigator and agreement in principle to sponsor the research is in place.
2. An appropriate process of scientific critique has demonstrated that this research proposal is worthwhile and of high scientific quality.
3. Any necessary indemnity or insurance arrangements, as described in question A76, will be in place before this research starts. Insurance or indemnity policies will be renewed for the duration of the study where necessary.
4. Arrangements will be in place before the study starts for the research team to access resources and support to deliver the research as proposed.
5. Arrangements to allocate responsibilities for the management, monitoring and reporting of the research will be in place before the research starts.
6. The duties of sponsors set out in the Research Governance Framework for Health and Social Care will be undertaken in relation to this research.

Please note: The declarations below do not form part of the application for approval above. They will not be considered by the Research Ethics Committee.

7. Where the research is reviewed by a REC within the UK Health Departments Research Ethics Service, I understand that the summary of this study will be published on the website of the National Research Ethics Service (NRES), together with the contact point for enquiries named in this application. Publication will take place no earlier than 3 months after issue of the ethics committee's final opinion or the withdrawal of the application.
8. Specifically, for submissions to the Research Ethics Committees (RECs) I declare that any and all clinical trials approved by the HRA since 30th September 2013 (as defined on IRAS categories as clinical trials of medicines, devices, combination of medicines and devices or other clinical trials) have been registered on a publically accessible register in compliance with the HRA registration requirements for the UK, or that any deferral granted by the HRA still applies.

This section was signed electronically by An authorised approver at ethics@lancaster.ac.uk on 09/11/2016 14:32.

Job Title/Post: Research Support and Systems Manager

Organisation: Lancaster University

Email: [REDACTED]

D3. Declaration for student projects by academic supervisor(s)

1. I have read and approved both the research proposal and this application. I am satisfied that the scientific content of the research is satisfactory for an educational qualification at this level.
2. I undertake to fulfil the responsibilities of the supervisor for this study as set out in the Research Governance Framework for Health and Social Care.
3. I take responsibility for ensuring that this study is conducted in accordance with the ethical principles underlying the Declaration of Helsinki and good practice guidelines on the proper conduct of research, in conjunction with clinical supervisors as appropriate.
4. I take responsibility for ensuring that the applicant is up to date and complies with the requirements of the law and relevant guidelines relating to security and confidentiality of patient and other personal data, in conjunction with clinical supervisors as appropriate.

Academic supervisor 1

This section was signed electronically by Dr Ian Fletcher on 09/11/2016 11:58.

Job Title/Post: Senior Lecturer
Organisation: Lancaster University
Email: i.j.fletcher@lancs.ac.uk



Research & Development Office



08 December 2016

Mrs Rosie Kirkham
Doctorate in Clinical Psychology, C27
Division of Health Research
Furness College
Lancaster University
Lancaster
LA1 4YG

Tel:

Emails:

Web:

Dear Mrs Kirkham

Letter of Access for Research

As an existing NHS employee you do not require an additional honorary research contract with this NHS organisation. We are satisfied that the research activities that you will undertake in this NHS organisation are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this NHS organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in this organisation. This letter confirms your right of access to conduct research through for the purpose and on the terms and conditions set out below. This right of access commences on 08/12/2016 and ends on 30/06/2017 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as notified to us. Please note that you cannot start the research until the Chief/Principal Investigator for the research project has received an email from us confirming we have the capacity and capability to support the research and all other regulatory approvals are in place.

You are considered to be a legal visitor to premises. You are not entitled to any form of payment or access to other benefits provided by this organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through you will remain accountable to your employer Lancaster University, but you are required to follow the reasonable instructions of the relevant service manager(s) in this NHS organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings

You must act in accordance with policies and procedures, which are available to you upon request, and the Research Governance Framework.

The Trust is committed to safeguarding children, young people and vulnerable adults and requires all staff and volunteers to share this commitment.



You are required to co-operate with [REDACTED] in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on [REDACTED] premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore, you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

[REDACTED] will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. Where applicable, your substantive employer will initiate your Independent Safeguarding Authority (ISA) registration in-line with the phasing strategy adopted within the NHS and the applicable legislation. Once you are ISA registered, your employer will continue to monitor your ISA registration status via the online ISA service. Should you cease to be ISA-registered, this letter of access is immediately terminated. Your substantive employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or ISA registration, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the NHS organisation that employs you through its normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

[REDACTED]
Director of HR & Corporate Services

Cc: Dr Anna Daiches, Clinical Director, Lancaster University

IRAS 218436 - Confirmation of Capacity and Capability at [REDACTED]

Sent: 13 December 2016 11:31
To: Kirkham, Rosie
Cc: Ethics (RSO) Enquiries; [REDACTED]
Importance: High
Attachments: Email to confirm capacity~1.docx (304 KB) ; 218436 HRA statement-acti~1.docx (76 KB)

Dear Mrs Rosie Kirkham,

RE: IRAS 218436. Confirmation of Capacity and Capability at [REDACTED]

Full Study Title: *Compassion satisfaction in clinical psychologists working in forensic settings: an interpretative phenomenological analysis*

This email confirms that [REDACTED] has the capacity and capability to deliver the above referenced study. Please find attached the agreed Statement of Activities as confirmation.

We agree to start this study on Tuesday 13th December 2016, as previously discussed.

In addition to the conditions set out in the HRA approval letter, we ask you to review the appendix as part of conducting research in [REDACTED]

If you wish to discuss further, please do not hesitate to contact me.

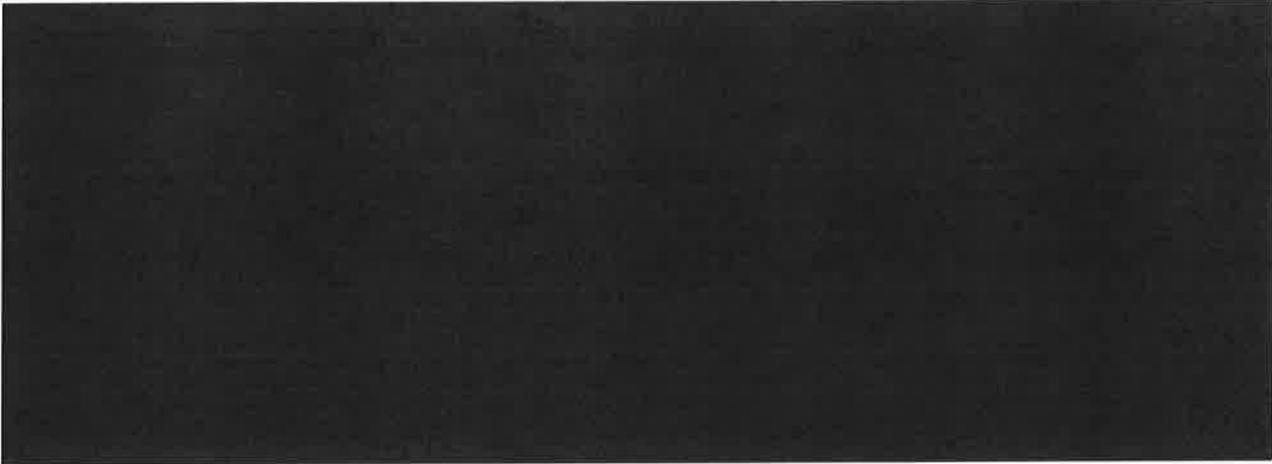
Kind regards

[REDACTED]

[REDACTED]
Associate Director of R&D
[REDACTED]

[REDACTED]

IMPORTANT: This message and any files transmitted with it are confidential and intended solely



2016/34 Kirkham: Confirmation of Capacity & Capability:

Sent: 21 December 2016 16:01
To: Kirkham, Rosie
Cc: Fletcher, Ian; Ethics (RSO) Enquiries;

Dear Mrs Kirkham,

Confirmation of capacity and capability at

Trust Ref :
Chief Investigator : Mrs R Kirkham
Full title : Compassion satisfaction in clinical psychologists working in forensic settings: an interpretative phenomenological analysis.

IRAS: 218436
HRA : 16/HRA/5922

This email confirms that has the capacity and capability to deliver the above study in high and medium secure only

This support is subject to the research team adhering to all statements in the IRAS application. In order to securely protect participant information and comply with Data Protection Act legislation it is vital that any personal identifiable information is held as per IRAS application. Dropbox accounts should never be used to store personal information as they do not provide adequate security and are hosted outside the European Union. Any potential data breach must be reported immediately to the Trust. If you are unsure about using, storing or sharing information please contact the R&D team in the first instance on for advice.

We agree to start this study on 21st December, 2016.

has suggested that the interviews of staff from High Secure Services could be carried out in building which is within the , but outside of the high secure facility.

Please send an email to to confirm the date of your first recruit or if you have any concerns about recruiting your first participant will also contact you regularly to monitor your recruitment

We look forward to working with you to successfully deliver this study.

If you wish to discuss further, please do not hesitate to contact myself or

Kind regards,

[Redacted signature block]

Kind regards

[Redacted signature block]

The NHS Constitution pledge to all patients
"to inform you of research studies in which you may be eligible to participate"

[Redacted line]

.....
This email and any files transmitted with it are confidential and intended solely for the use of the individual or entity to whom they are addressed. If you have received this email in error please notify the system manager.

This footnote also confirms that this email message has been swept for the presence of computer viruses.
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