A service evaluation project to explore the barriers and facilitators to family and carer involvement in low secure forensic services within Leeds and York Partnership Foundation NHS Trust (LYPFT)

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Low Secure Forensic Services

Leeds and York Partnership Foundation NHS Trust

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1 Introduction

1.1 Service Context

      This service evaluation project (SEP) has been commissioned by Leeds and York Partnership Foundation NHS Trust's (LYPFT) low secure forensic service. The service offers inpatient and community support to both males and females over the age of 18 (LYPFT, 2022) who experience serious mental health problems alongside forensic histories. The inpatient service has 37 beds across two sites: The Newsam Centre, Leeds and Clifton House, York, and is the focus of this SEP.

      After reflecting on family and carer (F&C) engagement in the low secure forensic service, the commissioners proposed a SEP which would allow greater evaluation of this aspect of service user (SU) care. Several proposals were taken to the clinical governance meeting where it was agreed that incorporating F&C views would be beneficial to the service as they are lacking within forensic mental health research (Pfammatter et al., 2006; Ridley et al., 2014). The commissioners drew on recently published guidelines to support the rationale for the SEP (British Psychological Society, 2021; Royal College of Psychiatrists, 2021). It was also important to understand if the recent COVID-19 pandemic had impacted F&C involvement in services.

1.2 Literature review/background

      1.2.1 Forensic Services.

      Forensic services in the UK are designed to provide care for individuals experiencing a combination of mental health problems and offending behaviours. Individuals are detained under the Mental Health Act (1983) if their mental health is contributing to them demonstrating high risk behaviour towards others, or themselves (Markham, 2021; Putkonen & Vollm, 2007). Forensic inpatient services in the UK have three levels of security; low, medium and high, as well as community services (Duke et al., 2018). Their aim is to

improve the mental health of individuals whilst reducing their risk of recidivism (Duke et al., 2018). There is a balance to be struck within forensic contexts as there is a duty to work in the least restrictive way possible to enhance recovery (Mental Health Act, 1983) whilst managing the risks associated with poor mental health and offending behaviour (Robinson et al., 2017; Seppänen et al., 2018).

Forensic mental health services have been described as overly restrictive and lacking stimulation as well as limited privacy (Duke et al., 2018). Recommendations suggest that appropriate facilities should be conducive to positive mental health and that individuals are located near to family and other support networks to further nurture and promote recovery (NHS England, 2018; Royal College of Psychiatrists, 2019). However, this is not appropriate for everyone due to complex family dynamics and risk related issues such as victims remaining in the area, or being family members. Bed availability is another influencing factor.

Access to technology is often restricted in forensic mental health services, meaning contact with F&Cs can be limited. During the COVID-19 pandemic, services saw increased flexibility regarding the use of technology due to in person visits being paused. The Care and Quality Commission (CQC) recommended that this flexibility should continue post pandemic (CQC, 2022). Whilst appropriately utilising technology could overcome some barriers to F&C involvement, it should be individually risk assessed and it may not be preferable for all F&Cs (CQC, 2022).

1.2.2 Family and carer involvement.
Widespread benefits of F&C involvement in SU care has been documented (Pharoah et al., 2010), including meeting the social and emotional needs of some F&Cs (Hill & Broady,

2019). Existing guidance emphasises the importance of offering family interventions (DoH, 2002; 2007) for people experiencing psychosis though there is little evidence to suggest that family interventions are routinely being offered in forensic services (Gatherer et al., 2020; Gournay, 2005; Richards et al., 2009). Much of the research focusses on SUs living in the community without forensic backgrounds, thus neglecting the needs of forensic SUs and their F&Cs (Eassom et al., 2014; Pearson & Tsang, 2004). F&Cs of forensic SUs may experience isolation, distress and stigma (Hill & Broady, 2019) which could impact motivation or willingness to be involved in ongoing care. Other barriers may include unsupportive families or families who are victims of the SU's offending. Nevertheless, Ridley et al. (2014) describes the unique insights and knowledge F&Cs hold, such as what was important and enjoyable to the SU before their admission to a forensic hospital (EHRC, 2020), demonstrating how F&C support could contribute to improved mental health for SUs (Pftammer et al., 2006).

NICE guidelines recommend that all healthcare staff should receive training surrounding shared decision making, including how to communicate with families and wider support networks (NICE, 2021). The belief is that F&Cs can support SUs to contribute to discussions about their care and share their views regarding treatment options and interventions. The 'Triangle of Care' model (Worthington et al., 2013) offers a framework to enhance F&C engagement by ensuring all corners of the triangle are actively involved in SU care: SUs, carers, and professionals. It outlines six standards (Worthington et al., 2013):

$\Rightarrow$ Carers are identified as soon as possible and their role clearly defined

$\Rightarrow$ Staff are both aware and trained in carer engagement

$\Rightarrow$ Clear policies in place r.e. confidentiality and information sharing

$\Rightarrow$ Defined carer leads

$\Rightarrow$ Carer introductions to service and staff

$\Rightarrow$ A range of carer support services can be accessed

1.2.3 Barriers and facilitators to family involvement.

Whilst F&C involvement has been effective in general mental health services, it is perceived as being poorly implemented in forensic mental health services (Absalom-Hornby, 2012; Gatherer et al., 2020).

Barriers to F&C involvement include geographical distance between SUs and their family, complex relationships between families and services, and the service's security level (Geelan & Nickford, 1999; Tsang et al., 2002). Robinson et al. (2017) found dual stigma (mental health and offending) was often a specific barrier to F&C involvement, especially for Asian communities. Other factors relate to the relationship between SUs and F&Cs and wider systemic/organisational issues such as staff training and perceived importance of F&C involvement (Smith & Velleman, 2002). Gatherer et al. (2020) describe the enthusiasm from both F&Cs and staff regarding family interventions but also highlight barriers such as F&Cs lacking trust in services and feeling unsupported by systems.

Absalom-Hornby et al. (2011) mention the use of technology as a potential facilitator to F&C involvement which has increased globally as an adaptive response to the COVID-19 pandemic.

1.2.4 Rationale

Existing research lacks F&C perspectives when exploring the care of forensic inpatients, unlike non-forensic services (Eassom et al., 2014). This is despite evidence suggesting that forensic F&Cs are more likely to be exposed to additional stressors, particularly related to offending behaviours (MacInnes & Watson, 2002).

LYPFT has produced a brochure providing a service overview and clear expectations F&Cs can have of staff. A 'carer's charter' outlines the commitments made by the service to enhance collaborative working with F&Cs (LYPFT, 2021). Whilst these initiatives demonstrate good practice regarding F&C involvement, the commissioners were keen to explore this area in more depth, and to embed a F&C perspective.

1.2.5 Aims

The aim of this SEP is to explore the barriers and facilitators to F&C involvement in the low secure forensic service within LYPFT. It also aims to highlight any areas of good practice and opportunities for future development.

2 Method
2.1 Design

This SEP is a qualitative study, using rapid evaluation methods of data collection and analysis. A rapid method has been chosen over more time consuming methods such as Thematic Analysis (TA) or Interpretive Phenomenological Analysis (IPA) due to the time restrictions in which the evaluation needs to be completed (Hamilton, 2013; Hamilton & Finley, 2019). The purpose of the evaluation, to look for themes in the experiences of staff and F&Cs, means that a quantitative design is inappropriate, and that in-depth data analysis is not required. Rapid methods of conducting research have been increasing within healthcare settings due to pressures of using research to influence practice and to inform various policies during times of change, budget cuts (Vindrola-Padros & Vindrola-Padros, 2018) and the impact of COVID-19.

Concerns regarding the quality and validity of rapid research methods add to existing queries surrounding rigor and trustworthiness of qualitative research more generally (Cypress, 2017; Houser, 2013). This evaluation has taken steps to increase the credibility of

data analysis by checking themes with peers and commissioners (Elliot et al., 1999; McNall & Foster-Fishman, 2007). A statement on reflexivity is included to ensure transparency of the researcher's stance (Elliot et al., 1999).

2.2 Participants

The commissioners and assistant psychologists working in each site supported recruitment using a purposive sampling method. A targeted recruitment poster was placed in both sites (see Appendix A) and a recruitment email (see Appendix B) was sent to all staff working in each service (n = 169). A follow up email was also sent to try increase participant numbers. F&Cs who had SU consent to be involved in their care were contacted using details held on CareDirector (online computer system), either email address or mobile phone number (see Appendix C). There were contact details for 22 of the 27 SUs.

Interested individuals made direct contact with the primary researcher via email and all appropriate documentation (see Appendices D & E) was emailed to participants.

A total of six people expressed interest in participating although only five gave consent. Three staff members and two F&Cs participated, representing both sites (Newsam Centre & Clifton House).

2.3 Procedure

Semi-structured interviews were used to collect data. The interview schedule (Appendix F) was developed in collaboration with commissioners to ensure it was fit for purpose and met the needs of the evaluation. A draft was piloted with other trainee clinical psychologists who had experience of working in forensic services. The final version was based on feedback received during this process. The same questions were used for both participant groups (staff and F&Cs) but were used flexibly so as not to lose any rich and detailed content.

Each participant engaged in an interview lasting between 26-49 minutes. Two were conducted over the phone and three were held via Microsoft Teams (MS teams). The primary researcher obtained consent for participation and for all interviews to be audio recorded using an encrypted dictaphone. The interviews conducted via MS teams were transcribed using the transcription feature on MS teams in addition to notes being taken during all interviews. All data was anonymised.

2.4 Ethical considerations

The evaluation was reviewed and approved by the University of Leeds School of Medicine Research Ethics Committee DClinPsy sub-REC (DClinREC 21-013). The head of the low secure forensic service approved the SEP and it was logged with LYPFT's research and development department.

Participants were provided with a comprehensive information sheet (see Appendix D) and were required to provide informed consent prior to engaging in the interviews. Consent was gained via electronic signatures and via an online survey (see Appendix E). Participants were informed of their right to withdraw and were informed of the importance of privacy and confidentiality regarding their own information and information regarding SUs. During the study explanation, the offer of choosing a pseudonym was given to each participant in order to protect anonymity. One person chose a pseudonym, the others were given by the primary researcher.

2.5 Reflective Statement

This evaluation lends itself to pragmatism, an epistemological stance which suggests that knowledge is created based on individual experiences. Patton (2005) explains that pragmatism allows us to focus on understanding real-world issues in a practical way.

Moreover it allows us to understand the connections between knowledge and action in context (Kelly & Cordeiro, 2020).

Following Elliot et al's (1999) recommendations for qualitative research, I will describe my own position within this research in order to reduce researcher bias. I have previously worked in forensic services which may influence what themes I identify from the data. During this service evaluation I found some of the data reinforced my own assumptions and experiences, therefore I have been conscious to appropriately check themes with peers and commissioners.

2.6 Data Analysis

The interviews were analysed using a rapid method which was informed by Braun and Clarke's (2006) six stages of TA (see Table 1).

Stage of thematic analysis as defined by Braun and Clarke (2006)	Description of process for this evaluation
1. Familiarising self with data	Listening to the audio recording, reading through MS teams transcripts and reading own notes made during the interview. A transcript summary table (see Appendix G) captured key information for each interview.

Information from individual transcript summaries was transferred to a matrix summary. |
| 2. Generating initial codes | Individual transcript summaries were actively re-read with the researcher beginning to assign codes using post-it notes. |
| 3. Searching for themes | Using the summary matrix table to begin identifying any recurrent themes.

Sub-themes were grouped into overarching themes. |
4. Reviewing themes	Themes and sub-themes initially reviewed with peers. Primary researcher further reviewed themes. Final review completed with commissioners. A thematic "map" created.
5. Defining and naming themes	Giving clear definitions and names to each theme. Done in collaboration with the commissioners.
6. Producing the report	Collating key quotes from the data and using these as examples of each theme. Relating results back to the literature and consider implications for service delivery and future clinical practice.

Table 1. Description of data analysis stages for this SEP, based on the six stages of TA (Braun & Clarke, 2006).

3 Results

After discussion with commissioners it was agreed that the data would be explored by separating the participants into staff and F&Cs. The overarching themes encompassed the whole data set whereas some subthemes were more present for specific groups (see Table 2).

Four overarching themes were identified for the whole data set:

1. Communication and transparency

2. Leadership

3. Accessibility

4. Relationships

Sub-themes will be discussed in more depth in the following section and a comprehensive table of themes, sub-themes and supporting quotes can be found in Appendix H.

Theme	Subtheme (staff)	Subtheme (F&C)
1. Communication & Transparency	⇒ Information Sharing	⇒ Information Sharing ⇒ Who's who ⇒ Regularity of contact
2. Leadership	⇒ Awareness of opportunities for F&Cs ⇒ Resources ⇒ Training	⇒ Awareness of opportunities for F&Cs
3. Accessibility	⇒ Enhancing connection ⇒ Lost voices ⇒ Safety	⇒ Enhancing connection
4. Relationships	⇒ Family dynamics	⇒ Mental health & risk ⇒ Carer support

Table 2. Table showing the key themes and subthemes for each participant group.

Communication & Transparency

This theme was present for both groups and was regarded as both a barrier and a facilitator to F&C involvement. Subthemes pulled from the data were: *information sharing, who's who,* and *regularity of contact.*

"I just want to know [they're okay]" [Helen, F&C]

Information Sharing

This linked to transparency regarding the rationale for clinical decisions. F&Cs wanted total transparency regarding decision making processes, describing increased worry and anxiety when this did not happen. Staff shared a desire for transparency but spoke about being bound by confidentiality and concerns regarding potential distress for F&Cs.

"I was sending a message every day and getting nothing back". **[Helen, F&C]**

"It's challenging that we can't always share that entire rationale." **[Brenda, staff]**

The staff who were interviewed highlighted the importance of regularly reviewing consent with SUs, demonstrating how this can facilitate later involvement of F&Cs.

"… don't say anything, OK, don't say anything bad … And then eventually like, yeah, I don't mind." **[Paulie, staff]**

Who's who

A key sub-theme often mentioned as a barrier for F&Cs was not fully knowing the teams. F&Cs reported having greater familiarity and involvement with the wider MDT after attending regular ward rounds or Care and Programme Approach (CPA) meetings. Contact

with the MDT facilitated some element of F&C involvement but more direct engagement with ward staff remained a barrier. This resulted in heightened anxiety, confusion and feeling "stuck" as F&Cs were unaware of who to contact, or how to make contact. Staff reported being unaware of whether SUs had F&C contact, or how to make contact with them.

"I mean, you don't know that service you don't know who to contact or how to contact."

[Belinda, F&C]

Regularity of contact

Regularity of contact was another barrier for F&Cs. Transitioning from children's services to adult services was a particular challenge as there was a significant reduction in the regularity of contact F&Cs received. Others described one-way communication with the ward.

"I know his nurse's name … But I have no calls from…" [Belinda, F&C]

Staff described how regular, formal meetings such as CPAs can be a facilitator as they provide a prompt to make contact with F&Cs.

"So then when it comes to CPA's and tribunals, it would be like a prompt for me, like, Oh yeah…I should e-mail or should call… It was like quarterly, I'd get a prompt." [Paulie, staff]

3.1 Leadership

Leadership was a key theme raised predominantly by staff and was further separated into these subthemes: *awareness of opportunities for F&Cs, resources,* and *training.* Staff described having no designated F&C leads despite this being something staff were interested in taking on as part of their existing roles. Some staff who were interviewed

described adequate availability of resource (staffing) which would ensure F&C leads could be embedded into services but this was not consistent feedback across all staff interviews.

Awareness of opportunities for F&Cs

Staff described having limited awareness regarding the range of opportunities for F&Cs to be involved in the service beyond attendance at ward meetings.

"I have no idea. I'll be honest. I don't know." **[Paulie, staff]**

This was also a barrier for F&Cs as they were unaware that they could attend SU meetings.

"I didn't even know at that time that I could ask." **[Helen, F&C]**

Other staff described a range of opportunities that were previously available to F&Cs, from attendance at ward meetings, to attending governance and quality involvement meetings. There had been opportunities to attend open days which had contributed to *"close working relationships"* (Ted, staff) with F&Cs.

"Now seems to be less awareness of how they can impact/influence services." (Ted, staff).

Resources

Staff described having limited time to dedicate to F&C involvement which was exacerbated by reduced staffing during COVID-19.

"I sort of said right, I'll, I'll be carers lead…and then nothing actually happened because…we were just fighting fires at that point." **[Paulie, staff]**

Training

Staff mentioned lack of training was a barrier to F&C engagement. They described uncertainty surrounding how to engage with F&Cs.

"And people not understanding the role of what is required of a family worker." **[Ted,**

staff]

3.2 Accessibility

Within this theme, three sub-themes were present: *enhancing connection, lost voices,* and *safety.*

Enhancing Connection

Enhancing connection was present for staff and F&Cs. Both groups described how the introduction of technology enabled families to either begin involvement with the service or maintain it. F&Cs could virtually attend meetings which was something valued by those living far away.

"So each week … I would join the meeting" **[Helen, F&C]**

Lost Voices

Despite speaking positively about using technology as a way of adapting to COVID-19, not all found it to be an inclusive process and some staff feared that voices were being lost.

"If you're in the corner on a laptop and everyone else is in person, your voice isn't heard."

[Brenda, staff]

The accessibility and reliability of technology also raised concerns.

"They were on a mobile phone and we're struggling with the technology… it felt tricky to

get that level of relationship with the family" [Brenda, staff].

Safety

The safety of the ward was primarily a concern for staff.

"…is it always safe for people's family to be coming onto the ward? Not necessarily."
[Brenda, staff]

F&Cs recognised the need for the ward to be safe before visiting but even then, some experienced accessibility issues as being unable to comfortably accommodate mobility aids.

"… the rooms were small and they're…in my chair very difficult to manoeuvre

around." [Helen, F&C]

3.3 Relationships

A final overarching theme, "relationships" was used to group the following subthemes: *family dynamics, mental health and risk,* and *carer support.*

Family dynamics

Staff regarded this subtheme as a barrier to F&C involvement in the service. This was due to what was described as "strained" relationships or being unaware of the quality of family relationships.

"I don't know if they've necessarily got close family and carers". **[Brenda, staff]**

Others described a lack of exploration regarding "strained" relationships and that this was an area for development, to enhance F&C involvement in the future.

Mental health and risk

This sub-theme linked to the relationship between fluctuating mental health and risk. It was important for the F&Cs interviewed to be aware of risk factors that may contribute to deteriorating mental health which could subsequently increase risk of further offending. Some felt that this has not been adequately explained to them and that this had led to a poor understanding of the SUs needs.

"I must have appeared like I was minimalizing what had happened because my understanding of what was happening very different from what had happened" **[Belinda, F&C]**

Others were aware that some information may not be relayed by staff, especially if mental health had deteriorated but they still wanted reassurance.

"Things aren't going great but [they're] safe" **[Helen, F&C]**

Carer support

F&Cs spoke about experiencing increased levels of stress and anxiety during the admission process. This was exacerbated during COVID-19 and the implementation of necessary restrictions.

"I got to see him for half an hour after a year of not seeing him." **[Belinda, F&C]**

It was mentioned that carer support is not widely, or consistently offered.

"And that is the first time that someone actually cares…But it's been nearly two years. **[Belinda, F&C]**

F&Cs reported feeling unsupported when it came to understanding risk and preparing for post-discharge. They shared a lack of understanding surrounding the criminal justice system, mental health diagnoses, risk and associated behaviours, and uncertainty surrounding recognising risk markers in the future.

4 Discussion
4.1 Main Findings

This SEP shined a spotlight on the experiences of F&Cs across the low secure forensic service and will contribute to the limited existing literature (Eassom et al., 2014). The main findings highlighted key areas of good practice whilst recognising opportunities for further consideration and development.

4.1.1. Facilitators

Key facilitators included having supportive and informative relationships between F&Cs and members of the wider MDT. This enabled F&Cs to feel able to ask questions and raise concerns. It facilitated their involvement in SU care as they were able to attend and contribute to regular MDT meetings either in person or virtually.

The use of technology has provided an opportunity for geographically distant F&Cs to maintain involvement in the care of their loved ones which was recommended by NHS England (2018). Technology was a key facilitator for F&Cs as it simplified their involvement and reduced the distance and cost of travel. Continuing to utilise technology would not only ensure F&Cs can remain involved in SU care but would also meet the recommendation set out by the CQC (2022). This would need to be individually assessed and any clinical decisions made regarding technology should be clearly communicated to F&Cs.

Regularly reviewing consent was regarded as a facilitator by staff and highlighted the fluidity of consent. Giving consent will be impacted by numerous variables including mental

state and the quality of family relationships. These are dynamic variables and thus consent should be regularly reviewed as is outlined by the Royal College of Psychiatrists (2019).

F&C involvement was previously perceived as a strength by those interviewed, describing several diverse opportunities. It is unclear why this is no longer regarded as a strength. COVID-19 may have impacted F&C involvement due to less options for face-to-face interaction and depleted staffing levels during the pandemic. This, in combination with needing to adapt to different ways of working in an ever-changing climate may have resulted in unintentional deprioritisation of F&C involvement. Alternatively, it may reflect the priorities of F&Cs, for example, wanting to focus on the direct care of their loved ones as opposed to influencing clinical practice and service delivery. There is evidence within this SEP that it could be possible to strengthen F&C involvement in the service.

4.1.2. Areas for consideration and development

The positive practice highlighted above was inconsistent across sites. A common barrier represented within the data surrounded communication and transparency. Whilst the need for consent was widely acknowledged and appreciated within the F&C group, there was also a shared sense of increased anxiety and worry when clinical decisions were implemented but not fully explained. Examples given included when SUs had technology removed, for risk related issues, F&Cs were unaware and suddenly had no communication or updates regarding their loved ones. This was exacerbated by not knowing the team or having contact numbers for them. Similarly, staff spoke of not knowing who to contact in relation to F&Cs. This highlights a need to clearly communicate comprehensive service information when SUs are admitted into the low secure services (Worthington et al., 2013). This should include contact details for the SU's care team and how to contact them. This should not just be the MDT but the core nursing team who provide daily care to the SUs.

Another area for consideration is enhancing a sense of leadership surrounding F&C involvement. Staff felt this was currently absent despite a keen interest in engaging in this area of work and was linked to having limited, if any, time to dedicate to this role. Embedding F&C leads in each service would not only mean that the Royal College of Psychiatrists (2019) and NHS England (2018) standards are being met, but some of the other themes mentioned throughout this SEP could also be addressed. A dedicated role could provide an opportunity for a more thorough review of current F&C involvement and could enhance the quality of relationships staff have with F&Cs (Worthington et al., 2013). Whilst some SUs may not consent to F&C involvement, the service should still offer basic information which could support the reduction of anxiety F&Cs have described (Royal College of Psychiatrists, 2019). Similarly, in these situations, services could continue to support F&Cs navigate the complexity of forensic contexts without breaking confidentiality. Enhanced leadership would provide clear direction and support for other staff members who may lack confidence when engaging with F&Cs. This may then negate the need for extra training. However, signing up to the Triangle of Care model means that appropriate training should be offered to staff focussing on carer engagement strategies (Worthington et al., 2013).

Technological adaptations due to COVID-19 have ensured contact with F&Cs could be maintained (NICE, 2021) throughout COVID-19 and beyond. This is particularly welcomed by those who are geographically distant, but it is important to explore the remaining barriers for F&Cs who do have face-to-face contact. The lack of accessible rooms, and limited options for visiting rooms contradicts the standards for forensic mental health services (Royal College of Psychiatrists, 2019) and is a barrier for F&Cs who have further to travel. It can, at times, mean their journeys result in being unable to see their family

member if the ward is assessed as being unsafe. There should be some consideration given about alternative options in these situations.

The final area for consideration is the relationships SUs have with their F&Cs. NHS England (2018) advise that family relationships should be maintained where possible and the results from this SEP suggest that regularly reviewing consent with SUs can create new opportunities for family involvement. This example emphasises the need for staff to not just accept when family relationships are described as "strained". Staff felt that more could be done to nurture such relationships and to support systemically during admission. This would not only provide hope for developing existing relationships but would also provide some insight into life post-discharge. F&Cs reported feeling uncertain about psychiatric diagnoses that had been given to their loved ones and how their mental health influences their risk. F&Cs felt that carer support was not currently offered and that they were navigating the confusing admission process alone which goes against one of the key elements of The Triangle of Care model (Worthington et al., 2013).

4.2 Strengths and Limitations

The small sample size was appropriate for the purpose of the SEP but only captured the experiences of two F&Cs, therefore, the potential for bias should not be ignored. Whilst efforts were made to recruit more participants by repeatedly extending the recruitment deadline, the research is likely to be biased by only gaining views of F&Cs whose contact details were in the system and who have contact with the service, suggesting somewhat positive experiences. A whole pool of potential participants was neglected as recruitment targeted those who had existing consent to be involved in SU care. It would be useful to explore the barriers experienced by F&Cs who do not have consent. Similarly, the staff interviewed were clearly supportive of F&C involvement compared to other staff who may

be disinterested in this aspect of patient care. Further research should aim to capture the views of this staff group in order to understand other, potentially unique barriers.

COVID-19 impacted final participant numbers due to some individuals contracting the virus. It is suggested that an alternative engagement opportunity is offered to F&Cs who were unable to participate in this SEP due to sickness.

Credibility checks were conducted as part of the data analysis which involved checking themes with commissioners and peers prior to the write up of the report. This ensured that the analysis was not biased by the researcher's own world view and prior experiences (Elliot et al., 1999).

Information regarding difference and diversity was not collected as part of this evaluation which may have resulted in overlooking any specific needs or barriers for different populations.

4.3 Dissemination

Results of this SEP were shared in the form of a brief verbal presentation with supporting poster as part of the requirements for the Doctorate in Clinical Psychology at the University of Leeds in October 2022. A full report will be shared with the commissioners and LYPFT for their records with a plan to publish an adapted version of the report in a clinically relevant journal. A further, summarised report will be produced for F&Cs which will be disseminated by the commissioning service.

5 Conclusions and Recommendations

Participants offered positive feedback as well as some clear recommendations to enhance F&C involvement in the services. F&Cs recognised the hard work of staff and any

criticisms were not directed at staff. They reflected frustrations with the wider system and the context in which their loved ones were in. There was also a recognition of the pressure services found themselves in during COVID-19 and beyond. A summary of the recommendations:

⇒ Provide an alternative feedback opportunity sent to all F&Cs to capture those unable to participate due to having COVID.

⇒ Utilise the Triangle of Care assessment framework in Appendix 1 (p.22) of the Guide to Best Practice document (Worthington et al., 2013) to self-assess current F&C engagement.

⇒ Embed a F&C lead at each site who will take responsibility for F&C engagement.

⇒ To develop clear guidelines and expectations regarding the service as well as providing insight into what engagement opportunities are available for F&Cs.

⇒ Review existing documentation. Information regarding the service and contact details, the Mental Health Act, Mental Capacity Act and The Criminal Justice System should be included. F&Cs should have the contact details for key members of the care team if consent has been provided. When consent has not been provided, a clear explanation of what information can be shared should be discussed with both the SU and F&Cs.

⇒ Develop a range of communication methods with F&Cs e.g. leaflets and electronic versions of documents.

⇒ Within the F&C lead role, develop a comprehensive plan for carer support. This may include establishing F&C networking events to develop peer support.

⇒ Regularly review consent with each SU and consider the quality of their relationships with F&Cs. It may be that these can be nurtured over time.

⇒ Continue using technology to facilitate F&C involvement where appropriate.

⇒ When visits are unable to go ahead, consider alternative ways of engagement. This could be utilising alternative rooms or offering some face-to-face time with a staff member.

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Appendix A – Recruitment
Advert

Appendix B - Recruitment Email for staff

Dear Team,

Re: Evaluating family/carer involvement in our service – please help!

Family and carer involvement is highlighted within the standards for forensic mental health services guidance (Royal College of Psychiatrists, 2019) as being part of a person's journey through services. We are keen to speak to both staff and families/carers to explore the barriers and facilitators to family and carer involvement in our low secure services.

I am currently a trainee clinical psychologist at the University of Leeds. I have been asked to interview staff members and families/carers and analyse the themes that arise from these interviews. I hope to conduct these interviews in July/August 2022. **Interviews will last no longer than one hour and can be held at the interviewees' place of work (the Newsam Centre or Clifton House), or can be held via MS teams.**
If you would like to take part, please contact me on the e-mail address below.

Please note that if an appropriate number of participants have displayed interest, recruitment may be paused or stopped.

All the information that you provide will be anonymised and every effort will be made to ensure that individuals cannot be identified.

The research has received ethical approval from the University of Leeds School of Medicine Research Ethics Committee (Approval date: Approval number: **DClinREC 21-013 201485062**).

If you have any questions, please feel free to contact me on umlr@leeds.ac.uk

Best wishes,

Leanne Race
Trainee Clinical Psychologist
Institute of Health Sciences
University of Leeds
School of Medicine
Level 10 Worsley Building
Clarendon Way
Leeds
LS2 9NL
Supervised by Dr David Turgoose

Follow up email reminder:

Dear Team,

I hope you are well. I contacted you a few weeks ago regarding the service evaluation project I am conducting; exploring the barriers and facilitators to family/carer involvement in our forensic services. We are hoping to recruit more colleagues to take part in this, if you can spare 30 minutes to one hour to take part in the interview it would be greatly appreciated. I have attached the initial email below for further details, please don't hesitate to contact me on umlr@leeds.ac.uk for further information or to express your interest.

Thank you very much in advance!

Best wishes,

Leanne Race
Trainee Clinical Psychologist
Institute of Health Sciences
University of Leeds
School of Medicine
Level 10 Worsley Building
Clarendon Way
Leeds
LS2 9NL
Supervised by Dr David Turgoose

Appendix C – Recruitment Email for F&Cs

Dear family member/carer,

Re: Evaluating family/carer involvement in our services – please help!

Family and carer involvement is highlighted within the standards for forensic mental health services guidance (Royal College of Psychiatrists, 2019) as being part of a person's journey through services. We are keen to speak to both staff and families/carers to explore the barriers and facilitators to family and carer involvement in our low secure services.

I am currently a trainee clinical psychologist at the University of Leeds. I have been asked to interview staff members and families/carers and analyse the themes that arise from these interviews. I hope to conduct these interviews in July/August 2022. **Interviews will last no longer than one hour and can be held via MS teams or over the phone.**
If you would like to take part, please contact me on the e-mail address below.

Please note that if an appropriate number of participants have displayed interest, recruitment may be paused or stopped.

All the information that you provide will be anonymised and every effort will be made to ensure that individuals cannot be identified. You will not be asked about any patient information, we are interested in your experiences of being involved with the service.

The research has received ethical approval from the University of Leeds School of Medicine Research Ethics Committee (Approval date: Approval number: **DClinREC 21-013 201485062**).

If you have any questions, please feel free to contact me on umlr@leeds.ac.uk

Best wishes,

Leanne Race
Trainee Clinical Psychologist
Institute of Health Sciences
University of Leeds
School of Medicine
Level 10 Worsley Building
Clarendon Way
Leeds
LS2 9NL
Supervised by Dr David Turgoose

Follow up email reminder:

Dear family member/carer,

I hope you are well. I contacted you a few weeks ago regarding the service evaluation project I am conducting; exploring the barriers and facilitators to family/carer involvement in our forensic services. We are hoping to recruit more family members/carers to take part in this, if you can spare 30 minutes to one hour to take part in the interview it would be greatly appreciated. I have attached the initial email below for further details, please don't hesitate to contact me on umlr@leeds.ac.uk for further information or to express your interest.

Thank you very much in advance!

Best wishes,

Leanne Race
Trainee Clinical Psychologist
Institute of Health Sciences
University of Leeds
School of Medicine
Level 10 Worsley Building
Clarendon Way
Leeds
LS2 9NL
Supervised by Dr David Turgoose

Appendix D – Participant Information Sheet

Participant Information Sheet

A service evaluation project to explore staff and family/carer perceptions of the barriers and facilitators to family and carer involvement in a low secure forensic service.

You are being invited to take part in a service evaluation project. Before you decide if you would like to take part, it is important for you to understand why the evaluation is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the project?

Family and carer involvement is highlighted within the standards for forensic mental health services guidance (Royal College of Psychiatrists, 2019) as being part of a person's journey through services. Involvement can range from receiving information about the service in a way that is accessible, to being involved in regular meetings such as multi-disciplinary meetings where the person's care and treatment pathways are discussed. Other support for families and carers can be signposting offered by the service. There should also be scope for families/carers to be involved in service development opportunities. As such, the low secure forensic services at The Newsam Centre (Leeds) and Clifton House (York) are interested in understanding more about the barriers and facilitators to family and carer involvement as part of developing these services.

The service evaluation will start in July 2022 and aims to be completed by August 2022 with a report being shared in November 2022.

Why have I been chosen?

Members of staff, families and carers from the low secure forensic services at The Newsam Centre and Clifton House have been contacted regarding the service evaluation project. You have been sent this additional information sheet as you have expressed an interest in being involved in the service evaluation project after seeing an advert.

Do I have to take part?

You do not need to take part in this service evaluation project. Any decision you make about taking part is your decision. If you decide not to take part, you do not need to give a reason and there will be no impact for yourself or anyone who is currently accessing low secure services. If you decide that you do want to take part, please keep this information sheet for your records and you will be asked to sign a consent form.

If you change your mind, this is ok, you can withdraw at any point before interviews have taken place. You do not need to give a reason. If you decide that you do not want your data to be used after you have been interviewed, you will have one week to contact the primary researcher. Your data will be removed from the evaluation and will not be included in the results.

What do I have to do?/ What will happen to me if I take part?

If you decide to take part in the service evaluation you will need to sign a consent form. This can be emailed to you, or an electronic link can be sent for you to complete online.

Once you have given your consent, you will be asked to attend an interview with the primary researcher, Leanne. This can be over the phone or online. In certain circumstances there is the possibility of face to face interviews but this would need to be discussed with the primary researcher. Interviews will be held in July and August 2022. The final date for interviews is Friday 12th August 2022.

The interview will last no more than one hour and you will be asked open questions about your experiences of family and carer involvement in low secure services. You will be asked to think about what helps (facilitators) and what makes it difficult (barriers).

All interviews will be recorded using a Dictaphone. Your faces will not be recorded. You will not be asked for any personal information or for any information regarding your relationship to patients.

Your answers will be analysed by the primary researcher using a form of thematic analysis. There are no right or wrong answers, we are interested in your experiences. We understand that no-one will have exactly the same experiences but there may be similar themes which we can learn from.

If you require any adjustments to enable you to take part in this service evaluation project, please contact the primary researcher to discuss these.

What are the possible disadvantages and risks of taking part?

We do not anticipate any disadvantages to taking part in this service evaluation but it may trigger feelings of frustration for some people, particularly when discussing barriers to involvement. Similarly, if participants are sharing negative experiences with the researcher, this may lead to some uncomfortable emotions.

There are processes in place should you feel the need to make a service complaint after taking part in the service evaluation. Further information can be obtained from the primary researcher.

What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will offer further insight into the barriers and facilitators to family and carer involvement in low secure services. It is hoped that it will highlight areas for improvement and will offer recommendations for future service development.

It is also hoped that it will offer families and carers the opportunity to be involved in the development of local low secure services, and to have their voices heard as part of this.

Use, dissemination and storage of research data

This service evaluation project, whilst being commissioned by the low secure services, also forms part of the requirements for the Doctorate in Clinical Psychology. This means that results from this evaluation will be shared with the low secure services (The Newsam Centre and Clifton House) and with the University of Leeds.

The results will be shared in the form of a short presentation which will include background and rationale for the evaluation and the key outcomes. This presentation will be viewed by students and staff involved in the Doctorate in Clinical Psychology at the University of Leeds.

A more comprehensive report will be produced which will be sent to the commissioning service. A simplified version of the report highlighting the key findings will also be sent to the commissioning service which can be used to inform participants of the outcomes and it can also be shared with patient councils and staff groups.

During the final write up, direct quotes may be used to support key findings but these will remain anonymous. There is a possibility that you may recognise one of your own quotes but no one else should be able to identify you in this way.

Will I be recorded, and how will the recorded media be used?

All interviews will be audio recorded. The audio recording of your participation in any interview for this service evaluation will only be used for analysis. Direct quotes may be used from the original audio recording. No one outside the project will be allowed access to the original recordings. The recordings will be kept for a minimum of 3 years and may be used in future research. If you are not happy for this to happen, please do not consent to participate in this evaluation.

What will happen to my personal information?

You will not be asked to share any personal information such date of birth or address. All efforts will be made to ensure that you remain anonymous throughout the evaluation and during any subsequent sharing of outcomes. It cannot be guaranteed that others will not be able to identify you based on what you say. Similarly, no information will be needed regarding service users who are currently accessing low secure services, the evaluation is to capture family and carer perspectives.

For further information regarding participant privacy, please read the **University Research Participant Privacy Notice** Sheet. If you have not received a copy of this, please ask the primary researcher for a copy.

What will happen to the results of the research project?

All the contact information that we collect about you during the course of this evaluation will be kept strictly confidential and will be stored separately from the evaluation data. We will take steps wherever possible to anonymise the evaluation data so that you will not be identified in any reports or publications.

Whilst we make every effort to keep information confidential, there are limits to this. For example, if a participant discloses an intent to hurt themselves, or someone else, then we have a duty of care to share this.

The interviews will be recorded using an encrypted Dictaphone or laptop and the data will then be transferred to a secure area of the University of Leeds OneDrive. No one else will have access to this data.

During analysis, direct quotes may be used as part of the feedback process but no identifiable information will be used. There may be a possibility that you recognise your own quote if it is included in the final results. Results will be shared with the two low secure services mentioned earlier in this document. The results will also be shared with University of Leeds academic staff and students on the DClinPsy. Results will be shared in the form of a short verbal presentation, and a

more comprehensive written report. The commissioning service may wish to publish a more accessible version of the report to share with families and carers.

What type of information will be sought from me and why is the collection of this information relevant for achieving the research project's objectives?

You will be invited to participate in a short interview to gather your views and opinions regarding the barriers and facilitators to family/carer involvement in low secure services. It is important that we ask both staff, and families/carers so we can compare the views. Your views and opinions will be used to help shape the development of the service, particularly with regards to family and carer involvement.

Who is organising/ funding the research?

The University of Leeds. This service evaluation project has been given ethical approval from the Doctorate in Clinical Psychology Research Ethics Committee at the University of Leeds (DClinREC 21-013 201485062).

Contact for further information

Leanne Race (primary researcher)

University of Leeds, Clarendon Way, Leeds, LS2 9LN

umlr@leeds.ac.uk

Dr David Turgoose (research supervisor)

University of Leeds, Clarendon Way, Leeds, LS2 9LN

d.turgoose@leeds.ac.uk

This information sheet is yours to keep. Informed consent will be gathered via an online survey so we will be able to provide you with an electronic copy of your signed consent form using the email address you provide. All electronic consent forms will be kept in a secure area of the University of Leeds OneDrive. Any documents returned via email will also be saved in the secure area of the OneDrive and will be deleted from the primary researcher's emails. Alternatively a copy could be posted out to your home address if you choose to share this. Any hard copies of consent forms should be returned to the recruiting site; either Newsam Centre or Clifton House. They will be kept in a locked office before being collected by the primary researcher. All forms will then be scanned and uploaded to the secure OneDrive. All hard copies will be destroyed.

Thank you for taking the time to read through this information and for considering participating in this service evaluation project.

Appendix E – Participant Consent Form

NHS (Programme in Clinical Psychology)
Leeds and York Partnership
NHS Foundation Trust

UNIVERSITY OF LEEDS

Participant consent form

Consent to take part in: A service evaluation project to explore staff and family/carer perceptions of the barriers and facilitators to family and carer involvement in a low secure forensic service.	Add your initials next to the statement if you agree
I confirm that I have read and understand the information sheet dated [13 June 2022] explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason prior to being interviewed. I am aware I can still withdraw my data up to one week after the interview date and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. **Leanne Race (primary researcher)** University of Leeds, Clarendon Way, Leeds, LS2 9LN umlr@leeds.ac.uk If I decide to withdraw my data, this will be destroyed by the primary researcher.	
I understand that members of the research team may have access to my anonymised responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. I understand that my responses will be kept strictly confidential.	
I understand that the data collected from me may be stored and used in relevant future research in an anonymised form.	
I understand that relevant sections of the data collected during the study, may be looked at by individuals from the University of Leeds or from regulatory authorities where it is relevant to my taking part in this research.	
I agree to take part in the above research project and will inform the lead researcher should my contact details change.	

Name of participant	
Participant's signature	
Date	
Name of lead researcher	Leanne Race
Signature	
Date*	

Appendix F – Interview Schedule

SEP - Barriers and facilitators to family/carer involvement in low secure services

Interviews will be conducted by the primary researcher and will be recorded using an encrypted Dictaphone or through features available on MS teams.

<u>Interview Schedule</u>

1. **Tell me about your experiences of family and carer involvement in the low secure service at Newsam Centre/Clifton House [delete as appropriate].**
   - Tell me about the types of involvement families/carers have in the service.
   - Tell me about any gaps in the service for family/carer involvement.

2. **How do you feel about the current involvement of family and carers in the service?**
   - Tell me about your involvement in the service during COVID.
   - Can you tell me about any changes that have been made to family and carer involvement during COVID.

3. **What influences family and carer involvement in the low secure forensic service?**
   - Are there any barriers?
   - Are there any facilitators?
   - Can you tell me about any recommendations you would like to share with the service?

4. **Is there anything else you feel is important to tell us about your experiences with the service?**

Appendix G – Transcript Summary Template

Question	Domain (neutral domain name)
Tell me about your experiences of family and carer involvement in the low secure service at Newsam Centre/Clifton House.	Opportunities for family/carer involvement in the service.
Tell me about the types of involvement families and carers have in the service	
Tell me about any gaps in the service for family/carer involvement	
How do you feel about the current involvement of family and carers in the service?	Current involvement and impact of COVID.
Tell me about your involvement in the service during COVID-19.	
Can you tell me about any changes that have been made to family/carer involvement during COVID-19?	
What influences family and carer involvement in the low secure forensic service?	Influencing family/carer involvement.
Are there any barriers?	
Are there any facilitators?	
Can you tell me about any recommendations you would like to share with the service?	
Is there anything else you feel is important to tell us about your experiences with the service?	Additional information.

Good Summary

- Brief (no more than 2 pages)
- Organised
- Thorough
- Readable (anyone reading it should get a sense of what the respondent said)
- Useful (provides pointers for what's in the transcript)

Interview & transcript by	Leanne Race
Transcript summary by	Leanne Race
Participant code/child name	
Site	
Interview time	

Opportunities for family/carer involvement in the service.

Current involvement and impact of COVID.

Influencing family/carer involvement.

Additional information.

Potential Recommendations

Important Quotes

Appendix H – Table of themes, subthemes and key quotes

Theme	Subtheme (staff)	Subtheme (F&C)
1. Communication & Transparency	⇒ **Information Sharing** *"We will have certain rationales for why we're doing things and I guess it's challenging that we can't always share that entire rationale."* [int 2] *"One patient we had one who was like, no, don't say anything, OK, don't say anything bad and then it's kind of changed. And then eventually like, yeah, I don't mind. And it kind of gradually changed."* [int 5]	⇒ **Information Sharing** *"So I was sending a message to every day and getting nothing back".* [int 4] ⇒ **Who's who** *"I didn't know who else to speak to."* [int 3] *"Knowing your loved ones, there's nothing that you can do and not knowing how you can support them, you feel a bit stuck. I mean, you don't know what service you don't know who to contact or how to contact."* [int 3] *"I was meeting people I didn't know existed."* [int 3] ⇒ **Regularity of contact** *"I know his nurses name … But I have no calls from her."* [int 3]

		"From being in children's services where like you said you you got regular updates and you knew everything to then then suddenly." [int 4]
2. Leadership	⇒ **Awareness of opportunities for F/C** *"I have no idea. I'll be honest. I don't know."* [int 5] *"I don't think that they realized the influence they can have on a service."* [int 1] *"I suspect we don't communicate to everybody's families or if you want to come to MDT, you can. If you want to come to CPA as you can."* [int 2] ⇒ **Resources** *"And we got senior people who could invest some time in it as well. So it's not like a we can't do it. So we've got the potential."* [int 1] *"I sort of said right, I'll, I'll be carers lead…and then nothing actually happened because really it we were just fighting fires at that point"* [int 5]	⇒ **Awareness of opportunities for F/C** *"I didn't even know at that time that I could ask."* [int 4]

	"And you haven't got time to sit and have a good one to one with every single person on the ward." [int 5]	
	⇒ **Training**	
	"And people not understanding the role of what is required of a family worker or a family bears on carer." [int 1]	
	"…meetings of different people who are engaged with families…You know, things like what problems, what are the benefits and what? What issues have you encountered? … So like, like learning sessions …" [int 1]	
	"I think training is helpful, but not in isolation. You know then it needs it's about culture." [int 2]	
3. Accessibility	⇒ **Enhancing connection** *"It's enabled us to have people attend while being far away from us."* [int 5]	⇒ **Enhancing connection** *"I hate that we're so far away"* [int 4] *"So each week … I would join the meeting"* [int 4]
	⇒ **Lost voices** *"If you're in the corner on a laptop and everyone else is in person,*	

	your voice isn't heard." [int 2] *"They were on a mobile phone and we're struggling with the technology. And sometimes I was just looking at the ceiling and. And so it felt tricky to get that level of relationship with the family that I would have liked to have."* [int 2] ⇒ **Safety** *"The ward is a restrictive environment"* [int 5] *"You know, is it always safe for people's family to be coming onto the ward? Not necessarily."* [int 2]	
4. Relationships	⇒ **Family dynamics** *"Especially when people don't have close links with their family or they've had strained links with their families. Easy to forget about."* [int 5] *"I don't know if they've necessarily got close family and carers".* [int 2]	⇒ **Mental health & risk** *"I must have appeared like I was minimalizing what had happened because my understanding of what was happening very different and what had happened"* [int 3] *"Things aren't going great but [they're] safe"* [int 4]

	"…Moms in hospital with Dad has to take over everything as Dad got time to then attend meetings and then get involved, you know?" [int 5]	⇒ **Carer support** *"One of the most stressful things I've been through."* [int 3] *"I got to see him for half an hour after a year or not seeing him a year."* [int 3] *"And that is the first time that someone actually cares…But it's been nearly two years. It was the first time…"* [int 3]