Mentoring within a high secure forensic inpatient service: service user perspectives on developing a mentor service

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Introduction

Historically, both offender resettlement and psychosocial rehabilitation have been the responsibility of professionals within that arena, with the offender or patient as the passive recipient of an intervention (Clark, 1981; Thornicroft & Tansella, 2005). Peer support programmes do exist in penal and other settings, for example in the form of the Listeners scheme in the prison service, but have undergone little evaluation. This scarcity is particularly evident in the context of forensic mental health settings, despite research which supports the benefits of peer support for service users with a severe mental illness and for offenders (Bouchard, Montreuil & Gros, 2010; Coatsworth-Puspokey, Forchuk & Ward-Griffin, 2008).

There could be several reasons for this, including matters of responsibility and confidentiality related to the challenge of formalising a peer support programme delivered by those who have a history of harmful interpersonal behaviours and attachment difficulties. Furthermore, the meaning of “mentoring” as it is practiced in other settings may be different for a forensic mental health setting, which is characterised by clear boundaries in both environment and social roles. There is therefore a value in hearing the perspectives of those with experience in this distinct setting. The aim of this audit was an exploration of service users’ perspectives on the concept of “mentoring” and the implications of this “expert by experience” view for establishing a formal mentor service in a forensic mental health setting, including benefits, risks and support needs for mentors.

Method

Design

This qualitative study adopted a focus group design and semi-structured interview method.

Participants

Seventeen male service users from a high secure hospital participated in the study. Three focus groups were conducted in the course of a clinical service audit. The numbers of participants in each group were 9 (FG1), 5 (FG2) and 3 (FG3) respectively for organisational reasons.

Procedure

A maximum variation sampling procedure was applied to include service users at all stages of the care pathway (admission, high dependency and assertive rehabilitation). Each group was audiorecorded, and duration varied between 45 minutes and 1.5 hours with a scheduled break in between. The role of the moderators was to facilitate the discussion with a basic topic guide used only to prompt participants on key issues. Audio recordings were transcribed verbatim.

Analysis

Focus group transcripts were analysed using the six steps for Thematic Analysis outlined by Braun and Clarke (2006), employed in combination with a critical realist framework. Coding aimed to be inductive, reflecting the participants’ understanding rather than prior theoretical frameworks on mentoring. The social context was considered as a mediating factor in how mentoring was constructed.

In order to triangulate the analytic process, one participant from each focus group was presented with a summary of themes and responses to this were incorporated into the analysis.

Results

“You don’t tell them ‘yeah, go and get another girlfriend’ or ‘go and do this and go and do that’, but you draw them out and… and... then through doing that, through talking about it, they heal themselves.”

“So what you’ve got to remember is that some people are really unstable and then maybe they need a bit more understanding because obviously, you’re the professionals, but we’ve had the experiences where someone might have hallucinated before, someone else might have heard voices before.”

“And I can’t always help myself and stuff like... but I feel really good when it helps somebody that a person need [inaudible] to me.”

Figure 1. Thematic Map. This illustrates both superordinate themes (in the middle of each cluster) and subordinate components of each theme.

Discussion

Implications

Previous literature has identified adjustment needs and emotional components of peer support relationships. These areas likewise came up in the focus groups. Mentoring relationships exist along two continua: intimacy and formality (Haggard, Dougherty, Turban & Wilbanks, 2010). In this study, the two were constructed as mutually exclusive by some participants. Assessment and consequences within the care system could make relating unsafe, but at the same time, there was concern about establishing a safe mentor role separate from these structures. Feeling secure and positive relationships have been identified by service users as an important aspect in both ward atmosphere and recovery (Brunt & Rask, 2007; Mezey, Kavuma, Turton, Demetriou & Wright, 2010). Locating a mentor between the existent roles of service user and staff while meeting these safety needs was difficult. The emphasis on a mentor’s personal skills suggests that extensive training and support would be necessary.

Limitations

Focus group designs tend to favour dominant voices, which can then become represented as a group consensus. Having smaller, evenly sized groups would have been preferable. Nevertheless, this analysis attempted to reflect different perspectives as much as possible.

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