SHARED-EXPERIENCE GROUPS IN A HIGH-SECURE PSYCHIATRIC HOSPITAL

Hannah Daniels and colleagues describe a study that explored the value and benefit of mutual support in a shared experiential mental health awareness programme.

Abstract
This study explores the benefits of shared-experience groups from a service user’s perspective, in a UK high-secure forensic mental health environment. Shared-experience groups have proved beneficial to treatment outcomes, however little research has investigated this in forensic settings.

A qualitative design was adopted with a sample comprising seven men who had participated in a mental health awareness course. They attended a focus group to share their experiences, which were recorded and anonymised. Thematic and saliency analysis identified three main themes: relating to others; increased understanding of mental health; and hope. These were all judged to be beneficial by participants.

The findings support the use of shared-experience groups in a forensic mental health population.

Keywords
Forensic, high-secure settings, mental health, personality disorders, shared-experience groups

IN THE UK, service users who present a high risk of harm to the general public and have been deemed either unmanageable in settings of lesser security or inappropriately placed in the prison system are treated in high-security psychiatric hospitals. Most of the patients in this category have a clinical diagnosis of mental illness, and many also present with significant features of personality disorder. The main aim of mental health services in a high-secure environment is to provide a comprehensive care pathway that enables service users to recover from mental health difficulties while reducing the risk of harm to themselves and others.

Psychiatric patients in high-security hospitals are legally detained under the Mental Health Act (2007) and present with severe and complex mental health disorders (Harty et al 2004). Psychological intervention is vital to ensure that treatment remains centred on the needs of the target population and to maintain and increase treatment effectiveness. The combination of severe mental illness, high levels of risk and the setting can all affect the quality of engagement and progress in treatment, which is why the involvement of clients in this process is crucial to ensuring that provision meets the needs of patients. Obtaining feedback from these service users is particularly valuable, because participants offer a unique insight into a niche mental health population group.

Mutual support groups
The mental health awareness group (MHAG) is offered to service users early on in the treatment pathway. A poor understanding of mental health has been associated with a range of negative outcomes, including an increase in stigma and...
a reduction in help-seeking behaviours (Jorm 2000, Lauber et al 2005). The MHAG programme values a shared-experience approach to learning and offers a mutually supportive environment to communicate experiences. The 16-week course aims to highlight a range of topics related to issues linked with mental illness and the achievement of a healthy mental state. The group is available to all service users in the mental health directorate. It consists of ten individuals per group and is managed by, on average, three staff at each session.

The programme is delivered in a group setting to ensure that participants can benefit from the shared-experience approach.

The main aims of the programme are to:

- Develop an awareness of a range of topics related to mental health.
- Increase understanding of issues individuals may face while living with a mental health problem.
- Promote the sharing of experiences and learning from other participants.
- Encourage reflection on individual experiences.
- Mutual support or peer support groups take place in a range of mental health settings and vary in formality and structure (Bradstreet 2006). They all share a common theme of people coming together to share experiences, also with the aim of supporting each other (Faulkner and Bassett 2012). Such peer support is a process of giving and receiving help and is grounded on the principles of respect, shared responsibility and a mutual understanding of what is supportive (Mead et al 2001). In 2010 their value was further recognised and authors then and later suggested that they should be given serious consideration for improving the delivery of mental health services (Basset et al 2010, Pratt et al 2013).

The literature indicates that shared-experience or mutual-support groups in non-forensic mental health settings are associated with a number of positive outcomes (Kyrrouz et al 2002, Conway 2004). A review of these publications highlights the benefits of mutual support groups, including a significant reduction in hospital readmissions and a general decrease in psychiatric symptoms. Peer support has been shown to benefit service users with the following: a shared identity; greater self-confidence; development and sharing of skills; improved mental health and wellbeing; information and signposting; and challenging stigma and discrimination (Faulkner and Bassett 2012). Yalom and Leszcz (2005) described the group as a ‘social microcosm’ and related the potential for a group to stimulate behaviour change directly to the presence of therapeutic factors of attending a group. The sense of belonging to a cohesive group was cited as essential for other therapeutic factors to operate.

In forensic mental health populations there are limited opportunities for affective sharing and acceptance in relationships, due to the restrictive environment and the nature of their offences. Therefore, shared-experience groups in these circumstances are valuable in offering members the therapeutic benefits of interpersonal sharing. At present, research evaluating the benefits of shared-experience groups in forensic mental health settings is sparse, and it is important that this is addressed. This study aims to evaluate service users’ experiences of such a group.

To do this, information had to be obtained from the patients and they needed to be included in planning and development (Trait and Lester 2005). The Care Quality Commission (2009) clearly states that service user involvement is an essential requirement across all NHS trusts, meaning that clients should be provided with the opportunity to express their opinions and experiences. Even though the importance of service user participation has been acknowledged in the literature, this is lacking in forensic mental health settings (Faulkner and Morris 2003, Stewart et al 2012).

The aims of this study were to answer the following questions.

- What do service users in a high-secure hospital value in shared-experience groups?
- From a service user’s perspective, do shared-experience groups improve understanding and acceptance of mental health difficulties in a high-secure hospital?
- Does sharing experiences support the aims of the MHAG?

**Method**

A qualitative design was used and a focus group was planned and conducted to gather detailed data of service users’ experiences of the MHAG, including their attitudes and personal reflections.

The setting was the largest high-security psychiatric hospital in the UK, which offers assessment and treatment for individuals with mental disorder and comorbid personality difficulties that require a high-security environment. The hospital is structured as follows: mental health, national learning disability, personality disorder, dangerous and severe personality disorder, national women’s services and national deaf services. This evaluation was conducted in the mental
health directorate, the largest in the hospital, holding 126 male patients, and the focus group was completed in August 2013.

Recruitment Service users were selected from a sample of 63 male, high-secure forensic mental health service users who had completed the MHAG between June 2008 and July 2013. They were invited in writing to attend a focus group, having been informed that this would be an opportunity to share their views and experiences through the MHAG. An information sheet outlined the evaluation and explained their rights to confidentiality and to withdraw from the study, with the contact details of researchers in the event of any distress experienced. Consent forms were provided and people were asked to complete and return these to the researchers if they wished to participate.

Ethical approval was obtained from the research management and governance department before conducting the evaluation. Consent was obtained from the responsible clinician as well as from the individual before engaging with the focus group. All data collected were anonymised and stored on a password-protected computer or kept in a locked filing cabinet.

Participants Of the sample of 63, 15 had been either transferred or discharged out of the hospital, two did not complete the MHAG programme, and one was deemed to be unfit to approach because his mental health had deteriorated. Therefore 45 clients were approached to take part in the focus group; 14 of these completed consent forms and agreed to attend, and seven attended the focus group – no reasons were provided by service users who did not attend the focus group. Before the session the evaluation was explained again and participants were debriefed at the end.

The mean age of participants was 32 years (ages ranged between 23 and 51 years). The mean length of time that they had spent in hospital was five years and six months. Most of them were detained under a section 37/41 and had a diagnosis of either schizophrenia or paranoid schizophrenia (Table 1, page 18).

The focus group undertook a detailed discussion of experiences with the MHAG. Puchta and Potter (2004) outlined relevant basic principles to ensure success: showing genuine interest; adopting an appropriate level of moderation; and being prepared to listen to views you may not agree with. These guidelines were followed to encourage the expression of honest and individual opinions, and to ensure that responses participants altered so that they would be more ‘socially desirable’, were kept to a minimum. The focus group structure was based on the five-stage model outlined by Cronin (2008) and included: introduction; opening circle; introductory questions; key questions; and ending questions. The session was conducted in a private therapy room by two researchers, and lasted 60 to 70 minutes. Following answers to the five key open-ended questions, researchers prompted appropriately to glean more in-depth information.

Data analysis Thematic analysis (Braun and Clarke 2006) and saliency analysis (Buetow 2010) were used to analyse the data, as they were deemed the most appropriate methods of analysing and interpreting the data so that important patterns and themes could be identified. Thematic analysis is not tied to any theoretical framework and can therefore be used flexibly. Saliency analysis enabled themes that were not common but were judged important to the aims of the study to be considered.

The audio recordings from the focus groups were manually transcribed and this was checked back against the recordings for accuracy. Initially, researchers familiarised themselves with the orthographic transcript, noting any preliminary interesting ideas. Throughout the data analysis, researchers continuously moved back and forth through the data set to ensure the entire data set was reviewed. Coding was completed manually, systematically organising the data into meaningful groups. Once coding was completed, overarching themes were identified, considering the relationship between codes. This was a refining process and researchers regularly met to review the identified themes until agreement was reached on the themes and sub-themes. Finally, each theme was defined with a name that aimed to reflect the essence of what each theme captured.

Results The following section outlines the three overarching themes and the sub-themes derived from the data via thematic and saliency analysis. Themes varied in frequency and saliency, as noted below.

Theme 1: relating to others The theme of relating to others was highly salient and appeared frequently throughout the focus group, and is therefore presented first. The majority of participants emphasised the importance of relating to other group members, making this the most common
theme. They discussed the value of this in improving their learning and sharing their experiences. Two sub-themes emerged.

**Sub-theme: mutual support** The concept of supporting each other featured frequently. Group members reported feeling less isolated after relating to each other’s experiences of mental health difficulties.

‘It was good to talk to each other about what you’ve been through and it makes you feel not as alone’ (service user (SU) 1).

‘You don’t feel as if you are alone as much when you hear other people’s experiences because you can kinda relate to some of the symptoms’ (SU 7).

‘When you hear voices it is a scary thing and before you come into the group, you think it has only happened to you, but you see other people sharing the same problem as well … it makes it better. It’s not just me’ (SU5).

**Sub-theme: learning from each other** Participants described having an advantage over the mental health professionals present, who might not share the same experiences. The researchers interpreted that this was a powerful element of the MHAG.

‘You can read about it in books, but I found out more from us [referring to the group]’ (SU3).

‘When we talk about our experiences, there are stories involved and you retain a lot more’ (SU3).

‘Well, if you hear it from another person [in the group], something similar might have happened to me’ (SU4).

**Theme 2: increased understanding of mental health** Theme two also recurred frequently, but researchers interpreted it as less salient in relation to the initial aims of evaluating the

<table>
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<tr>
<th>Category</th>
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<tbody>
<tr>
<td>Ethnicity</td>
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<tr>
<td>Asian</td>
<td>1 (14.3%)</td>
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<tr>
<td>Other Asian</td>
<td>1 (14.3%)</td>
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<tr>
<td>Black</td>
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<td>Caribbean</td>
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<td>White</td>
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<tr>
<td>British</td>
<td>4 (57.1%)</td>
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<tr>
<td>Irish</td>
<td>0 (0%)</td>
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<tr>
<td>Mental Health Act (1983) Section</td>
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<tr>
<td>Section 3 Admission for Treatment</td>
<td>0 (0%)</td>
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<tr>
<td>Section 37/41 Hospital Order with Restrictions</td>
<td>4 (57.1%)</td>
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<tr>
<td>Section 38 Interim Hospital Order</td>
<td>1 (14.3%)</td>
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<tr>
<td>Section 47/49 Home Office Transfer</td>
<td>2 (28.6%)</td>
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<tr>
<td>Index offence</td>
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<tr>
<td>Murder</td>
<td>3 (42.9%)</td>
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<tr>
<td>Attempted murder</td>
<td>1 (14.3%)</td>
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<tr>
<td>Manslaughter</td>
<td>2 (28.6%)</td>
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<tr>
<td>Attempted robbery and possession of a firearm</td>
<td>1 (14.3%)</td>
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<tr>
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<tr>
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<td>3 (42.9%)</td>
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<td>Other (psychotic illnesses)</td>
<td>1 (14.3%)</td>
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importance of shared experiences. Participants described that they had improved their understanding of general mental health issues, referring to particularly helpful topics that were covered in the MHAG. Some reported that they were able to apply their knowledge to their own personal circumstances.

‘I have learned a few things: what causes schizophrenia … early warning signs … how to deal with it in the right way’ (SU5).

‘When I first came here … I didn’t know much about mental illness and then I started the MHAG and I learned a lot from it’ (SU6).

‘It helped me to learn more about stress and depression and what can lead to a mental breakdown’ (SU1).

Sub-theme: personal reflection Some participants reported that the group had helped them gain more clarity about their mental health difficulties and develop a level of acceptance and realisation.

‘It just made me realise the stuff I was going through, it helped me to come to terms with it and accept it’ (SU1).

‘When you’re becoming ill, its loads of different stressors and it all builds up … learning about that stuff, it helped me to realise what was wrong’ (SU3).

Theme 3: hope Although theme 3 was not the most frequent theme identified, it was deemed highly salient when considering the therapeutic benefits of hope (Yalom and Leszcz 2005) and the difficulties of encouraging hope and optimism in a forensic mental health setting. Participants described how the MHAG had increased their sense of optimism, helping them to look beyond the here and now.

Sub-theme: increased coping responders referred to their improved ability to cope with their mental health difficulties, some specifically referring to their symptoms.

‘It helped me to deal with voices … like stress and ways to cope with … I know more ways to cope’ (SU3).

‘I notice things straight away, like early warning signs and I know what to do about it and get it sorted straight away. It will make sure I don’t relapse’ (SU5).

Sub-theme: hope for recovery Individuals described feeling more hopeful about their own futures and recovery following the MHAG. Researchers interpreted that the MHAG was motivational and supported patients with other treatment.

‘The group gives you some hope’ (SU5).

‘When you do the group and you understand more and find out more, you feel like you have another chance to move on, and that’s a good thing’ (SU).

Discussion
This article outlines the qualitative findings of a focus group that explored the value and benefits of a shared-experience group in a challenging environment among a population with complex mental health needs. The findings suggest that the shared-experience element of the MHAG benefits participants and supports them in meeting the main aims of the group. As previously outlined, shared-experience groups have been linked with several positive outcomes, notably an improved understanding of mental illness. Most of the service users reported increasing their knowledge of general mental health issues.

The value of sharing experiences of mental health difficulties with others was clearly demonstrated in promoting individuals’ realisation and acceptance of mental health difficulties. As in previous research, some participants discussed elements of personal reflection, describing that the group had helped them to conceptualise their experiences and apply their knowledge to themselves and others (Munn-Giddings and Borkman 2005). Fitting with this, people also described how by sharing experiences they were able to see these in a broader context (Munn-Giddings and Borkman 2005) and how they valued achieving a level of acceptance that enabled them to come to terms with and better understand their experiences, all of which are important aims of shared-experience groups (Kilkku et al 2003).

Early group cohesiveness with non-judgemental acceptance promoted a sense of belonging, universality (having problems similar to others, not alone) and altruism (wishing to help and support others), so the therapeutic aspects of therapy groups were effective in this forensic mental health population. Research has shown that benefits may persist even years later, suggesting that the positive outcomes of the MHAG are not only short-term.

Mutual support is a valuable element of shared-experience groups and is crucial to personal development. Helping each other and contributing to the care of others is linked with an increased sense of empowerment and
responsibility over one’s own mental health (Corrigan 2002, Segal and Silverman 2002). The theme of mutual support was a focal point throughout discussions in the focus group. Participants emphasised the value of listening to others’ experiences and finding commonalities. It is apparent that this learning experience was unique and distinct from the psycho-educational approach.

Yalom and Leszcz (2005) highlighted the importance of achievement and maintenance of realistic hope in successful therapy. It is essential to aim for these in psychological interventions, particularly in the controlling and pervasive culture of a secure setting that creates challenges when trying to provide effective rehabilitation and recovery (Mason and Adler 2012). Clients reported that attending the MHAG did help them to feel more hopeful about their future. Previous research suggests that hope and optimism are not commonly experienced in high-secure care (Mason and Adler 2012).

Strengths and limitations
There are strengths and limitations that should be recognised when considering the conclusions of this study. The moderators of the focus group were also involved in the data analysis and so had prior knowledge of the aims of the session. Therefore, in an effort to represent the entire data set, instances that contradicted themes were actively sought (Yardley 2008). To ensure rigour, a recommended structure was used (Morse et al 2002) and, to guarantee methodological coherence, researchers maintained congruence between the aims and methodology. Researchers also kept detailed documents of the analysis process to ensure re-test reliability.

The study follows the social constructivist tradition that knowledge is largely generated within a person’s contextual experience. The limited sample consisted of seven men who best represented the research topic. Researchers who conducted the focus group had previously worked with some of the participants and had already established a therapeutic relationship, and it is possible that this may have contributed to biased responses. Equally, however, it may have helped responders to feel more at ease and to be honest and open.

The evaluation used a retrospective design and patients who attended the focus group had completed the MHAG at different times (October 2009 to March 2013). It is possible that memory fatigue may have affected the reliability of their contributions, and subsequent learning may have done the same. However, the group maintained a clear structure focusing attention on experiences from the MHAG.

Although the focus group was managed following guidance outlined by Puchta and Potter (2004) and Cronin (2008), it was impossible to eliminate all ‘social desirability’ in people’s responses. Research has shown that the challenge posed by people making their responses ‘socially desirable’ is particularly prevalent among offender populations (Andrews and Meyer 2003). The present authors tried to minimise this by creating a relaxed environment and maintaining a non-judgemental attitude throughout the session. In addition, it was reiterated to participants that the data would not be used for any purpose other than evaluating the MHAG group, reassuring them that there were no right or wrong answers.

One of the main strengths of this study was the in-depth exploration of the views of a forensic mental health population in a high-secure environment. As outlined in the introduction, it is clear that there is a considerable gap in the literature with regard to the study of such a unique group. This research affords a valuable opportunity to access the views of such complex service users, and contributes to the literature and to the progression of service delivery, particular in high-secure hospitals and wider mental health provision.

Future research could explore whether shared-experience groups are more beneficial to service users than psycho-educational groups or whether a combined approach is more favourable. It would also be useful to identify whether the benefits of shared-experience groups differ across mental health client populations, for example, in the community or in low- or medium-secure settings. This would ensure that mental health awareness groups are delivered in the most advantageous way.

This evaluation captures qualitative data; to continue this exploration and increase robustness, quantitative research may be desirable, thereby allowing other outcomes to be measured. These could include the effect of a shared-experience group on risk reduction, length of stay or frequency of re-offending. In the current economic climate of the NHS, group interventions are becoming increasingly valuable, particularly when considering their cost-effectiveness in addition to the continuing developing evidence base.
Conclusion
This study supports the inclusion of the MHAG in the high-safe treatment pathway. In particular, the shared-experience modality was found to benefit clients. This is not to claim that shared-experience groups should replace other psychological interventions, but they do offer unique therapeutic benefits for service users. It might be that shared-experience and mutual-support groups could be used more broadly in forensic mental health services, enabling more patients to experience these benefits and progress towards recovery. It is therefore recommended that forensic mental health services consider integrating shared-experience or mutual-support groups to complement and enhance existing interventions, as part of service-users’ recovery pathways.

Implications for practice
- The severity of mental illness, levels of risk and the forensic setting affect the engagement and progress of service users in treatment and interpersonal relationships.
- Mental health awareness groups are effective in increasing understanding of mental health issues, sharing of experiences and learning from other participants.
- Early group cohesiveness with non-judgemental acceptance promotes a sense of belonging, mutual support and hope.
- More research and wider use of shared-experience groups are needed.

References


