

Understanding therapeutic climate in intellectual disability secure services: a thematic analysis of service user perspectives

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Abstract

Purpose – *The purpose of this paper is to better understand how inpatients with Intellectual Disabilities (ID) make sense of the therapeutic climate in their secure units, particularly in terms of therapeutic hold, patient cohesion and safety.*

Design/methodology/approach – *This study uses Thematic Analysis to analyse the qualitative comments collected using the Intellectual and Developmental Disabilities adaptation of the Essen Climate Evaluation Schema (EssenCES-IDD) in Medium and Low Secure services. Three years of data collected as part of routine clinical care were retrospectively analysed from detained patients in ID secure services.*

Findings – *Under the three superordinate themes of Therapeutic Hold, Patient Cohesion and Experienced Safety, relational consistency emerged as a unifying mechanism underpinning positive experiences of care. When staff were experienced as familiar, emotionally available and reliable, participants reported greater therapeutic engagement, improved peer relationships and enhanced feelings of safety.*

Originality/value – *This study contributes to a limited evidence base exploring ward climate from the perspective of patients with ID in secure settings. By analysing the qualitative data generated by the EssenCES-IDD, it provides novel insight into how safety is subjectively experienced within these environments.*

Keywords Intellectual disabilities, Climate evaluation, Secure services, Inpatient, Forensic, EssenCES

Paper type Research paper

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Introduction

In the UK, secure services provide healthcare treatment aimed at risk management and reduction in cases where custodial disposals are required, but prison is deemed unsuitable for the individual. This includes secure services for people with Intellectual Disabilities (ID) whose presentation requires ongoing detention and cannot be safely managed in the community. Individuals within secure services are predominantly detained under Sections of the Mental Health Act, McNally *et al.*, 2007 (1983/2007), most commonly Criminal Sections of the Act, due to their ongoing risk of offending or risk behaviour.

In recent years, awareness has grown regarding the care of people with ID within such services, particularly following the Transforming Care strategy, which aimed to improve treatment and reduce the length of stay in such settings, and latterly the Assuring Transformation monitoring system. Despite these developments, limited research has explored the perspectives of people with ID and the staff who support them, especially concerning their experiences of the units in which they reside and the social climates they inhabit. Importantly, people with ID require measures that are appropriately adapted to their cognitive abilities to ensure their views on therapeutic climate are accurately captured.

There remains a notable gap in research examining how people with ID within forensic inpatient settings experience the environments in which they live. Existing studies have

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tended to focus on related but distinct areas. For example, [Brown and Beail \(2009\)](#) explored experiences of self-harm in secure services, identifying themes centred on interpersonal dynamics, emotional experiences and the management of self-harm. [McNally et al. \(2007\)](#) investigated experiences of detention under the Mental Health Act, with participants frequently describing hospitalisation as a negative experience that adversely affected self-perception, emotional well-being and family relationships. More recent studies have examined experiences of specific interventions or conceptualisations of secure care. These include [Rose et al. \(2015\)](#) work with men with mild ID detained in secure hospitals following deliberate fire-setting; [Dhaliwal's \(2017\)](#) investigation of engagement in Cognitive Enhancement Thinking Skills programmes; and [Williams et al. \(2017\)](#) exploration of how women with ID understand the concept of “home” within secure care, highlighting their mixed perceptions of hospital as both helpful and undesirable.

The concept of ward atmosphere (also referred to as social, emotional and/or therapeutic climate) was devised by [Moos and Houts \(1968\)](#) and has been the focus of numerous studies. [Sommerstad et al. \(2021\)](#) summarise core components of ward atmosphere identified in the literature as involving containment, support, structure, involvement and validation. To explore this in relation to the experiences of adults with ID the authors conducted interviews with ten adults with comorbid mental health difficulties and ID within inpatient wards to explore patient understanding of ward atmosphere. Data were analysed using content analysis and demonstrated that patients' experiences of their relationships with ward staff were central aspects to therapeutic environments. Feeling safe, contained and validated were also cited as other important aspects. However, this research was not conducted within secure services.

[Melvin et al. \(2022\)](#) completed a systematic review of inpatient psychiatric care for people with ID and/or Autism, specifically focusing on effectiveness, patient safety and experience. This research reviewed 106 studies of which 25 were conducted within secure services. Whilst this review did not focus specifically on people's understandings of ward climate, it did highlight evidence of improvements in mental health, social functioning behaviour and forensic risk through hospital admission and found that factors such as length of admission, levels of seclusion and physical intervention, challenging environments, staff support and relationships, being away from home, and family contact were important aspects of therapeutic environments and care.

However, to specifically examine the therapeutic climate and everyday environment in which service users, and the staff who work alongside them, live and work a number of researchers have sought to develop specific tools. Indeed, a range of tools is available to assess therapeutic climate. Some of these include The Good Milieu Index (GMI) ([Friis, 1986](#)); the Ward Atmosphere Scale (WAS) ([Moos, 1987](#)); the Group Climate Questionnaire (GCQ) ([MacKenzie et al., 1987](#)); the Correctional Institutions Environment Scale (CIES), ([Moos, 1987](#)), the Social Climate Scale (SCS) ([Moos, 1974](#)); and the Forensic Inpatient Quality of Life Questionnaire (FQLQ) ([Vorstenbosch et al., 2014](#)).

One widely used measure is the Essen Climate Evaluation Schema (EssenCES; [Schalast et al., 2008](#); [Schalast and Tonkin, 2016](#)). This is a 17-item questionnaire assessing three domains:

1. Therapeutic Hold;
2. Patients' Cohesion and Mutual Support; and
3. Experienced Safety.

Although originally designed to produce quantitative data, it is routinely used in secure settings to inform ward-level improvements for both patients and staff.

This tool has previously been utilised with individuals with ID in secure services, however, it has been identified that the tool required some adaptation to be effectively accessible to such populations. (e.g. [Chester et al., 2015](#)).

More recently, the EssenCES has been adapted for individuals with Intellectual and Developmental Disabilities (EssenCES-IDD; [Bell et al., 2018](#)). During validation trials conducted by [Barker et al. \(2020\)](#), the authors simplified the language of the tool and added picture supplements to support comprehension alongside the opportunity to provide qualitative comments. In this study it was concluded that the modified scale preserves the original three-factor structure of the EssenCES and shows good factor validity. Despite modification, there remain questions about whether subscales like Cohesion or Therapeutic Hold measure the same constructs in ID populations as in non-ID groups as people with ID may interpret questions differently or have difficulty with abstract items, which may impact validity and reliability.

Recent further work by [Morris \(2025\)](#) has explored the predictive validity of this tool within ID secure services establishing a relationship between number of incidents and Experienced Safety in Medium Secure units. In this study the incidents were categorised by “actual or attempted” absconding, violence (threatened violence), property damage, allegations, self-harm, possession of contraband and disruptive behaviour.

Aims of the current study

Although the EssenCES-IDD has been applied in forensic inpatient ID settings, research to date has focused exclusively on its quantitative outputs. Building on existing research, the current study will explore the qualitative comments generated by the adapted tool.

The secure service in the current study consists of Medium and Low Secure facilities for adults with ID and Autism. Within this service the EssenCES-IDD has been used for three years (Between June 2022 and June 2025) to evaluate and assess the therapeutic climate on the wards as part of routine clinical practice. This data is then used in an iterative manner to improve the quality of care and living environments.

The present study therefore aims to use thematic analysis (TA) to analyse the anonymous qualitative data pre-collected from patients' responses, to gain further insight into how patients with ID construct their understanding of the three underlying domains of Therapeutic Hold, Patient Cohesion and Experienced Safety. This will contribute to a richer understanding of how individuals with ID interpret key components of forensic social climate.

The research question is therefore:

RQ. How do inpatients with Intellectual Disabilities make sense of the therapeutic climate in their secure units, particularly in terms of therapeutic hold, patient cohesion and safety?

Methods

Participants

In the current service, the EssenCES-IDD has been administered as part of routine clinical care every three months since June 2022 to June 2025 to monitor therapeutic climate and support quality improvement.

The service comprises of two units, one male Medium Secure Unit of 15 beds and one male Low Secure Unit of 15 beds. Participants were therefore inpatients in these units detained under Section of the Mental Health Act (3, 37, 37/41, 47/49, 38). Service users are all assessed as having a diagnosis of ID and having either violent, sexual or fire-setting offences. All patients resident on the units at the time of administration were offered the opportunity to complete the questionnaire, either independently or supported by the Assistant Psychologist collecting data, if literacy support was required.

Participants were eligible to complete the measure if they met the following criteria:

Inclusion:

- must be deemed to have capacity to consent to complete the assessment;
- a mild ID diagnosis (full scale IQ between 50 and 70);
- English fluency; and
- aged between 18 and 65 years.

Exclusion:

- not having capacity as decided by their Responsible Clinician and MDT;
- moderate to profound ID diagnosis (full scale IQ below 50);
- non-English speakers; and
- serious mental health difficulties or health concerns which would interfere with participation or ability to consent.

No new data was therefore collected during the current research. During the data collection period (as part of routine care), the EssenCES-IDD was administered on a total of 11 separate occasions. This included 78 completions by Medium Secure patients and 81 completions by Low Secure patients. In total the analysis reviewed 195 separate comments. It is possible and likely that some of the same patients completed the tool on multiple administrations given that it is completed on a quarterly basis. Given the data is anonymised at the time of collection it is not possible to establish the exact number of independent participants.

Research design

The current research represents a limited retrospective, anonymous data review of pre-collected qualitative data. Data were collected as part of routine clinical care and analysed for descriptive data. For the current research, the qualitative comments were analysed by an independent researcher not involved in the data collection. Qualitative data were extracted from the questionnaires and analysed using TA.

Sampling design

On a three-monthly basis all service users meeting the above criteria were offered the opportunity to complete the EssenCES-IDD questionnaire, either independently or with staff support.

Measuring instruments

The EssenCES-IDD questionnaire is a 15-item measure which assesses the following environmental traits of Secure Units: Patients' Cohesion (PC). This refers to peer support from other patients; Experienced Safety (ES). This describes how safe people feel on the ward; and Therapeutic Hold (TH). This refers to perceptions of staff support.

Each subscale is scored out of 25, with higher scores indicating a more positive perception of that aspect of the ward.

The EssenCES-IDD version provides free-text boxes for respondents to offer qualitative responses to each of the questions.

Methods of data collection

In the current service, the EssenCES-IDD has been administered quarterly since June 2022 to June 2025 as part of routine clinical practice to monitor therapeutic climate and support quality improvement. Respondents are approached by an Assistant Psychologist and invited to consent to participate in providing feedback. If there are identified literacy needs,

the Assistant Psychologist and/or additional staff offer support, however where this is not required respondents are able to complete the questionnaire independently.

Data are then returned to an independent Psychologist for analysis.

Ethical considerations

The research was submitted through the NHS Integrated Research Application System (IRAS). It was concluded that there was no requirement for an NHS Research Ethics Committee (REC) to review applications limited to the analysis of retrospectively collected, fully anonymised data. As such, HRA Approval was granted from the Proportional Committee.

The principal ethical concerns relating to the current research were:

Consent. The Psychological Service collected the data as part of routine clinical NHS activity within the hospital, to which all respondents provided informed consent as part of their clinical care. This study involves retrospectively analysing the anonymous qualitative data to understand the themes of comments made in relation to the topic of therapeutic climate.

At the time of collecting the data, consent for its use to answer a research question was not sought. In addition, an unidentifiable number of patients were likely to have left the service since the commencement of data collection.

Privacy and confidentiality. All data collected was fully anonymised at the point of collection by the psychological services team. No personal data was available only the fully anonymised data set.

The current qualitative data were analysed by the researchers separate to the data collection team.

Method of data analysis

Braun and Clarke's (2006) TA approach was used to analyse the qualitative comments. TA is a flexible method for identifying, analysing, and reporting patterns of meaning (themes) within qualitative data. Analysis followed the six-phase process outlined by Braun and Clarke:

1. familiarisation with the data through repeated reading;
2. systematic generation of initial codes across the dataset;
3. searching for potential themes by collating codes into broader patterns of meaning;
4. reviewing themes to ensure coherence and consistency with the coded data and the full dataset;
5. defining and naming themes to capture their central organising concepts; and
6. producing the final report by selecting illustrative extracts and relating the analysis to the research questions and relevant literature.

Results

The results are structured beneath the three superordinate themes of Therapeutic Hold, Patient Cohesion and Mutual Trust and Experienced Safety.

Theme 1: therapeutic hold

This theme captures how patients experience emotional support, engagement and continuity of care from staff. While many described positive and supportive relationships, others raised concerns regarding inconsistency, lack of time or disconnects with agency staff.

Subtheme 1.1: feeling heard and understood. Many participants described staff as attentive and responsive, emphasising the value of being listened to and understood:

Staff listen a lot.
I tell them what I like to do and they listen.

Feeling known on a personal level, especially when staff are aware of personal histories, appeared to foster trust and emotional safety. This relational consistency appeared to underpin a positive therapeutic environment:

Staff read up on my history, trauma and how to help me when I am down.
I feel comfortable enough to speak to all staff if I have a problem.

Subtheme 1.2: inconsistency in staff engagement and availability. A central theme that emerged was that of the importance of having staff who know patients well. The absence of this, or inconsistency in familiar and available staff was viewed negatively by respondents:

Agency and new staff do not always know the patients or the ward – there is a lot of them!

While some staff are seen as committed, others are viewed as disengaged or stretched too thinly:

It can be very hard to get hold of staff.

Participants frequently mentioned difficulties in accessing staff, particularly during night shifts or when temporary staff are on duty. These gaps appeared to undermine continuity of care and affected patients' sense of stability:

Sometimes staff do not engage with me on my observations.
Staff don't really spend a lot of time helping patients.

Subtheme 1.3: support for progress and recovery. Responses indicated that staff support was often linked to patients' future goals, particularly discharge and reintegration into the community:

Staff always make clear they want us to get out of hospital. They work with us.

When staff communicated hope and progress, it reinforced a sense of purpose and empowerment. This forward-looking orientation appears to be a key component of therapeutic hold and recovery-focused care:

Staff help patients to get out of here.
Staff help us and say all the good things we are doing.

Theme 2: patient cohesion and mutual support

This theme explores the social environment among inpatients from mutual understanding and camaraderie to mistrust and occasional hostility. For many, the ward is a temporary "home", influencing how relationships are formed and maintained.

Subtheme 2.1: a sense of community and shared experience. In positive instances, patients described a strong sense of belonging and shared purpose:

Sometimes it's like a second family. One for all and all for one.
We all like to see each other do well.

Engaging in joint activities or simply spending time together appeared to foster informal peer support, which may enhance well-being. Describing the unit as a “home” reflects the significance of this cohesion for everyday life and emotional stability:

I like the support between us patients, we always try to make each other feel comfortable. It is our home for now.

Subtheme 2.2: conditional support and emotional guarding. Responses indicated however, that peer support was often perceived as inconsistent, dependent on mood, familiarity, or perceived trustworthiness:

Patients only care about other patients' problems when they have something they might lose.
Patients care about each other 50/50.

Some participants spoke of selective alliances, while others were wary of sharing personal information. This conditional dynamic reveals a protective stance that may be shaped by past trauma or a lack of safety:

Only particular patients look after me and keep me safe.

Subtheme 2.3: disconnection and distrust. Respondents suggested that at times, the ward is experienced as hostile or emotionally unsafe:

Nobody is here to care for you, you are here to care about yourself.

Participants spoke of mistrust, conflict, or feeling targeted. These dynamics may reflect the impact of living in a secure setting with individuals at different stages of recovery. They also pointed to the need for structured interventions that promote emotional safety and healthy peer interactions:

Sometimes patients try to get personal to find out info to target you in the future.

Theme 3: experienced safety

This theme addresses how patients experience physical and emotional safety on the unit, as well as how they manage feelings of fear, discomfort and vulnerability.

Subtheme 3.1: exposure to potential threat. Aggressive or unpredictable incidents significantly shaped patients' perceptions of safety. Witnessing aggression, even if not directly involved, can contribute to heightened stress, hypervigilance, or withdrawal:

If it kicks off, some patients are scary.

The physical and emotional toll of such incidents reinforces the need for trauma-informed practices and sufficient staffing:

Scary things happen like staff getting attacked, chairs being chunked, people tying ligatures.

“I’m scared of what the stronger lads might do”.

Subtheme 3.2: strategies, coping and personal focus. In response to unpredictability, many patients spoke of adopting coping strategies such as focussing on themselves and their own recovery:

If it kicks off, I just go to my room.

While this can be adaptive, it may also reduce opportunities for therapeutic engagement and social connection:

I keep myself to myself.
I stay mostly in my room.

Subtheme 3.3: feeling safer with familiar or caring staff. Despite incidents of unpredictability and discomfort, many patients highlighted the crucial role of familiar and consistent staff in maintaining a sense of safety:

Staff help us feel safe, we are looked after, thank you to the staff!

It's safe when the permanent staff members are on shift.

Most of the time we find the unit safe, the staff keep us safe and do a good job of it.

Relationships with known staff members provided a buffer against the stress of ward incidents and helped foster trust in the overall environment.

Discussion

The current study set out to gain further insight into how patients with ID construct their understanding of the three underlying domains of Therapeutic Hold, Patient Cohesion and Experienced Safety as measured by the EssenCES-IDD. The aim was to develop a richer understanding of how individuals with ID interpret key components of forensic social climate. Specifically seeking to answer how do inpatients with ID make sense of the therapeutic climate in their secure units.

A number of subthemes emerged related to the three interrelated domains of therapeutic relationships, peer dynamics and safety. Together, these themes highlight the importance of relational processes, particularly consistency, familiarity and emotional attunement of staff, in shaping patients' perceptions of care, belonging and safety. Importantly, participants' accounts suggest that therapeutic environments are experienced as fragile and contingent, with safety and support fluctuating according to staff availability, engagement and interpersonal trust. Relationships and mutual cohesion were noted to be equally fragile and conditional upon a number of dynamic factors:

The results provide insights into the voice of service users with ID in Secure Services and indicate practical clinical strategies that may be beneficial in improving experiences of secure care.

Whilst the current results were structured under *a priori* themes of the EssenCES-IDD, several subthemes were generated related to these concepts. However, the results indicated that the importance of being known and “held” whilst in care services appeared to be the strongest and most clinically relevant theme, reflective of previous similar findings by [Sommerstad et al. \(2021\)](#).

The findings indicate that Therapeutic Hold within Secure ID settings is experienced primarily through relational continuity and staff familiarity, rather than through formal therapeutic input alone. Participants' accounts of feeling heard and understood reflect experiences of emotional attunement, where staff demonstrate knowledge of individuals' communication styles, histories of trauma, and patterns of distress. In Secure ID contexts, where emotional expression may be difficult and distress is frequently communicated behaviourally, such attunement appears critical to developing and maintaining psychological safety and therapeutic engagement.

These findings are consistent with Trauma Informed approaches to care and the Positive Behavioural Support approaches adopted within these settings. Psychologically, these dynamics may be understood through the concepts of containment ([Bion, 1962](#)) and the holding environment ([Winnicott, 1965](#)), which have been applied to forensic psychiatric settings to describe how staff and institutions can contain and process intense emotional states experienced by patients ([Adshead, 2012](#); [Yakeley, 2010](#)). Many individuals within secure services have experienced disrupted attachments, institutionalisation and repeated relational ruptures or early trauma. The presence of consistent, emotionally available staff may provide reparative therapeutic experiences. Feeling “held in mind” by staff appeared to reflect patients' confidence that their needs, risks, and vulnerabilities were recognised

and responded to, even when they were unable to communicate these explicitly. This sense of “being known” may reduce anxiety and the perceived need to express distress through behaviours that are often viewed as risk-related or challenging.

Importantly, staff familiarity also appeared to support a more accurate understanding of behaviours. Participants’ accounts suggest that when staff know them well, there is a reduced likelihood that emotional distress, withdrawal or agitation will be misinterpreted as deliberate non-compliance or elevated risk. This is particularly relevant in secure settings, where risk management practices can be restrictive.

Conversely, inconsistencies in staff engagement, particularly in the context of agency or unfamiliar staff, appear to have been experienced as undermining Therapeutic Hold. Participants described difficulties accessing staff and feeling less confident that temporary staff understood their needs. Such disruptions may weaken relational security, increase anxiety, and impede progress or discharge planning. Taken together, these findings highlight the role of relationally informed, consistent staffing in supporting therapeutic environments within forensic ID services. These findings are consistent with recent research conducted by [Souverein et al. \(2023\)](#) in small-scale youth justice facilities. Whilst this was more community focused their three-year evaluation involved conducting 63 semi-structured interviews with staff, young people and parents and ultimately concluded that staff attitude and therapeutic stance, constructive staff-service user alliance and consistent staff presence were critical to producing a safer and more therapeutic institutional climate.

The secondary key theme group related to Patients Cohesion and peer relationships. Participants’ accounts suggest a nuanced form of patient cohesion characterised by both connection and caution. Consistent with the EssenCES construct, many described a sense of community based on shared experiences of restriction, vulnerability and co-habitation. This is to a degree consistent with the findings of [Williams et al. \(2017\)](#), who highlighted service users’ importance of people and shared experiences as a contributory factor to perceptions of homeliness in Secure ID Services for women. Indeed, referring to the ward as a temporary “home” or even a “second family” highlights how shared circumstances can foster belonging, mutual understanding and informal peer support.

However, this sense of cohesion was rarely unconditional. Alongside expressions of solidarity, participants described emotional guarding, selective alliances and ambivalence about trust. Peer support was often experienced as inconsistent or contingent on perceived safety, familiarity, or personal gain. From a trauma-informed perspective, such emotional self-protection may be understood as an adaptive response within unpredictable and potential risk dominated environments.

Experiences of disconnection and mistrust further complicate the potential for peer relationships in secure settings to be therapeutic in themselves as patients may struggle to trust one another enough to form supportive and emotionally open relationships. Certain social processes may also be relevant, as in-group and out-group dynamics appear to shape relationships and support amongst peers. Patients at different stages of recovery, or perceived as more vulnerable, may be particularly exposed to these dynamics, or even conversely afforded more understanding and tolerance.

Taken together, these findings suggest that patient cohesion in secure ID settings is best understood as conditional and contextually informed. Emotional guarding and disengagement may represent adaptive strategies rather than barriers to progress.

The final set of themes relating to Experienced Safety again suggest that this was experienced as a relational phenomenon rather than as a function of physical or procedural security. Notably, participants rarely referred to environmental safeguards such as locked doors, observation levels, or formal procedures when describing what made them feel safe. Instead, safety was most frequently associated with the presence of familiar and supportive staff, predictability in the ward environment, and trusting relationships. This is consistent

with findings from [Wilson et al. \(2023\)](#) who comment on the centrality of balancing the three security domains (physical, procedural, relational) and highlight that an overemphasis on physical security can in fact undermine therapeutic relationships.

Exposure to aggression and unpredictable behaviour from other patients was a prominent feature shaping perception of safety. Participants described witnessing incidents of aggression and expressed concerns of being harmed by others on the ward. These experiences contributed to a heightened sense of vulnerability and uncertainty. In response, some individuals described withdrawing from communal areas or limiting their interactions with others as a strategy for self-protection. While such withdrawal may represent an adaptive response to perceived risk, it may also reduce opportunities for social engagement and therapeutic participation.

Despite these concerns, participants consistently highlighted the protective role of staff. Similar to above, feeling safe was closely linked to the presence of familiar, permanent staff members who were perceived as attentive, supportive and capable of holding boundaries on the ward. This would be consistent with literature emphasising the importance of relational security in forensic and secure settings, wherein safety emerges through staff knowledge of patients, therapeutic relationships and consistent interpersonal engagement. This finding is highlighted throughout the literature (e.g. [Rodwell and Frith, 2024](#); [Souverein et al., 2023](#)) including in a literature review ([Stevenson and Taylor, 2020](#)) of nurses' perspectives of factors that influence therapeutic relationships in secure inpatient hospitals, which concluded that staff awareness of the intrapersonal constructs of patients was key to developing positive therapeutic relationships. In contrast, an overreliance on physical or procedural security alone may do little to enhance patients' subjective sense of safety.

In summary, across all three themes, relational consistency emerged as a unifying mechanism underpinning positive experiences of care. When staff were experienced as familiar, emotionally available and reliable, participants reported greater therapeutic engagement, improved peer relationships and enhanced feelings of safety. Conversely, inconsistency in staff engagement appeared to erode trust across multiple domains, highlighting how organisational factors may indirectly shape patient wellbeing. These findings emphasise the importance of focusing on relational approaches to security in Secure Settings when applying frameworks such as See Think Act (STA) and the Relational Security Explorer (RSE) and designing inpatient environments.

Clinical implications

The findings of this study highlight several important implications for clinical practice within Secure ID services (and indeed beyond this, applying to community models of care). Firstly, the results emphasise the importance of staff continuity in fostering a sense of safety within inpatient environments. Participants consistently described feeling safer when familiar and permanent staff members were present, suggesting that stable staffing and relational consistency may play a key role in shaping patients' perceptions of safety. Services may therefore benefit from prioritising workforce stability and reducing reliance on unfamiliar temporary staff where possible.

These findings also reinforce the importance of relational skills within the care team. Training that emphasises relational security, therapeutic communication and trauma-informed approaches adapted for individuals with ID may help staff to respond effectively to distress, aggression, and interpersonal conflict. In addition, opportunities for reflective practice, supervision and staff Protected Learning Time focused on relational dynamics may support staff in understanding and responding to the complex interpersonal environments that develop within secure inpatient settings.

The findings further suggest that peer relationships within secure units are not uniformly protective and may, at times, contribute to feelings of vulnerability or fear. As such, positive

peer interaction should not be assumed to emerge naturally. Staff play a critical mediating role in modelling safe relational practices, supporting prosocial interactions, and intervening when peer dynamics become harmful. Structured and trauma-informed approaches to fostering emotional safety may therefore be beneficial. Likewise promoting a sense of cohesion through shared activities, mutual respect and clear boundaries is critical. Initiatives such as Therapeutic Patient Meetings, unit-based discussion groups and joint staff patient “business” meetings have proved effective in the current service.

Finally, the use of the EssenCES-IDD offers value as a service development tool. When used alongside qualitative feedback from patients, the measure may provide services with a deeper understanding of ward climate and help identify areas for targeted improvement.

Limitations

Positively, the current research adds qualitative depth to understanding how people with ID in Secure Services make sense of their environments and understand the settings in which they live. It adds the importance of lived-experience and service user voice to this area of research into therapeutic climates, using the validated framework of the EssenCES-IDD.

There are a number of limitations, however. As this research was conducted as a retrospective analysis of anonymous prior collected data, it was ultimately impossible to accurately define the sample size, which inevitably impacts generalisability of findings. A priori themes were, to an extent, imposed upon the findings and alternative qualitative approaches (such as Interpretative Phenomenological Analysis) may offer deeper insights into service users’ experiences. Similarly, it is important to highlight a notable limitation was that participants’ comments were likely to be significantly primed by the 15 questions contained in the EssenCES-IDD measure itself. As such, it could be considered that participants were somewhat led in terms of their responses, which would inevitably shape the results. The EssenCES is a measure that focuses to a degree on relational phenomenon and therefore the emphasis in the results on relational factors could be understood through this lens. Furthermore, there are the inevitable limitations of communication constraints in this area of research. Responses were often offered in the form of short phrases in limited physical response spaces on questionnaires. In addition, literacy requirements often meant that respondents required support to complete the measure. Despite this being a member of research team who was largely external to the unit they remained an active member of the care provision team. The presence of staff during completion may have therefore influenced participants’ responses, potentially limiting the extent to which individuals felt able to express critical or negative views about the ward environment. Likewise, it is important to note that whilst the analysis was conducted by independent researcher, they were also a member of the wider care provision team, which introduces the potential for interpretative bias in the analysis.

Future research

Alongside the current research, work in preparation is currently focusing on staff members’ perspectives of therapeutic climates in ID secure services and will serve as complementary to the current accounts. Future research may adopt a more phenomenological approach to investigating service users’ (and staff members’) lived experiences of inpatient Secure Care. Furthermore, a longitudinal exploration of relational consistency regarding clinical outcomes would be an avenue of further exploration.

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