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RECOVERY IN FORENSIC MENTAL HEALTH SERVICES

Section A

Recovery in Forensic Mental Health Services: A Review and Meta-Ethnography of Reported Accounts of Service User Experiences

Word Count: 7,980

Section B

“My Journey through the System”: A Grounded Theory of Service User Experiences of Recovery in Forensic Mental Health Services

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Summary of the Major Research Project

Section A

This is a literature review of reported accounts of service user experiences of recovery in forensic mental health services, using a meta-ethnographic approach to synthesise twenty-two qualitative papers. Findings suggest nine core themes that aid recovery processes: safety and security helping to provide a secure base; the passage of time allowing for reflection and change to occur; relationships enabling connectedness and belonging; processing the past; self-reflection aiding the development of a sense of self; engaging in meaningful activities; psycho-pharmacological intervention; enhancing freedom through increased autonomy; and developing a sense of hope for the future. Practice and research implications are considered.

Section B

This is an empirical paper presenting a grounded theory study that aims to develop a theoretical model of service user experiences of recovery in forensic mental health settings. This is the first study of its kind. Findings identified core recovery processes as: feeling safe and secure, connectedness, hope for the future, who I am and empowerment. These superordinate categories inter-related in a cyclical process and occurred in three phases of 1) feeling safe and secure, 2) moving forwards, and 3) empowerment. These processes were encompassed by two additional themes of arriving at hospital and changes over time. Findings are discussed in relation the wider literature. Practical and research implications are considered.

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Section A: Literature Review Paper

Recovery in Forensic Mental Health Services: A Review and Meta-ethnography
of Reported Accounts of Service User Experiences

For submission to the Journal of Forensic Psychiatry and Psychology

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Abstract

There is a growing body of qualitative research exploring reported accounts of service user recovery experiences in forensic mental health settings. This review aimed to draw the literature together. Four electronic databases (PsycINFO, Web of Science, ASSIA and Social Policy and Practice) were systematically searched and a manual search was carried out. Twenty-two qualitative papers met the set inclusion criteria. Findings were synthesised using a meta-ethnographic approach and nine core themes were identified. These were: safety and security helping to provide a secure base; the passage of time allowing for reflection and change to occur; relationships enabling connectedness and belonging; processing the past; self-reflection aiding the development of a sense of self; engaging in meaningful activities; psycho-pharmacological intervention; enhancing freedom through increased autonomy; and developing a sense of hope for the future. This review updated and brought new information to light from past reviews in the same subject area, as well as comparing findings to the wider literature. Practice implications of incorporating these processes into services are discussed and future research is recommended. Strengths and limitations of this review are considered.

Keywords: recovery, forensic mental health, service user

Introduction

This paper reviews existing qualitative literature of reported accounts of service user experiences of recovery in forensic mental health settings, using a meta-ethnographic approach (Noblit & Hare, 1988). The paper will first provide a background of “recovery” in general and forensic mental health services in the UK.

“Recovery” in Mental Health

“Recovery” is a term used in mental health theory and policy since the 18th century (Roberts & Wolfson, 2006). From the 1980’s attention was re-focused on recovery, and a conceptual distinction was made between ‘clinical recovery’ and ‘personal recovery’. ‘Clinical recovery’ was considered a concept rooted in a medical understanding of difficulties, focusing on alleviation of symptoms and returning to a pre-morbid functioning, which is the same for everyone (Lieberman & Kopelowicz, 2002). ‘Personal recovery’ was differentiated as a subjective, whole-person, values-driven concept and was motivated by service users (e.g. Lovejoy, 1984; Coleman, 1999) and their personal accounts (e.g. Deegan, 1988). One definition of personal recovery is provided by Anthony (1993) as:

“A deeply personal process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness”.

This demonstrates personal recovery prioritises considerations of how to live well alongside a long-term mental health condition and beyond clinical recovery (Care Services Improvement Partnership [CSIP], Royal College of Psychiatrists [RCPsych] & Social Care Institute for Excellence [SCIE], 2007). It is a dynamic process of regaining active control over one’s life; this may involve discovering a positive sense of self, accepting and coping with the reality of

on-going distress (e.g. Woodbridge and Fulford, 2004), resolving issues like social isolation that may contribute to mental health difficulties, taking on meaningful social roles and calling on support systems (Leibrich, 1999).

Key Elements of Recovery

Whilst recovery is an individual process, attempts have been made to identify common elements across peoples' experiences, in order to aid services in structuring thinking about recovery. A large-scale systematic review and narrative synthesis produced a model of recovery with five domains (Leamy, Bird, Le Boutillier, Williams & Slade, 2011): hope and optimism about the future, connectedness, identity, meaning in life and empowerment. Repper and Perkins (2003) reviewed recovery literature and elicited three key ideas: hope (including a sense of personal agency), control (taking back control of one's destiny) and opportunity (the chance to do things you value).

Recovery-orientated Policy and Practice in Mental Health Services

The concept of personal recovery has become widely accepted and integrated into policy and service design as "recovery-orientated practice" (Department of Health [DoH], 2011). Recovery is not something that is 'done' to someone, but service providers can create environments that foster individuals' recovery (Deegan, 1988). This means a holistic approach is taken; service users are at the heart of their care and given real choice around services they receive (O'Hagan, 2004). There are suggestions recovery-orientated services are associated with better mental health and social outcomes from general adult services (Warner 2010), though there is less evidence about the value or applicability of recovery approaches in specialist mental health services (Turton et al., 2009).

Recovery Applied to Forensic Mental Health Settings

There is debate about how recovery principles can be applied within forensic mental health services (Turton et al., 2009). Whilst the concept of risk is important in general services, it plays a larger role in forensic settings (Drennan & Alred, 2012); to meet criteria for being in forensic services, the individual most commonly has committed a serious crime, having a profound bearing on how their care is approached (Drennan & Alred, 2012). Forensic service users carry a double stigma of being ‘mentally ill’ and ‘dangerous’ (Brooker & Ullman, 2008). The risk of serious harm to others and of potential security breaches affects all areas of forensic service delivery, creating a tension with autonomy and control that underlies personal recovery (Pouncey & Lukens, 2010). Even the promotion of hope can be seen as creating false expectation (Mezey & Eastman, 2009).

Factors like positive risk-taking, trust and choice for service users have been highlighted as necessary for meaningful organisational change in services (Shepherd, Boardman & Burns, 2010). Roberts, Dorkins, Wooldridge and Hewis (2008) suggested ‘optimal choice’ was more appropriate for forensic populations, compared to ‘maximal choice’ for mainstream service users; this is due to being legally detained and needing to demonstrate risk reduction to the satisfaction of services before discharge, which compromises a person’s capacity to exert choice and control in their journey.

Drennan and Alred (2012) suggested those in forensic services have an additional recovery task: ‘offender recovery’; this refers to subjective experiences of coming to terms with having offended, perceiving the need to change qualities that led to past offending, and accepting social and personal consequences of having offended. This may interact with recovery from mental health difficulties in important ways (Drennan & Alred, 2012). The ‘offender patient’ has to work through their personal guilt and reconcile their ‘mental illness’, with their sense of personal responsibility (Dorkins & Adshead, 2011). Thus, offending

behaviour itself is often seen as one of the greatest obstacles to a person's recovery. Offender recovery dovetails with literature from the purely forensic perspective focusing on narratives of desistance from crime, which emphasises many similar processes such as finding meaning in life (Maruna, 2001).

Despite this, and within limitations, the recovery approach has been helpful in forensic services. Gudjonsson, Savona, Green and Terry (2011) suggested implementing this approach doubled engagement and it has been argued the approach can be easily incorporated into existing programmes (Gudjonsson, Young & Yates, 2007).

Rationale for Review

There have been calls for further research to support adequate understanding of recovery in forensic mental health settings (Dorkins & Adshead, 2011). At the heart of recovery is the subjective and individual experience. An understanding of service user experiences of recovery is a crucial perspective to have.

There are two published literature reviews exploring service user perspectives of recovery in forensic mental health settings (Clarke, Lumbard, Sambrook & Kerr, 2016; Shepherd, Doyle, Sanders & Shaw, 2015). Clarke et al. (2011) applied thematic synthesis to evaluate eleven papers and Shepherd et al. (2015) synthesised and examined five papers. Since these reviews, there have been several additional studies published. To ensure services continue to work in recovery-orientated ways, an up-to-date understanding of reported service user experiences is imperative.

Aim of the Review

The review aims to examine and evaluate the available literature that answers the question "What are service users' experiences of recovery in forensic mental health services?".

Methodology

Scope

Recovery. Papers were included if the concept of recovery was the main focus of the study.

Forensic mental health. Papers were included where participants have been in forensic mental health settings. Other forensic contexts (e.g. prisons) have therefore been excluded. No limit was placed on the type of forensic mental health service; for instance, the research may have been carried out in a high-secure facility or in community settings.

Reported accounts of service user experience. Papers were included if there was evidence of service user experience being reported; for example, self-report (e.g. via direct interview) or a staff/family member reporting what a service user has said, with the use of verbatim quotes.

Literature Search

An electronic literature search was carried out on 17th, 21st and 24th October 2018 to identify appropriate studies (Figure 1). Four electronic databases (Table 1) were searched for articles containing the following search terms in their title or 'key concepts':

(recover*) AND (forensic OR secure OR offend*) AND (mental* OR psych*) AND (disorder OR ill* OR health OR problem).

Truncation was used where appropriate to broaden the search. The Boolean operator 'AND' was used to combine unrelated terms, and 'OR' was used to ensure different terminology for words were captured. The search was not filtered by a time period to maximise its scope.

Table 1.

Electronic databases searched.

Database	Articles retrieved
PsycINFO	555
Web of Science	855
Social Policy and Practice	84
Applied Social Sciences Index and Abstracts (ASSIA)	541
Total	2035

A manual search was carried out on 26th and 29th October 2018: Google Scholar was searched; references were checked from articles identified in the electronic search, from previous relevant literature reviews and from ‘Secure Recovery’ (Drennan & Alred, 2012). One of the authors of ‘Secure Recovery’, Dr. Gerard Drennan, was contacted for any relevant articles. One additional research paper was located.

To check if the articles met the inclusion criteria, titles were screened, duplicates were removed, abstracts were screened and full articles were retrieved and assessed for eligibility. They were marked against a quality assessment tool. Twenty-two studies met the criteria and were included in the review.

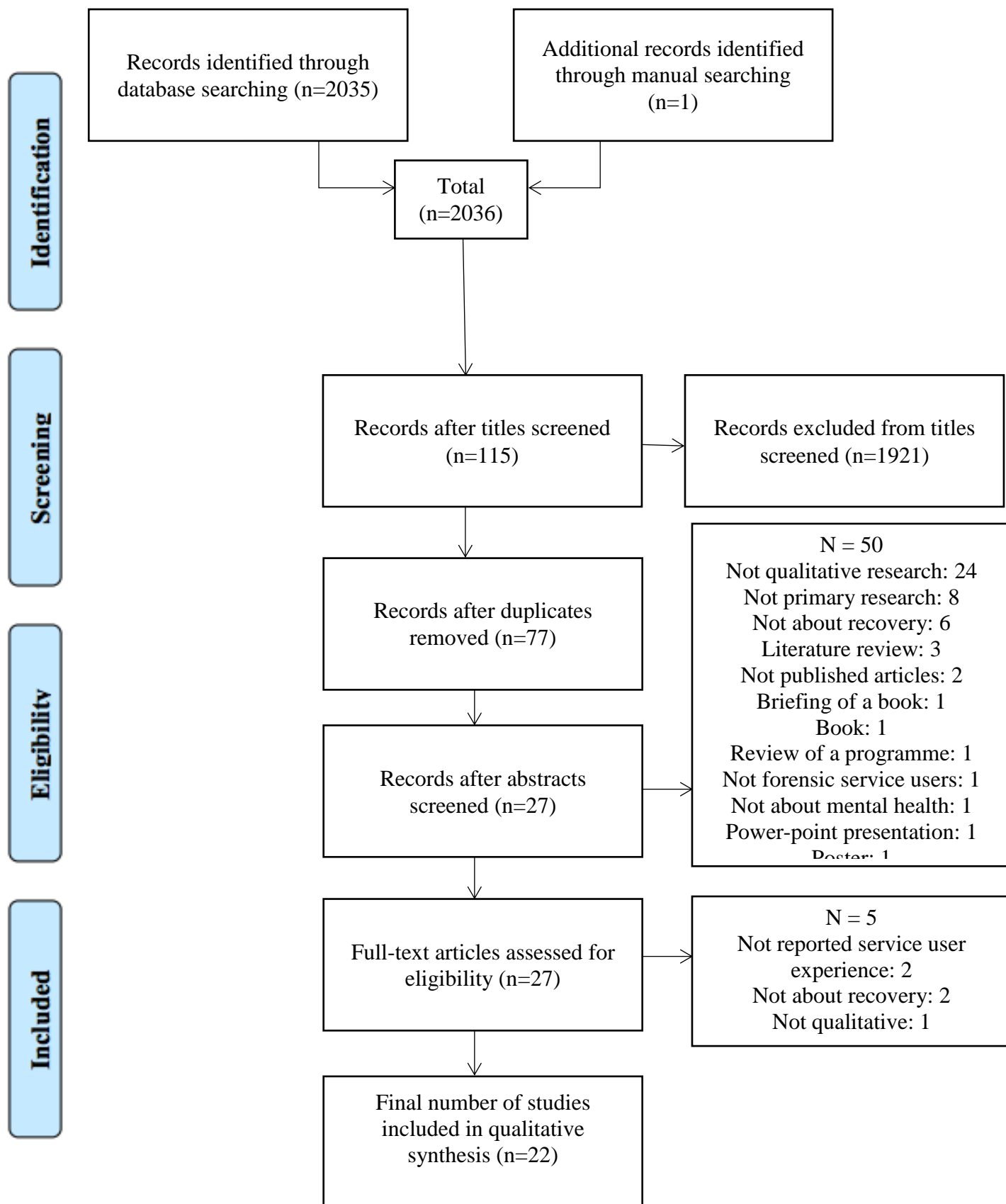


Figure 1. PRISMA diagram of study selection process

Eligibility Criteria

Table 2.

Eligibility criteria.

Inclusion criteria	Exclusion criteria
<ul style="list-style-type: none"> • Qualitative studies • Written in the English language • Primary research • Peer-reviewed • Main focus of the study was recovery • Based in a forensic mental health setting • Participants: service users, staff or carers reporting on service user experience 	<ul style="list-style-type: none"> • Papers assessed as poor quality, and below the lowest cut-point (below 55%) as measured by Kmet, Lee, and Cook's (2004) quality criteria, as they would limit the accuracy of the findings

Structure of this Review

The studies' characteristics are first presented, then they and their methodologies are critiqued, guided by Kmet, Lee and Cook's (2004) quality assessment tool. The findings, which have been synthesised using a meta-ethnographic approach (Noblit & Hare, 1988), are then presented. In the discussion, findings are considered in the context of the wider literature. Clinical and research implications are discussed. Finally, the review presents its strengths, limitations and conclusions.

Review

Study Characteristics

All studies comprised of qualitative research. Different qualitative data collection approaches were implemented: interviews (n=16), notes from group sessions (n=3), focus groups (n=1), focus groups and interviews (n=1), and a case study (n=1). A variety of data analysis methods were used: thematic analysis (n= 13), content analysis (n=4), interpretative phenomenological analysis [IPA] (n= 4) and grounded theory (n=1). The majority of the studies' participants were service users (n=15), four studies' participants included service

users, staff and carers, and three were staff members reporting on service user experience. The studies were conducted in six countries: UK (n=14), New Zealand (n=2), Australia (n=2), Sweden (n=2), Canada (n=1) and Belgium (n=1). These were across a range of settings from high-secure hospitals to living in the community. Most studies did not focus on any specific population of forensic mental health service user experience but some did; for instance, women who committed maternal filicide and high-security homicide patients. Table 3 summarises the key characteristics of the 22 papers. See Appendix 1 for a table of the studies and their titles.

Table 3.

Summary of reviewed studies.

Author (Date)	Journal	Country	Aims	Design	Location	Participants	Data collection	Data analysis	Findings
Barsky & West (2007)	The British Journal of Forensic Practice	UK	To understand patient perspectives and to allow them to contribute to the debate: does the provision of long-stay medium-secure beds provide in-patients with a more therapeutic environment, and does this environment improve better rates of recovery than the traditional high-secure 'special' hospitals?	Qualitative	2 long-stay, medium-secure wards at a regional secure unit	Service users (n=6). Gender: Male. Average length of stay: 1.5 years and all had experience of a high-secure hospital, with an average stay of 12 years. All were sectioned under the Department of Health (1983) and diagnosed with a psychotic illness or personality disorder. All had a history of serious and violent offending.	Interviews	Thematic content analysis	Participants identified increased scope for recovery at the long-stay, medium-secure facility, and that this is promoted by increased flexibility due to less emphasis on security. Important factors were increased access to activities, graded access into the community, the different atmosphere in hospital sites and differences in potential for developing trusting relationships with staff and fellow in-patients.
Mezey, Kavuma, Turton, Demetriou & Wright (2010)	The Journal of Forensic Psychiatry & Psychology	UK	To explore forensic psychiatric patients' perceptions and experiences of recovery and to identify whether they had different narratives and emphases from non-offender patients, that could inform service planning and interventions.	Qualitative	Medium-secure unit	Service users (n=10). Gender: females (2), males (8). Ethnicity: White (4), Black and Minority ethnic (6). Age: range: 24-56 (Mean: 37.1). Diagnosis: Schizophrenia (7), Schizoaffective disorder (3). Average length of stay: 4 years (range 1-11 years). Section: 37/41 (7), 3 (2), 37 (1). Offences: Manslaughter, GBH/ABH, rape, arson.	Interviews	Thematic analysis	Most patients defined recovery as getting rid of symptoms and feeling better about themselves. Medication and psychological work, relationships with staff and patients and being in a secure setting were all cited as being important in bringing about recovery. The stigma associated with being an offender, as well as having a serious mental illness, was perceived as a factor holding back recovery, particularly in relation to discharge and independent living in the community. Core recovery concepts of hope, self-acceptance, and autonomy are more problematic and appear to be less meaningful to individuals, who are detained for serious and violent offences.
Cook, Phillips & Sadler (2005)	Journal of Psychiatric and Mental Health Nursing	New Zealand	To explore the experience of the Tidal Model by eliciting viewpoints from the two groups who directly experience the model (Registered Nurses and Patients). To investigate if participants had noted any problematic issues.	Qualitative	A regional secure mental health forensic unit	Nurses (4), service users (4): n = 8	Interviews	Thematic analysis	The Tidal Model engendered a sense of <i>hope</i> , where nurses felt they were making a difference and patients were able to communicate in their own words their feelings of hope and optimism. <i>Levelling</i> was experienced as an effect emerging from individual and group processes whereby a shift in power enhanced a sense of self and connectedness in their <i>relationships</i> . These interpersonal transactions were

									noted by the special patients as being positive for their recovery. This enabled effective nurse–patient collaboration expressed simply as <i>working together</i> . The participants reported a feeling of humanity, so that there was a <i>human face</i> to a potentially objectifying forensic setting. Implications arising from this study are that the use of the model enables a synergistic interpersonal process wherein nurses are professionally satisfied, and patients are validated in their experience supporting their recovery.
Laithwaite & Gumley (2007)	Clinical Psychology and Psychotherapy	UK	To present service users' perspectives on being a patient in a high-security setting and the factors they consider to be important in their recovery.	Qualitative	High-security hospital in Scotland	Service users (n=13). Gender: male (12), female (1). Age: 22-60. Diagnoses: Bipolar affective disorder, Schizophrenia, Bipolar affective disorder. Length of stay: 1-10 years. Index offence: Sexual offence, manslaughter, attempted murder, assault, attempted rape, murder and sexual offence, violent assault.	Interviews	Grounded theory	Contrasting accounts of recovery were apparent from the way in which participants spoke about their experiences. The main themes included experiences that enabled their recovery but also barriers to their recovery: Past experiences of adversity; Parental break-up and loss; feeling rejected and worthless; relationships with significant others; perspectives on past selves; recovery in the context of being in hospital; frightening vs safety; feeling entrapped, the importance of relationships; development of trust, coping; valued outcomes; relationships and a changing sense of self.
Stanton & Simpson (2006)	Behavioural Sciences and the Law.	New Zealand	To present the main themes the perpetrators described with respect to their recovery.	Qualitative	Not stated	Service users (n=7). Gender: Female Diagnosis: Personality disorder, major depressive disorder, schizoaffective disorder, schizophrenia, alcohol abuse. Ethnicity: White (5), Maori (1), New Zealander of Pacific Island descent (1). Index offence: Filicide	Interviews	Thematic analysis	The women described patchy but horrific memories they avoided thinking and talking about. They described intense self-judgement and self-hate. They valued ongoing relationships with surviving children and were distressed by perceptions that they might be a danger to other children. Managing illness was not described as a major challenge. Acknowledgement of illness was described as important in coming to terms with what they had done. Surviving children and relationships with family and other support networks were described as important in their rehabilitation.
Ferrito, Vetere,	Journal of Forensic	UK	To explore the processes of 'recovery' and redemption	Qualitative	High-security	Service users (n= 7). Gender: Male.	Interviews	IPA	The main themes were: the role of past experiences - early life trauma; Impact

Adshead & Moore (2012)	Psychiatry & Psychology		in the narratives of a sub-group of homicide perpetrators who were admitted to a secure hospital for treatment.		hospital	Age: 25-46. Diagnosis: Schizophrenia, borderline personality disorder, Schizo-affective disorder, psychopathic disorder, antisocial personality disorder. Ethnicity: Black British, White Irish, Mixed race, Black African, White British. Index offence: Homicide			on personal development - mistrust, social isolation, perceived helplessness; Periods of 'loss of grip on reality' - loss of control over feelings, confusion, emotional release; Reframing: events via therapeutic intervention; Internal integration - confronting existential issues and discovering meaning, forms of repayment, hope; Roadblocks to the process of recovery - communication breakdown with professionals, stigmatization.
O'Sullivan, Boulter & Black (2013)	Journal of Forensic Psychiatry & Psychology	UK	To explore the experiences of individuals in MSUs with dual diagnosis who have been recalled, in order to inform treatment for this poorly understood population.	Qualitative	Medium secure unit	Service users (n=5). Gender: Male. Age: 26-42. Ethnicity: Afro-Caribbean, British Caucasian, Mixed heritage. Diagnosis: Paranoid Schizophrenia, Schizo-affective disorder	Interviews	IPA	Five themes were identified relating to identity, control, autonomy and recovery. These were self and other; transition of the self as substance user; disempowerment; self-determinism; recovery.
Walker, Farnworth & Lapinski (2013)	The Journal of Forensic Practice	Australia	To investigate staff and patients' understanding of community day leaves and how recovery principles were embedded.	Qualitative	Secure forensic psychiatric service - rehabilitation ward	Staff (10), Service users (9): n = 19 Gender: Service users - male. Length of stay: average 7 years. Diagnosis: Service users - Schizophrenia.	Interviews	Thematic analysis	Although staff and patients expressed their understanding differently, they had a similar overall understanding of the function of community day leaves, that being, to successfully reintegrate and practice daily living skills. Recovery principles practiced, included developing a sense of connectedness to others, power over their own lives, the roles they value, and therefore, hope for themselves. However, how these were facilitated by staff and practiced by patients, varied.
Skinner, Heasley, Stennett & Braham (2014)	Journal of Forensic Psychology Practice	UK	To explore the extent to which a motivational programme in a high-secure psychiatric hospital can achieve its goal of promoting recovery.	Qualitative	High-security hospital	Service users (n = 7). Gender: Male. Index offence: Murder, GBH. Diagnosis: Schizophrenia, Paranoid Schizophrenia, Other (psychotic illnesses). Ethnicity: Asian, Black, White. Age: 23-57 (mean: 33.71)	Focus groups	Thematic analysis	Five main themes emerged suggesting that the program had a positive impact on a variety of recovery-related factors such as: confidence, hope, taking control and responsibility, identifying strengths, and improving access to social support.
Nijdam-Jones, Livingston, Verdun-Jones & Brink	Criminal Behaviour and Mental Health	Canada	To understand the qualities of services identified by patients in a forensic hospital as being important and meaningful to	Qualitative	Forensic mental health hospital	Service users (n = 30). Age: 19+ Length of admission: Had been an involuntary resident for at least one month	Interviews	Thematic analysis	Five themes emerged: Involvement in programmes, belief in rules and social norms, attachment to supportive individuals, commitment to work-related activities and concern about

(2015)			recovery.						indeterminacy of stay.
Colquhoun, Lord & Bacon (2018)	Journal of Forensic Psychology Research and Practice	UK	To gain insight into the understanding and experience of recovery for the mentally disordered sex offenders (MDSO); to use this understanding to highlight some practical implications that can inform effective delivery of MDSO treatment groups.	Qualitative	Secure forensic hospital	Service users (n = 5). Gender: Male. Age: 25-50. Diagnosis: Paranoid schizophrenia; Asperger syndrome; Paranoid personality disorder; Anxious-avoidant personality disorder. All had histories of substance misuse and must have completed the Sex Offenders Group.	Interviews	IPA	Four subordinate themes were found: Not being the person I was; Gaining new perspectives; Social relationships; and Barriers.
Shepherd, Sanders & Shaw (2017)	BMC Psychiatry	UK	To map out pertinent themes relating to the recovery process in personality disorder as described by individuals accessing care in either community or forensic settings.	Qualitative	Community and forensic clinical settings	Service users (n = 41). Diagnosis: Emotionally unstable personality disorder, dissociative personality disorder.	Interviews	Thematic analysis	Recovery was presented by participants as a developing negotiated understanding of the self, together with looked for change and hope in the future. Four specific themes emerged in relation to this process: 1. Understanding early lived experience as informing sense of self 2. Developing emotional control 3. Diagnosis as linking understanding and hope for change 4. The role of mental health services.
McKeown, Jones, Foy, Wright, Paxton & Blackmon (2016)	International Journal of Mental Health Nursing	UK	To explore diverse viewpoints regarding how people make sense of recovery and experiences of recovery orientated assessment and treatment initiatives within the hospital.	Qualitative	High-secure hospital	Staff (nurses, healthcare assistants, occupational staff and other staff roles) (30), Service users (25), n = 55.	Interviews and focus groups	Thematic analysis	Four broad accounts were identified of how recovery was made sense of in the high secure environment: the importance of meaningful occupation; valuing relationships; recovery journeys and dialogue with the past; and recovery as personal responsibility.
Adshead, Ferrito & Bose (2015)	Criminal Justice and Behaviour	UK	To explore how discussion of the index offence fits into recovery paradigms and how reflection on offender identity relates to recovery.	Qualitative	High-secure hospital	Clinical material obtained from a therapy group. Material was drawn from data 'sets' generated by 41 service users over a 10-year period. Over 400 data sets. Each set consists of notes that were taken immediately after each session based on therapist recall. Content was agreed by 3 therapists. All had completed 'The Homicide Groupwork Programme'. Gender: Male.	Data sets, which were notes that were taken after each session (and verbatim quotes were recorded for each man as much as possible).	Thematic analysis	Four key themes emerged: Coming to terms with having offended; Identity change; Abnormal mental states and identity; Therapist roles in facilitating narrative change.

						Offence: Homicide (manslaughter on the basis of diminished responsibility, and unfitness-to-plead, and murder). Age: 19-63.			
Olsson, Strand & Kristiansen (2014)	Scandinavian Journal of Caring Sciences	Sweden	To explore how forensic patients who had decreased their assessed risk of violence experienced their turn towards recovery.	Qualitative	Maximum security forensic psychiatric clinic	Service users (n = 10). Gender: Male (8), Female (2). Age: 26-62 (average 36). Average length of stay: 3-7 years.	Interviews	Inductive content analysis	Three themes were identified: (i) the high- risk phase: facing intense negative emotions and feelings (ii) the turning point phase: reflecting on and approaching oneself and life in a new way (iii) the recovery phase: recognising, accepting and maturing. In the high- risk phase, chaotic and overwhelming feelings were experienced. The turning point phase was experienced as a sensitive stage, and it was marked by being forced to find a new, constructive way of being. The recovery phase was characterised by recognising personal circumstances in life, including accepting the need for structure, a feeling of maturity and a sense of responsibility for their own life.
Williams, Moore, Adsheed, Mcdowell & Tapp (2011)	British Journal of Forensic Practice	UK	To document reflections on experiences of stigma and discrimination as described by predominantly black and ethnic minority service users via a slow-open therapy group.	Qualitative	High-secure hospital	Staff members had recorded and electronically stored records of notes from the 'Stigma and discrimination' group from 18 participants, where experiences of care, discrimination, hope, despair and recovery were shared.	Electronically stored records of group sessions	Thematic analysis	Themes relating to isolation and distance, other barriers to recovery and strategies for coping 'against all odds' were illustrated.
Pollak, Palmstierna, Kald & Ekstrand (2018)	Journal of Forensic Nursing	Sweden	To explore forensic psychiatric inpatients' own views on what aspects of care and personal recovery are important in reducing their risk of serious re-offending.	Qualitative	Forensic Psychiatric Clinic	Service users (n = 9). Gender: Female (2), Male (7). Diagnosis: Schizophrenia, Intellectual disability, Autism spectrum disorder. Offence: Violent crime, arson, serious sexual crime	Interviews	Content analysis	The results highlight aspects of care and personal recovery. Four themes emerged: Time: opportunity for change; Trust: creating a context with meaningful relations; Hope: to reach a future goal; Toolbox: tools needed for recovery.
Aga, Vander Laenen, Vandeveldde, Vermeersch & Vanderplassehen (2017)	International Journal of Offender Therapy and Comparative Criminology	Belgium	To examine recovery based on first-person narratives of offenders formerly labelled as not criminally responsible of whom the judicial measure was abrogated and to identify	Qualitative	Living independently (7); Living in an illegally inhabited garage (1);	Service users (n =11). Gender: Female (2), Male (9). Age: 36-62 (mean 49)	Interviews	Inductive thematic analysis	Descriptions of recovery resources followed recurrent themes, including clinical, functional, social and personal resources.

			resources for recovery in this population.		open ward of a general psychiatric hospital (2); Private service (1); Service for people with disabilities (1)				
Adshead, Pyszora, Thomas, Gopie, Edwards & Tapp (2013)	Law Psychiatry	UK	To examine the concept of recovery from the point of view of men who are assumed to be 'recovered' to some degree but still feel disabled and anxious about the future.	Qualitative	High-secure hospital	Staff members recorded notes from 81 service users who had attended a group. All attended a 'Leavers' group ranging between 1-98 sessions. Gender: Service users – male.	Notes of the discussion process following the group session. Notes included as much verbatim material as possible, and the temporal sequence of communications.	Thematic analysis	Three overarching themes emerged: Why are they leaving? Where are they going? What are their challenges?
Chandley & Rouski (2014)	Mental Health and Social Inclusion	UK	To highlight how an individual account of recovery and the academic literature offer up related and important perspectives that have serious clinical utility.	Qualitative	High-secure hospital	Service user (n=1).	Case study – biographical account.	Thematic analysis	Key themes emerged: Qualities in others that have helped, turning points, hopes and future plans, how I contribute, what recovery means to me, things I would change, after here.
McKenna, Furness, Dhital, Park & Connally (2014)	Journal of Forensic Nursing	Australia	To provide a description of service delivery in a secure in-patient mental health service, which has developed a self-professed recovery-orientated model of service delivery.	Qualitative	Secure, extended-care facility	Service users and staff (15), Carers (5). N = 20.	Interviews (service users and staff) and focus groups (carers)	Content analysis	A common vision was described; ways to promote hope and autonomy; examples of collaborative partnership which enhanced the goal of community integration; a focus on strength-based, holistic care; and the management of risk by taking calculated risks.
Stuart, Tansey & Quayle (2017)	Journal of Theoretical and Philosophical Criminology	UK	To explore perceptions of recovery, in particular beliefs about barriers to its achievement, in people discharged from secure psychiatric care.	Qualitative	Living in the community (former inpatients at a	Service users (n = 8). Gender: Male (5), Female (3). Age: 30-60. Diagnosis: psychotic illness. Average duration of secure admission was 5.5 years.	Interviews	IPA	Five superordinate themes were found: Living in the shadow of the past, power imbalances, security and care, reconfigured relationships, and 'recovery' as a barrier to recovery.

medium-
secure unit

Quality Assessment

Quality assessment tool. Kmet et al.'s (2004) quality assessment tool uses a systematic scoring system (Appendix 2) with specified standards against which qualitative studies can be scored. Papers which score above the highest cut-off (>75%) are considered good quality, and those scoring below this are considered as relatively worse quality. The lowest cut-point is 55%, suggesting poor quality. Consideration can then be weighted towards better quality findings. No study was excluded due to their score; thirteen studies achieved 75% or over and nine achieved 55% or over. A random sample of four studies were independently coded by a researcher colleague, which achieved a 75% consensus rate. Appendix 3 displays the studies' ratings and Table 4 summarises each study's key strengths and limitations. This assessment tool does not consider ethical issues; this will be considered alongside other critiques.

Table 4.

Key strengths and limitations of the studies, guided by Kmet et al., (2004) quality assessment tool.

Study	Key strengths	Key limitations
Barsky & West (2007)	<ul style="list-style-type: none"> Context of the study is clear. Verification procedure used to establish credibility. The independent researcher has a 75% concordance rate with the primary researcher ratings. Use of quotations to support the findings. 	<ul style="list-style-type: none"> 5 out of 6 of the sample had all experienced the same high-security hospital; which limits the extent to which findings can be generalised across different high-security hospitals.
Mezey, Kavuma, Turton, Demetriou & Wright (2010)	<ul style="list-style-type: none"> Clear description of the data collection process and of the interview schedule, making it replicable. Analysis using Grounded Theory clearly described and justified. 	<ul style="list-style-type: none"> All participants were from the same medium-security hospital and responses may reflect that particular service, rather than being generalisable to all medium secure patients. Degree of selectivity in the recruitment process; staff members would have been less likely to put forward patients who lacked insight, uncooperative or non-compliant.
Cook, Phillips & Sadler (2005)	<ul style="list-style-type: none"> Study design is evident and appropriate to answer the question. The context of the study is adequately described (e.g. about the implementation of 'The Tidal Model'). 	<ul style="list-style-type: none"> Sampling strategy not described adequately. It is unclear which participants were selected or invited to take part. No mention of reflexivity being used to help inform the research.
Laithwaite & Gumley (2007)	<ul style="list-style-type: none"> Reflexivity is considered and the researcher assessed the likely impact of their own personal characteristics on the research. Researchers considered the context of the study and were sensitive to this (e.g. quality of disclosure of participants during interview). 	<ul style="list-style-type: none"> Sampling strategy not clearly justified. It was unclear what the Responsible Medical Officers (RMOs) used in their decision-making process of selecting participants.
Stanton &	<ul style="list-style-type: none"> Methodology appropriate for the research 	<ul style="list-style-type: none"> The context of the study is not explicitly described.

Simpson (2006)	<p>question.</p> <ul style="list-style-type: none"> Data analysis is clearly described and justified. 	<ul style="list-style-type: none"> Verification procedures not used, which limits the credibility on the findings. No account of reflexivity.
Ferrito, Vetere, Adshead & Moore (2012)	<ul style="list-style-type: none"> Data analysis is clearly described and is systematic. Verification procedures used to establish credibility of the results. 	<ul style="list-style-type: none"> No account of reflexivity. Sample biases; all participants had engaged in individual or group therapy, which may have excluded a sample of patients in secure services, thus making the sample not fully representative.
O'Sullivan, Boulter & Black (2013)	<ul style="list-style-type: none"> The sample is representative of dual diagnosis populations. Data collection approach clearly described, and interview schedule questions are explicit, allowing for it to be replicated. 	<ul style="list-style-type: none"> The findings cannot be applied to female populations. Recruitment bias may have occurred with the clinical team acting as gate keepers, and only participants with a certain view point may have been referred. Small sample size. No debrief offered.
Walker, Farnworth & Lapinski (2013)	<ul style="list-style-type: none"> Data collection method clearly thought about, stated and justified. Researcher kept a reflective journal to diarise their feelings, assumptions and biases about data collection. 	<ul style="list-style-type: none"> Lack of discussion and conclusions following the results and relating it to wider research. Verification methods not utilised to help establish credibility.
Skinner, Heasley, Stenney & Braham (2014)	<ul style="list-style-type: none"> Conclusions are supported by the results and the findings are linked back to concepts of recovery. Participant sample includes a diverse range of ethnic origins represented in a high-secure hospital. 	<ul style="list-style-type: none"> The retrospective design may have affected the data obtained. There were differences in time completions of the groups and this may have impacted on the reliability of the service users' self-reports. Small sample size used due to various barriers of service users wanting to participate in the evaluation. The use of two small focus groups may have reduced the depth and conversation meaning to the analysis.
Nijdam-Jones, Livingston, Verdun-Jones & Brink (2015)	<ul style="list-style-type: none"> The theoretical framework and literature that informed the study was sufficiently described. Direct quotations used to help support the findings. 	<ul style="list-style-type: none"> Participants were self-selected and it is possible that those who were more engaged with treatment took part in the study as they had more positive perspectives on the process.

	<ul style="list-style-type: none"> • Data analysis clearly described and systematic. 	<ul style="list-style-type: none"> • Potential for receiver bias as all the interviews and analysis was conducted by a single person.
Colquhoun, Lord & Bacon (2018)	<ul style="list-style-type: none"> • Analysis of data clearly described and justified. • Findings of the study and discussed in the context of other literature about recovery. 	<ul style="list-style-type: none"> • Small sample size. • Participants were only included if that had a diagnosis of a mental health difficulty. This excludes offenders with a learning difficulty or autism spectrum disorder, and therefore limits the generalisability to these populations.
Shepherd, Sanders & Shaw (2017)	<ul style="list-style-type: none"> • Large sample size. • Interview process clearly outlined. • Use of reflexivity accounted for how the researcher's own theoretical experiences and understandings interacted with the analysis. • In the development of the analysis, themes were discussed with a service user advisory group. 	<ul style="list-style-type: none"> • Debrief not offered following interviews.
McKeown, Jones, Foy, Wright, Paxton & Blackmon (2016)	<ul style="list-style-type: none"> • Sensitivity to the context is discussed. • Heterogeneity of the sample was considered when selecting participants to reflect the demographics of the hospital. • Quotations used to help support findings. 	<ul style="list-style-type: none"> • No account of reflexivity. • Demographic information is not reported.
Adshead, Ferrito & Bose (2015)	<ul style="list-style-type: none"> • Context of the study clearly described. • Research aim is clear and explicit. 	<ul style="list-style-type: none"> • No account of reflexivity. • The data is not first hand from service users but therapists reporting on the experiences; this may therefore not be able to fully capture the service user experience and the therapist memories in terms of what was recalled and selected is biased. • Participants were not randomly selected.
Olsson, Strand & Kristiansen (2014)	<ul style="list-style-type: none"> • Context of the study clearly described. • Verification procedures used to establish credibility of findings. • Quotations used in the analysis to further enhance 	<ul style="list-style-type: none"> • Men and women participated but due to the predominance of men in forensic services, the perspective of gender was difficult to comment on. • No account of reflexivity.

	<ul style="list-style-type: none"> credibility of the findings. Type of content analysis clearly stated. 	
Williams, Moore, Adshead, mcdowell & Tapp (2011)	<ul style="list-style-type: none"> Design of the study is evident and appropriate to answer the research question. Context of the study clearly described. Verification procedures used. 	<ul style="list-style-type: none"> No account of reflexivity. Findings are not discussed and supported by the wider literature.
Pollak, Palmstierna, Kald & Ekstrand (2018)	<ul style="list-style-type: none"> Setting of the study is clearly described. Data collection approach and analysis are plainly described, justified and systematic. Participants were selected with heterogeneity in mind. 	<ul style="list-style-type: none"> Results are difficult to compare with those of other studies because so few have explored the patients' view in this context. No account of reflexivity.
Aga, Vander Laenen, Vandevelde, Vermeersch & Vanderplasschen (2017)	<ul style="list-style-type: none"> Diverse sample of participants were recruited. Data collection methods were clearly justified and described. Findings are linked to the wider literature about recovery processes and forensic recovery. Quotations used to support findings. 	<ul style="list-style-type: none"> Small sample size. No account of reflexivity. Study focussed on the situation in Belgium and its specific interment procedure, which limits generalisability to other settings. Data collection was limited to a single interview and repeated follow-up interviews may have provided additional insights.
Adshead, Pyszora & Thomas (2013)	<ul style="list-style-type: none"> Context of the study clearly described. Verification procedures used to establish credibility. 	<ul style="list-style-type: none"> No account of reflexivity. The data is not first-hand account from service users but from staff. This may cause bias in what the therapists felt was important to report and recall.
Chandley & Rouski (2014)	<ul style="list-style-type: none"> This is the first co-produced paper surrounding recovery in high-secure care. Service user experience of recovery is clearly reported. 	<ul style="list-style-type: none"> As a case study, there is no clear description of how the service user was selected to provide their account. There is a lack of information about how the data was analysed and described in a thematic way.
McKenna, Furness, Dhital, Parl & Connally	<ul style="list-style-type: none"> Context of the study clearly described. One of the researchers was a service user. The service user aided analysis of findings. 	<ul style="list-style-type: none"> All the data was collected from one service and, therefore, may not represent descriptions of recovery in similar services.

(2014)	<ul style="list-style-type: none"> • Quotations used to help support findings. • Verification procedures in place, which helps credibility of the findings. 	<ul style="list-style-type: none"> • No account of reflexivity.
Stuart, Tamsey & Quayle (2017)	<ul style="list-style-type: none"> • Data collection and analysis clearly described and justified. • Study design is evident and appropriate to answer the research question. • Contingency plans were put in place in case of any distress or disclosure of risk by participants. 	<ul style="list-style-type: none"> • Lack of service user input into the design and implementation of the research. • Lack of individual contextual information about the participants due to confidentiality issues. • No account of reflexivity.

Ethical considerations. The majority of studies (n=17) either reported that ethical approval was obtained or commented on why it was not (e.g. in the case of a service evaluation, Skinner et al., 2014). Cases where ethical approval was not noted (e.g. Barsky & West, 2007) create concern; ethical approval protects the researcher and participants, their dignity, safety and well-being, which is in line with NHS values (DoH, 2015). In most cases, informed consent was clearly specified. The process of how consent was obtained was largely well described. Written information was provided prior to consent being given. This was particularly clear in Pollack et al. (2018) and Stuart et al.'s (2017) studies; they distinctly explained the type of information given (e.g. right to withdraw, participation not affecting treatment and care), and explained how this was delivered (e.g. via information sheets). Only four studies (Mezey et al., 2010; Ferrito et al., 2012; Skinner et al., 2014; Stuart et al., 2017) explicitly commented about participants being offered a debrief to address possible distress. Participation in research should have benign consequences and therefore mitigation of distress seems desirable ethically. Due to the sensitive nature of this research, confidentiality of participants is an essential consideration. Most studies noted either identifying information was omitted or that pseudonyms were used. However, only a minority of studies commented on how information would be stored to ensure confidentiality and data protection, in line with The Data Protection Act (1998) (Skinner et al., 2014; Shepherd et al., 2017; Stuart et al., 2017).

Study design and aims. All studies explored reported accounts of service user experiences of recovery in forensic mental health services; therefore, qualitative methodology can be considered the most appropriate research design (Elliott, Fischer & Rennie, 1999), which all studies employed. The papers stated the aims of their research and were grounded in the context of existing theory, research and practice. Most studies lacked service user input into the design and implementation of the research, such that the balance of power and

interpretation remains with the researchers. Marginalised voices are heard, but only articulated by professional researchers who analysed and presented the perspectives in the studies. This continues the distinction of ‘them and us’ (Barnao, Robertson & Ward, 2010). McKenna et al. (2014) employed a service user for the research, and Chandley and Rouski (2014) co-produced the research. This allows for different perspectives to be thought about and minimises the power imbalance.

Participants and sampling. Whilst the majority of the studies commented on their approach to sampling, their strategy was often unjustified with unclear motivation. Only three papers discuss this, using purposive sampling (Ferrito et al., 2012), selective sampling (Walker et al., 2013), and convenience sampling (O’Sullivan et al., 2013). In some cases, there was no mention of how participants were recruited (e.g. Barsky & West, 2007; McKenna et al., 2014); this raises questions around the decision-making process of recruitment. Seventeen studies specified eligibility criteria; there were varying degrees as to how clear these were.

The most common approach to recruiting participants was through clinicians suggesting potential participants (e.g. Mezey et al., 2010; Laithewaite & Gumley, 2007; Stanton & Simpson, 2006; O’Sullivan et al., 2013). Whilst this may have been to ensure the potential participant had capacity to consent and was not too unwell to take part, it may have resulted in selection bias, such that participants may have been selected due to being ‘articulate’ or having a good relationship with the staff. Other studies (e.g. Walker et al., 2013) recruited by directly approaching participants in a community meeting, limiting this bias.

Participants for all studies are appropriate, in that they have all had involvement in forensic mental health services. All participants reported on service users’ experience of recovery in these settings, from staff or service users directly talking about their experience.

Some studies explored specific sub-groups of this population, such as perpetrators of maternal filicide (Stanton & Simpson, 2006) and homicide (Ferrito et al., 2012); this decreases the applicability of findings to wider forensic populations, as trajectories of specific offences may impact on one's experience of recovery.

Reporting demographic information of participants ranged across studies. This knowledge enables the reader to see whether the sample is representative of the population. Four studies failed to provide any information (Cook et al., 2005; McKeown et al., 2016; Chandley & Rouski, 2014; McKenna et al., 2014) and three only commented on the participants' gender (Adshead et al., 2015; Williams et al., 2011; Adshead et al., 2013). McKeown et al. (2016) justified not reporting or collecting these data by stating they aimed to encourage as wide as possible participation; it is not clear whether collecting this would have impacted on participation. However, not reporting on demographic factors makes it more difficult to understand if this influenced the findings in any way; a sub-group of the population may have been left unconsidered, meaning the results may only be applicable to particular groups. The majority of studies reported detailed demographic data without breaking confidentiality; for example, Mezey et al. (2010) reported on gender, average length of stay in hospital, ethnicity, diagnoses, section and offences committed by the service users.

Only two studies (McKeown et al., 2016; Pollak et al., 2018) explicitly thought about the heterogeneity of the sample and attempted to have a range of ages, genders, ethnicities and location. Other studies would have benefitted from this to help diversify findings. Generally, participants were recruited from the same hospital; it would have been advantageous to recruit from various sites. This potentially biases results and adds to the homogeneity of sampling. It is recognised for some studies this would not have been possible due to the specific nature of the research, for example, Adshead et al. (2013), where a specific group was being evaluated in relation to recovery.

Sample sizes ranged from a case study (Chandley & Rouski, 2014) to group notes about 81 service users (Adshead et al., 2013). Literature for qualitative research suggests generally at least six participants is necessary for reaching theoretical saturation (Guest, Bunce & Johnson, 2006; Crouch & McKenzie, 2006). Apart from the case study and O'Sullivan et al. (2013), who had five participants, all studies had more than this, which strengthens the robustness of the findings.

Data collection. All studies but two (Barsky & Mezey, 2007; Chandley & Rouski, 2014) gave clear descriptions of data collection methods employed. The use of interview schedules was well explained; they either commented on topics that were covered in the interview (e.g. O'Sullivan et al., 2013) or provided sample questions (e.g. Nijdam-Jones et al., 2015). This shows transparency about the process and how themes may have been derived. It was often not considered that participants may find it difficult to report their experiences to a researcher interviewer, with whom they had no relationship. A minority of studies justified the use of interviews as a data collection tool (e.g. Colquhoun et al., 2018; Aga et al., 2017) and were guided by work from Flowers, Larkin and Smith (2009), in keeping questions open ended and non-directive. Studies that conducted focus groups (Skinner et al., 2014; McKeown et al., 2016) used this approach, stating it allowed researchers to access a broad range of views. It would have been of value for these studies to acknowledge the potential for group dynamics and difficulty inferring consensus (Sim, 1998), which may have impacted findings. The studies using 'data-sets' from group notes acknowledged they tried to make them as verbatim as possible. However, this introduces the therapists' bias in terms of what is considered important or relevant enough to record. Failure to reflect on this in a reflexive manner may have resulted in the potential bias being unchecked.

Data analysis. All studies stated their analysis process, although the detail of description varied. It is important to have a detailed description so the reader can consider whether the analysis is sufficiently rigorous and adhered to the chosen approach. The studies using IPA (Ferrito et al., 2012; O'Sullivan et al., 2013; Colquhoun et al., 2018; Stuart et al., 2017) explained their rationale, and the process was described in a way that enabled the reader to follow how themes emerged. In contrast, some of the studies using thematic analysis (e.g. Adshead et al., 2013), were unclear about why this analysis was chosen. Other studies using this approach (e.g. Nijdam-Jones et al., 2015), justified it and followed guidance from Braun and Clarke (2006). Of the studies using content analysis (Barsky & West, 2007; Olsson et al., 2013; Pollak et al., 2018; McKenna et al., 2014), only one (Olsson et al., 2013) provided information about what type of content, latent or manifest, they focussed on; this is a core principle of this type of analysis (Graneheim & Lundman, 2004). The study using grounded theory (Laithwaite & Gumley, 2007) described this in detail, with data collection and analysis occurring concurrently, allowing the reader to follow the process. Direct quotations were used to aid this.

Data validation. Only four studies (Stanton & Simpson, 2006; Walker et al., 2013; Adshead et al., 2015; Chandley & Rouski, 2014) failed to include at least some method of data validation. The majority of studies (n=16) validated data through other research colleagues, which is in line with recommendations for qualitative research (Yardley, 2000); this was carried out in various forms such as audit trails (e.g. Aga et al., 2017), investigator triangulation (e.g. O'Sullivan et al., 2013) and independent researcher checking (e.g. Shepherd, Sanders & Shaw, 2017). There is a likelihood co-researchers hold similar views, limiting the possibility for assumptions or alternative views to be challenged. Seeking out respondent validation would likely enable this to happen, which only two studies did (Cook et al., 2005; Nijdam-Jones et al., 2015).

Reflexivity. It is significant only seven studies (Mezey et al., 2010; Laithewaite & Gumley., 2007; Walker et al., 2013; Nijdam-Jones et al., 2015; Colquhoun et al., 2018; Shepherd et al., 2017; Stuart et al., 2017), reported their epistemological stance or demonstrated reflexivity. It is imperative in qualitative research to consider the influence of the researcher's theoretical orientations and role, as well as reflecting on interactions between themselves and the participants. Shepherd et al. (2017) kept a reflexive journal following each interview. Keeping a reflective journal or triangulation would have been useful in the other studies as this adds to the credibility of qualitative research.

Methodology of the Synthesis

A meta-ethnographic approach was used to synthesise reported accounts of service user experiences of recovery. This was developed by Noblit and Hare (1988); it is an established methodology for qualitative data synthesis, and is grounded in the interpretive paradigm (Campbell et al., 2003). It aims to interpret results from an array of studies, rather than aggregating them.

First, relationships between studies were determined by summarising and comparing key concepts in each paper (Noblit & Hare, 1988), to see whether they supported or contradicted one another. A table of key concepts relating to reported accounts of service user experiences of recovery was drawn up for each study (Appendix 4). Concepts from the studies were translated into one another, by comparing the meaning of them (Noblit & Hare, 1988) (Appendices 5 and 6). The concepts all looked at reported accounts of service user experiences of recovery, with the studies identifying different aspects of this topic; therefore, a 'line of argument' synthesis was deemed the most appropriate way to synthesise the translations (Noblit & Hare, 1988), drawing together the information to a new interpretation (Appendix 7). Findings have been interpreted with caution, holding in mind the quality limitations identified.

Findings

Line or argument synthesis. What emerged from the synthesis was a range of experiences service users have that aid recovery in and from forensic mental health services; these have been categorised into nine core themes. The meta-ethnography suggests overlaps between some of the themes outlined, although does not explain how they are linked; it highlights key experiences that enhance recovery from reported accounts of service user experiences in forensic mental health services (Figure 2). The themes and their development are outlined in Table 5.

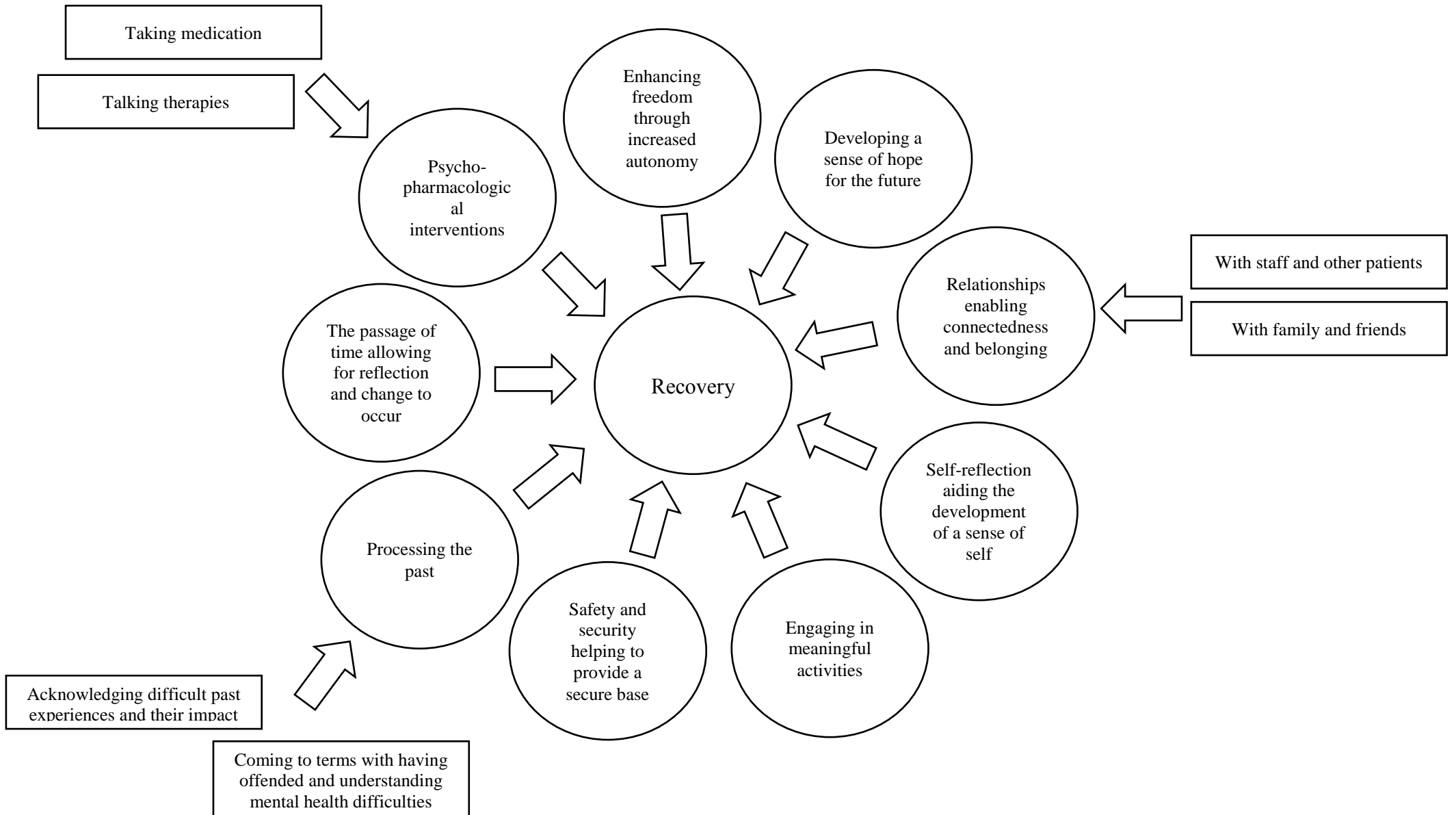


Figure 2. Line of argument synthesis model

Table 5.

Illustration of the line of argument synthesis.

Source/s	First-order theme (illustrative quotation)	Second-order theme	Summary theme (translation)	Third-order theme
Barsky & West, 2007	‘When I first came here I was a bit snappy, err a bit paranoid. Then I learned that I didn’t have to be here’.	Atmosphere on the wards	Safety and security	Safety and security helping to provide a secure base
Laithewaite & Gumley, 2007	‘Being in here was a rest initially.. away from violence, hallucinations. Quiet, quiet’.	Recovery in the context of being in hospital: frightening versus safety		
Stuart et al., 2017	‘..and just to be in a safe environment where everything is done for you’.	Security and care: wanting to feel safe and secure		
Mezey et al., 2010	‘You can sit and think here and just reflect on everything, that’s what helped me anyway... just having a time out’.	What helps bring about recovery: time	Time	The passage of time allowing for reflection and change to occur
Pollak et al., 2018	‘You’ve got plenty of time here and I’ve used the time for different reflections of different kinds, such as what was it that really happened, how come I did that crime and how it has been earlier’.	Time: opportunity for change		

McKeown et al., 2016	A) 'It's all about the relationships with staff. I wouldn't even have started my recovery if I hadn't started to trust some staff'.	Valuing relationships	Relationships A) In the hospital B) In the community	Relationships enabling connectedness and belonging: A) With staff and other patients B) With family and friends
Nijdam-Jones et al., 2014	'My index offence was so terrible. I wouldn't have been able to go on much longer personally without their [staff] support'.	Attachment to supportive individuals: staff, friends and family		
Aga et al., 2017	B) 'A partner is important, because you can say: I'm doing this for her. I want to do it for her'.	Social recovery resources: social network		
Laithewaite & Gumley, 2007	'I am building up more of a relationship with my family. I am hoping to have a relationship with them, which I didn't have before'.	Recovery in the context of being in hospital: the importance of relationships		
Ferrito et al., 2012	A) '..so they were loving parents. But then it suddenly goes bad.. beatings, starvations, humiliations, more beatings..'.	The role of past experiences: early-life trauma	Processing the past	Processing the past: A) Acknowledging difficult past experiences and their impact B) Coming to terms with having offended and understanding
Chandley & Rouski, 2014	'When I came to terms with the past and I learned	Turning points		

mental health difficulties

Adshead et al., 2015	<p>to put it behind me and focused instead on the future’.</p> <p>B) ‘I feel a lot of guilt around the index offense. I’ve taken a son away from a mother. I’ve become a murderer. All this plays on my mind a lot’.</p>	<p>Coming to terms with having offended: identity change</p>		
Skinner et al., 2014	<p>‘You have to understand that you’re the one who committed that action, so it helped me to become more responsible’.</p>	<p>Gaining control and taking responsibility: responsibility for past behaviours</p>		
O’Sullivan et al., 2013	<p>‘I can be me rather than some crazy whatever.. not many people like me when I’m smoking. I turn into an animal’.</p>	<p>‘I can be me rather than some crazy whatever: self and other</p>	Sense of self	Self-reflection aiding the development of a sense of self
Colquhoun et al., 2018	<p>‘..what I need to change and what I need to leave in the past and what I need to take with me; you need to bring some stuff with you’.</p>	<p>Not being the person I was</p>		
Nijdam-Jones et al., 2010	<p>‘Occupational therapy has given me some structure to my day. I like to be productive, I like to accomplish things, and it’s allowed me to do that’.</p>	Involvement	Meaningful activities	Engaging in meaningful activities

McKeown et al., 2016	'I've got quite a busy schedule here and if I didn't, I know that keeps me ticking over'.	The importance of meaningful occupation		
Aga et al., 2017	A) 'Medication is no golden bullet, but I need to say that it can help you to balance your spirit and orientation in time'. B)	Clinical recovery resources: medication	Intervention: A) Medication B) Talking therapies	Psycho-pharmacological interventions: A) Taking medication B) Talking therapies
Mezey et al., 2010	'Having a psychologist has worked.. she talks to me like an equal, she tries to get to the bottom of what is really bothering me and I've found I'm able to talk to her'.	What helps to bring about recovery: diagnosis, psycho-education and medication		
Laithewaite & Gumley, 2007	'I did 'Coping with mental illness' (hospital group) and eventually helped me identify early trigger signs for becoming unwell. I feel more in control now'.	Recovery in the context of being in hospital: valued outcomes		
Walker et al., 2013	'It's a new scooter.. it will get me from A to B, hopefully help me to hold down a job'.	Having a scooter to get me to and from work	Autonomy and freedom	Enhancing freedom through increased autonomy
Barsky & West, 2007	'I went shopping yesterday for the week. I got some baccy and some shopping. I cook	Access off the wards and the security wall		

	Mondays..?.			
Pollak et al., 2018	'For me specifically, it's important this thing about clarity, so you can see what you see, what the actual goal is'.	Hope: to reach a future goal	Hope	Developing a sense of hope for the future
Ferrito et al., 2012	'One day everything was coming together.. I can envision my future; back with my family, having a job..?.'	Internal integration: hope		

Safety and security helping to provide a secure base. People often arrive in secure services feeling frightened and traumatised (Laithewaite & Gumley, 2007; Olsson et al., 2014). The hospital acts as a ‘safe haven’, where one is looked after; this provides a place of refuge and relief from unmanageable lives (Adshead et al., 2013; Stuart et al., 2017), and is responsive to individual needs (McKenna et al., 2014). It is important for the environment to be quiet and feel safe, which helps provide people with the motivation to change (Ollson et al., 2014), and build confidence and self-esteem, free from outside world pressures (Mezey et al., 2010). Participants indicated a desire for security in some form (Stuart et al., 2017), with rules and structure helping them feel more able to function in wider society (Nijdam-Jones et al., 2015; Pollak et al., 2018). For some, locked doors were viewed as beneficial, to protect and shield oneself (Mezey et al., 2010). Conversely, the physical environment could be experienced as toxic, for example, being on wards with violence and limited opportunity to get away from others (Barsky & West, 2007; Mezey et al., 2010).

The passage of time allowing for reflection and change to occur. The passage of time was regarded as helping recovery (e.g. Mezey et al., 2010). This offered the opportunity to reflect on experiences and a possibility for change (e.g. Pollak et al., 2018). Being in hospital gave people a ‘time out’ from their lives (Mezey et al., 2010), in an environment where they could be patient and develop awareness of their internal strengths (Olsson et al., 2014). However, detention in hospital and the passage of time can widen the gap between the person and their community of origin and difficulty arose in maintaining these meaningful relationships (Williams et al., 2011).

Relationships enabling connectedness and belonging.

With staff and other patients. Relationships with staff, as well as other patients, is pivotal in the recovery process (e.g. McKeown et al., 2016). Positive relationships with staff is particularly important, because of the length of time spent in hospital and frequent absence

of positive and affirming relationships outside (Mezey et al., 2010), which perpetuates feelings of frustration, loneliness and sadness (Nijdam-Jones et al., 2014). Development of relationships is difficult due to past difficult experiences (Laithewaite & Gumley, 2007). Service users valued when staff seemed to genuinely care about them (e.g. Ferrito et al., 2012; Cook et al., 2005; Aga et al., 2017), were friendly, willing to help (Barsky & West, 2007), joked with them (Cook et al., 2005), and built rapport through informal activities (Aga et al., 2017; McKenna et al., 2014); these processes allowed for trust to develop (Pollak et al., 2018), and provided patients with a sense of belonging, inclusion and companionship they had not previously encountered (Mezey et al., 2010). It allowed patients to be themselves without fear of being different (Aga et al., 2017). Some patients saw staff as parental figures, where the staff held responsibility for some aspects of their care, which at times was a relief (Stuart et al., 2017).

Negative relationships with staff had a profound impact on individuals' recovery trajectories and left people feeling isolated, unsupported and passive about their care (Ferrito et al., 2012). This was when staff were perceived to be aggressive, antagonistic (Barsky & West, 2007), insensitive (Mezey et al., 2010), dismissive (Shepherd et al., 2017), only there to earn a living (Nijdam-Jones et al., 2014) and undermining (O'Sullivan et al., 2013). Some commented on the power imbalances, which causes friction in the therapeutic relationship (Stuart et al., 2017).

Connecting with other patients was beneficial (Skinner et al., 2014). These relationships enabled people to share experiences (Skinner et al., 2014; Stuart et al., 2017), providing them with a source of support, acceptance and camaraderie (Nijdam-Jones et al., 2014).

With family and friends. Having a stable network of family and friends was generally considered valuable (Aga et al., 2017; Colquhoun et al., 2018), particularly as the

majority of individuals perceived themselves to be ‘outcasts’ from family and society (Williams et al., 2011). Being in secure services enabled people to ‘build bridges’ with social networks, where relationships had previously broken down (Laithewaite & Gumley, 2007; McKeown et al., 2016), although this process was not straightforward (Stuart et al., 2017). Stanton and Simpson (2006) described the experience of surprise service users who committed homicide had, with the ‘overwhelming support’ they received from loved ones, which helped their sense of belonging in wider society. Acts of trust helped solidify relationships (Stanton & Simpson, 2006).

For some, the stigma and isolation of being in a forensic hospital was perceived as having disrupted valued relationships (Nijdam-Jones et al., 2014). At times, support offered by family was experienced as invalidating, failing to understand peoples’ experiences (Stuart et al., 2017). There was a conflict for some about which relationships to maintain; recovery was about developing pro-social networks and avoiding ‘bad friends’ (Aga et al., 2017). Often, pro-social networks were limited (Aga et al., 2017). Activities in the community provided opportunities to develop new relationships (Walker et al., 2013) but there was a dilemma for some of whether to disclose their past (Stuart et al., 2017; Williams et al., 2011).

Processing the past.

Acknowledging difficult past experiences and their impact. Past experiences of adversity and trauma were prevalent (e.g. Ferrito et al., 2012; Stuart et al., 2017) and were associated with being in forensic services; this included parental break-up, abuse, relationship breakdowns and bullying (Laithewaite & Gumley, 2007). These experiences left individuals feeling lonely and worthless (Laithewaite & Gumley 2007), and had an enduring negative impact on the development of relationships with others and their well-being (Ferrito et al., 2012). There was a need for individuals to understand their life story (Ferrito et al., 2012) and wider aspects of their background (Colquhoun et al., 2018), enabling them to ‘let go’ of

the past (Aga et al., 2017). This was seen as a turning point in recovery (e.g. Chandley & Rouski, 2014).

Coming to terms with having offended and understanding mental health difficulties. For some, committing an offence was hugely traumatising and they had to manage the horror of these memories (Stanton & Simpson, 2006). Coming to terms with having offended was important in terms of one's journey through services. Although distressing, the thoughts and feelings associated with the offence were imperative to explore, for the person to process and articulate their experience (Adshead et al., 2015; Pollak et al., 2018). People reflected on their offences and demonstrated understanding into the factors contributing towards this and subsequent admission to hospital (Colquhoun et al., 2018). These recollections were accompanied with emotional appraisals such as guilt and shame (Ferrito et al., 2012), which led to intense self-judgement (Stanton & Simpson, 2006). There seemed to be a tension between pushing away what had happened and trying to accept it (Stuart et al., 2017). Acceptance extended beyond themselves, to their victim, family and others they may have hurt (Mezey et al., 2010).

The majority of patients thought being given a mental health diagnosis was an important step in understanding their experience (e.g. Mezey et al., 2010). This allowed people to begin a process of engagement with recovery and develop a sense of hope for the future (Shepherd et al., 2013). Stanton & Simpson's (2006) participants described how realising they had an illness helped them to understand some of their actions and find compassion rather than just anger towards themselves. Others felt ashamed and stigmatised by diagnoses and being part of the forensic mental health system (Ferrito et al., 2012; Stuart et al., 2017). Adshead et al. (2015) described progression in narratives throughout a treatment group, from a position where people struggled to accept their mental illness led them to have intentions that were 'wrong' and hold beliefs of 'I didn't commit the offence',

through to ‘I did it but I was mentally ill’ to ‘I did it’. This demonstrates accepting responsibility for one’s actions (McKeown et al., 2016). This helped people feel more in control of making decisions about their life (Skinner et al., 2014). Whilst processing the past was important, people recognised recovery ‘does not mean cure... if you chopped your arm off, you will recover but you won’t have your arm back’ (Stuart et al., 2017).

Self-reflection aiding the development of a sense of self. Participants spoke about the development of their sense of self (e.g. Ferrito et al., 2012). One user described it as, ‘from becoming broken to becoming whole again’ (Chandley & Rouski, 2014). A reciprocal relationship was discussed between learning about oneself and developing relationships (Laithewaite & Gumley, 2007). There seemed to be a complex interplay between past selves and possible future selves. Integral to learning about oneself was the capacity to reflect on and understand past experiences (e.g. Laithewaite & Gumley, 2007). People thought developing greater control over their emotional life gave them a greater sense of stability and self-confidence (Shepherd et al., 2017; McKenna et al., 2014), which made returning to society seem much more possible (Walker et al., 2013). Self-reflection helped people incorporate past experiences (e.g. of offending) into a new identity for better or worse, but one that was authentic (Adshead et al., 2015). However, there was a sense some people wished to disconnect with their offending and past (Colquhoun et al., 2018), and a feeling of being divided into two parts, of the ‘Self’ and ‘Other’ or ‘old self’ (e.g. O’Sullivan et al., 2013). The ‘Other’ was associated with offending and mental illness, with one patient describing feeling ‘dehumanised and like an animal’ when unwell, and the ‘Self’ being how they saw themselves when well (O’Sullivan et al., 2013). Some wanted to leave the ‘old self’ behind in hospital (Adshead et al., 2013); a common way of dealing with anxieties about the ‘old self’ was to assume a new identity, which can be achieved through converting to a new

religion (Adshead et al., 2013), moving oneself away from their past and feeling their ‘true self now’ (Stuart et al., 2017).

Engaging in meaningful activities. Often individuals found being in hospital difficult to cope with (Laithewaite & Gumley, 2007); in order to tolerate this, engaging in meaningful activities and having choice in this was important (Barsky & West, 2007; McKeown et al., 2015). Participating in activities provided structure and routine (Nijdam-Jones et al., 2014) and kept people busy, which alleviated boredom (e.g. McKeown et al., 2015; Pollak et al., 2018). Engaging in activities gave people a sense of achievement (Laithewaite & Gumley, 2007) through acquiring new skills (Nijdam-Jones et al., 2014) and completing vocational training (Barsky & West, 2007), which enhanced self-esteem and well-being (McKeown et al., 2015). Achievement was created through learning ways to manage difficulties, which enabled people to feel in control of their lives (Nijdam-Jones et al., 2014). Some wanted to give back and help others (e.g. Stuart et al., 2017), which was attained through activities like delivering lectures and publishing books on their experiences (Aga et al., 2017; Chandley & Rouski, 2014). Physical exercise helped aid physical and mental wellbeing (Stuart et al., 2017).

Psycho-pharmacological intervention.

Taking medication. People had mixed feelings towards medication (Ferrito et al., 2012). Medication alone did not produce recovery, but helped with symptoms such as hearing voices, reinstated service users’ sense of control and restored balance of their ‘spirit and orientation in time’ (Aga et al., 2017; Ferrito et al., 2012). People generally accepted they would need life-long medication (Olsson et al., 2014). Some patients described medication as unnecessary and unhelpful (e.g. Mezey et al., 2010) and thought it was prescribed to them to ‘suppress my rage’ (Williams et al., 2011).

Talking therapies. There was a general consensus that psychological therapies were beneficial (e.g. Barsky & West, 2007). Patients spoke about the importance of having a safe space to talk, where they were listened to, believed, taken seriously and ‘treated like an equal’ (Mezey et al., 2010; Chandley & Rouski, 2014). There seemed to be a need for rationalisation of events and understanding of one’s life story (Ferrito et al., 2012; Aga et al., 2017), which psychological work provided. Other people considered psycho-education about mental health helping recovery and spoke about developing awareness of triggers for relapse and learnt how to monitor and control these (e.g. Laithewaite & Gumley, 2007). Group therapies were valuable through sharing experiences with others (Laithewaite & Gumley, 2007) and helped gain new perspectives (Colquhoun et al., 2018). There was a concern that what people talked about would get misinterpreted and affect their care (Chandley & Rouski, 2014) and some described feeling they were not being offered psychological therapy due to lack of consistency across services (Barsky & West, 2007).

Enhancing freedom through increased autonomy. Freedom in secure services is limited in various ways and there was often a feeling of being ‘stuck and entrapped’ (Laithewaite & Gumley, 2007). Some individuals described a lack of control over their life (Ferrito et al., 2012). Freedom seemed to be enhanced through increased autonomy; this was achieved through means such as having kitchen access to make tea, feeling they were receiving ‘that little bit more trust’ (Barsky & West, 2007). Time off the wards and leave into the community was viewed as important (Barsky & West, 2007; Walker et al., 2013). Autonomy was increased through being given choices where possible (McKenna et al., 2014), for example, the type of medication administration and being an active participant in the development of care plans.

Developing a sense of hope for the future. Hope was defined as a belief that life has purpose and meaning, and the development of hope creates optimism for the future (Cook

et al., 2005; Ferrito et al., 2012). Hope helped counteract feelings of despair and provides motivation for change, as it offers a new way of being and a belief that one's life is worthwhile (Walker et al., 2013). Hope was ascertained through different means; co-produced care plans between staff and service users were viewed as fundamental to creating a culture of hope (McKenna et al., 2014) and helped people envision a future (Pollak et al., 2018; Chandley & Rouski, 2014). Setting short-term goals developed hope and provided a launching pad to embark on more adventurous goals (McKenna et al., 2014). Being granted leave was seen as a milestone in the nurturing of hope; this enabled a gradual transition to life back in the community (Barsky & West, 2007; McKenna et al., 2014). Individuals' sense of hope was increased through attending groups, which related to their belief in their ability to achieve concrete goals associated to a meaningful life (Skinner et al., 2014). Engaging in personally meaningful activities enabled hope for a life not defined by illness or offending history (Walker et al., 2013). Hopelessness and despair were felt, if participants could not see a way out of hospital (Nijdam-Jones et al., 2014; Pollak et al., 2018).

Discussion

This meta-ethnography's results suggest parallels with the previous literature reviews in this area (Clarke et al., 2016; Shepherd et al., 2015). All comment on dimensions of hope, relationships, processing of offending, understanding mental health difficulties and the concept of a shift in identity or a changing sense of self. This review and Shepherd et al. (2015) remarked on safety and security being an important feature of recovery, and this review and Clarke et al. (2016) acknowledged notions of freedom and a range of interventions. A unique finding was the passage of time aiding recovery. This review is important in drawing ideas together, as well as bringing additional aspects of recovery to light. It goes into significantly more depth and incorporates a much larger amount of

emerging literature into the analysis, providing a greater understanding of the intricacies aiding recovery.

Some emerging themes map onto ‘The Good Lives Model’ (Ward & Brown, 2004), a relatively recent rehabilitation approach, which is holistic and strengths-based. This approach to managing risk has had an impact on offending behaviours such as sexual offending (Willis & Ward, 2013) but has only recently been applied to offenders with mental health problems (Robertson, Barnao & Ward, 2011). However, it is a positive step forward with rehabilitation and recovery models aligning in their views, suggesting services and their service users are working towards similar goals in comparable ways.

The themes extracted are consistent with recovery processes identified in general mental health literature (e.g. Leamy et al., 2011). While there is overlap between recovery in general and forensic mental health settings, the differences lie in the increased barriers forensic service users face. For instance, a sense of hope is universally important but forensic service users face greater obstacles to achieving this; if someone is detained under a Section 37/41, the Secretary of State for Justice has ultimate power over decision making processes for when the person leaves (DoH, 1983). Feelings of hopelessness when a can come about when a way out of hospital cannot be envisaged (e.g. Pollak et al., 2018); this highlights the recovery approach should provide forensic service users with realistic expectations of what lies ahead and enabling hope around this.

The theme ‘enhancing freedom through increased autonomy’ shares some ideas of ‘empowerment’ in the general literature but trajectories in forensic settings appear to be focused on freedom and autonomy as opposed to empowerment. This demonstrates the pertinence of these concepts in forensic populations, which starkly contrasts with being detained under the Mental Health Act on a forensic section, where freedom is taken away even though this may be a necessary measure. This juxtaposition highlights another

challenge for forensic service users, where they work towards earning back their freedom via demonstrations this can be used responsibly, safely and not to harm others.

This review identifies unique themes of recovery in forensic mental health settings, such as 'safety and security' and 'processing the past'. Safety is relevant for this population as they have often experienced considerable trauma, with higher reported rates than the general population (Wright, Borrill, Teers & Cassidy, 2006). Research shows there is a clear link between chronic trauma and anti-social behaviour (Maxfield & Widom, 1996). Forensic populations' upbringings have often been criminal (Green, Batson & Gudjonsson, 2011), including victimisation along with intergenerational experience of violence (Burton, Foy, Bwanausi, Johnson & Moore, 1994). As a result of this, forensic service users may have never truly felt safe before (Spitzer, Chevalier, Gillner, Freyberger & Barnow, 2007); physical and relational security helps to provide a sense of safety (DoH, 2010). This can be considered as demonstrating a basic human need (Maslow, 1943) that may have not previously been fully met in these individuals' lives.

Processing the past is pertinent to this population; a longing to understand can be a significant feature of recovery in forensic settings (Drennan & Alred, 2012). This is a complex process in a myriad of ways. The concept of acceptance of offending and the more dangerous aspects of oneself is highlighted as important for recovery. This raises questions whether some offending treatment programmes contradict this idea by using models that involve challenging and changing the unacceptability of violent behaviours (Ministry of Justice, 2018).

Clinical Implications

Practice implications can tentatively be drawn from the findings, as well as identifying areas for further development. Whilst applying the recovery processes outlined

above is challenging within the constraints of forensic services (Slade et al., 2014), changes can be made. The results can be held in mind at all levels of service delivery, from psychology groups being underpinned by recovery principles to how relationships are formed between service users and staff. The below implications are not exhaustive but some ideas of how the findings can be embedded into services.

For service users to feel safe and secure, the therapeutic milieu model is pertinent to follow and is a basic mental health nursing practice (Thomas, Shattell & Martin, 2002), creating a healing culture, which includes the staff, the physical structure of the unit and the emotional climate of those in it. Organisational forms such as therapeutic communities (Leon, 2000) could provide this, as well as emphasising the involvement of service users in their care. Service users being at the centre of services (DoH, 2001), appears to be essential in the instillation of hope for one's future and having increased autonomy. This can also be implemented through user involvement initiatives of being actively involved in one's care-plans (Bowser, 2012) using personalised approaches such as 'My Shared Pathway' (Ayub, Callaghan, Haque & McCann, 2013). There is scope for further development of practices doing this, in an authentic and meaningful way.

Having positive relationships was identified as pivotal in the recovery process. Whilst in hospital, this can be enhanced by staff members holding a compassionate position at all times (Strauss et al., 2016). This is best fostered by supporting staff and attending to organisational culture; practices such as clinical supervision, reflective practice (Cutcliffe, 2003) and training has helped enable staff to build recovery-orientated relationships (Gudjonsson, Webster & Green, 2010). Services would benefit from supporting practices like Restorative Justice, which can help repair previously damaged relationships with service users' loved ones (Cook, Drennan & Callanan, 2015). Family therapy interventions aim to bring service users and families together, attending to offending as well as mental health

needs (Absalom, McGovern, Gooding & Tarrier, 2010), with the aim of strengthening these relationships.

Services should ensure opportunities are provided for individuals to access psychological therapies to help them process the past, and occupational therapies to engage people with individualised and meaningful activities.

Research Implications

This review identifies nine factors contributing to reported accounts of service user experiences of recovery. There are suggestions of inter-connections between these themes but it is unclear how these are related currently. There should be further research, using a Grounded Theory approach, to develop a deeper theoretical understanding of this and providing a clear presentation of the recovery process in forensic mental health settings. This new knowledge would hope to help staff implement this into their work and for services to make appropriate changes, enhancing recovery-orientated practices that are inclusive of service users' perspectives on their recovery. As service users are at the heart of recovery, it would be pertinent to have solely service users' perspectives.

Bearing in mind the context of forensic services and descriptions service users gave about feeling a lack of freedom and control in their lives, it would be useful to further examine this. Research exploring the relationships between power, freedom and autonomy in forensic settings, may help articulate more clearly the dynamics of this and how services can work with this to promote recovery in a safe way. This could be explored via qualitative and quantitative correlational research design. This may help illuminate other aspects of power and difference, such as differences between service users and staff in terms of class and race, which are notably absent from this review. None of these ideas came up but the multiple

layers of identity by which forensic service users might be socially excluded may have important ways of interacting with recovery.

Strengths and Limitations

There is a limitation in the concept of ‘recovery’ itself. By definition, it is something that is individual, idiosyncratic and complex. Each person, staff or service user, may have a slightly different understanding. This review is not intended to provide a rigid view of what recovery ‘is’ in forensic mental health settings; rather, it is better understood as a resource for future research and clinical practice to draw on.

Findings in this review have been separated into different themes but there is some cross-over; Laithewaite & Gumley (2007) comment on the reciprocal relationships between developing a sense of self and relationships. While this review brings structure to a broad topic area, it is possible if someone were to replicate the meta-ethnography, the findings may be grouped slightly differently. It may have been beneficial to have another researcher co-analysing the results, to minimise the impact of personal theoretical bias on this process.

This review analysed 22 studies, and so was the largest review carried out to date in this area. It used a structured method to analyse the findings, which strengthens the robustness of the results yielded. The literature included was of good methodological quality, but more attention needed to be paid to reflexivity.

Conclusion

By drawing together existing qualitative research, this review adds to understanding of reported accounts of service user experiences of recovery in forensic mental health settings. It produced nine themes that support and develop from previous reviews. It highlights additional recovery processes forensic service users undergo, compared to individuals within general mental health systems. The studies had methodological strengths,

such as appropriate research design and use of data validation. The principal limitations lay within lack of researcher reflexivity and inadequately justified sampling strategies, which limit the findings' robustness. There are clinical implications and a need for future research to develop a framework of recovery from service user perspectives, which can be achieved through a Grounded Theory design.

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Section B: Empirical Paper

“My Journey through the System”: A Grounded Theory of Service User
Experiences of Recovery in Forensic Mental Health Services

For submission to the Journal of Forensic Psychiatry and Psychology

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Abstract

The 'Recovery Approach' is widely regarded as the guiding principle for mental health service delivery in the UK. Forensic services face unique challenges in applying this approach. Numerous studies have explored themes associated with recovery in these settings but it is currently unclear how themes relate to each other. This study set out to build a theoretical model of service user experiences of recovery in forensic mental health settings. Semi-structured interviews were conducted with sixteen service users about their experience of recovery. Grounded Theory methodology, with a constructivist epistemology, was used to analyse the interview data. A cyclical model was developed, with five core recovery processes that inter-related; these were: the environment, connectedness, hope for the future, who I am and empowerment. These occurred in three phases of 1) feeling safe and secure, 2) moving forwards, and 3) empowerment. These processes were encompassed by two additional themes of arriving at hospital and changes over time. This study is the first to provide a clear model of service user experiences of recovery in this setting. Clinical and research implications are discussed.

Keywords: recovery, forensic mental health, service user

Introduction

Recovery in Mental Health Services

Anthony (1993) provided the most widely accepted definition of recovery:

“A deeply personal process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying life even with limitations, caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness”.

Support for personal recovery from mental health difficulties is an explicit goal for modern mental health services (Shepherd, Boardman & Slade, 2008) and is increasingly promoted as the guiding principle in the UK (Department of Health [DoH], 2007, 2009, 2011). This places service users’ personal recovery at the centre of services, empowering them to have control and choice. The recovery movement started in the 1980s and aimed at restoring human rights and full community inclusion of people with mental health difficulties, who had previously faced stigma and exclusion from society (Commonwealth of Australia, 2008).

“What service users want is not expensive: it is to be heard and valued, understood and respected and supported to attain their aims” (Carr, 2008).

A conceptual framework of recovery was proposed in Leamy, Bird, Boutillier, Williams & Slade’s (2011) literature review. Key themes of connectedness; hope; identity; meaning; empowerment; and spirituality, were identified. The recovery approach promotes a holistic ideology (Slade, 2009); it advocates for empowering individuals to achieve quality of life, despite challenges associated with mental health difficulties (Anthony, 1993), rather than focusing on clinical recovery and symptom reduction (Lieberman & Kopelowicz, 2002).

Recovery is a process and not an outcome to be achieved, and has forward and backward momentum (Andresen, Oades & Caputi, 2003).

Recovery in Forensic Mental Health Services

While individuals in general mental health settings have faced challenges, forensic mental health service users are doubly stigmatised; they have typically had contact with the criminal justice system, as well as experiencing mental health problems so severe that they have been sectioned (Drennan & Wooldridge, 2014). This duality increases the complexity of recovery, potentially increasing time spent within in-patient services and the likelihood of readmission following discharge (Klassen & O’Conner, 1998a). Many individuals have been subjected to adverse life experiences and social inequalities from birth (Drennan & Wooldridge, 2014), with criminal behaviour perpetuating in their families and wider systems (Green, Batson & Gudjonsson, 2011). Research suggests correlations between chronic trauma and adult offending and violence (Maxfield & Widom, 1996). This indicates the recovery process for this population may have additional challenges, which raises the question: How are these individuals able to feel connected to others, have hope for the future, establish a positive identity, and have meaning in their lives?

The implementation of the recovery approach initially proved contentious in forensic mental health services, which have traditionally been led by a bio-medical model; this is often orientated towards impairment, staff-led treatment decision-making (Borrell-Carrio, Suchman & Epstein, 2004; Ghaemi, 2006) and concepts of security and risk (Clarke, Lombard, Sambrook & Kerr, 2016). Recovery and risk often seem to be in tension with each other (Livingston, Nijdam-Jones & Brink, 2012). Drennan and Alred (2012) outlined how risk of further potential harm to others affects all areas of forensic service delivery (Drennan & Alred, 2012) and has a profound impact on how individuals’ care is approached. Characteristics of some forensic service users, such as anti-social personality traits, criminal

histories, limited insight into mental health and treatment non-compliance, have been highlighted as impediments to adopting recovery-orientated approaches (Green et al., 2011). Feelings of powerlessness and oppression are part of the subjective experience of receiving forensic services (Livingston & Rossiter, 2011). This highlights a tension forensic mental health practice faces within the recovery paradigm; empowerment and choice are core aspects, which is juxtaposed with the need to manage risk of recidivism (Pouncey & Lukens, 2010).

Two literature reviews (Clarke et al., 2016; Shepherd, Doyle, Sanders & Shaw, 2015) have explored recovery within forensic settings from service user perspectives. Clarke et al. (2016) ascertained six superordinate themes: connectedness; sense of self; coming to terms with the past; freedom; hope; and health and intervention. Shepherd et al. (2015) ascertained three tertiary themes: safety and security as a necessary base for the recovery process; the dynamics of hope and social networks in supporting the recovery process; and identity work as a changing feature in the recovery process. These findings sit alongside recovery concepts in general mental health but acknowledge unique aspects, such as coming to terms with having offended. Recovery from mental health difficulties does not necessarily mean ‘recovery’ from antisocial behaviour and this needs to be addressed separately (Green et al., 2011). Drennan and Alred (2012) support this notion with their proposal of ‘offender recovery’ where the reality of the offence poses a recovery task. The ‘offender patient’ has to work through their personal guilt and reconcile their ‘mental illness’ with their sense of personal responsibility (e.g. Dorkins & Adshead, 2011).

While there are challenges faced from implementing a recovery model in these services, they are not impenetrable. It requires thoughtful considerations at all levels, from organisational systems to service users, about the balance of how risk is managed, and how

recovery principles can be embedded alongside this. The advantages of adopting a recovery-orientated approach are systemic, not only helping the service users but society as a whole.

Rationale

At the heart of recovery is the subjective experience. An understanding of service user experiences of recovery is a crucial perspective to have. This has been highlighted as paramount in maintaining the integrity of the premise of personal experiences that underpins recovery (Donnelly et al., 2011). Literature reviews summarise key components of recovery processes from service user perspectives in forensic mental health settings. Yet it is not currently clear how different components relate to each other and interact to form the recovery process. Developing a model grounded in service user experience could help further theoretical understanding of the process of recovery from when a service user enters forensic mental health services.

Research Questions

1. From a forensic mental health service user perspective, what is their experience of recovery?
2. What are the relationships between the emerging themes of recovery in forensic mental health settings?

Method

Design Overview

A non-experimental qualitative design was used, with a Constructivist Grounded Theory [GT] approach (Charmaz, 2006). Data were collected using semi-structured interviews, which were transcribed and analysed using GT methods. This was adopted because it offers a way to develop an explanatory framework, with which to understand the phenomenon under investigation (Willig, 2013), rather than only describing themes. A

constructivist position recognises how contributions by the researcher, participants and the context influence the developed model. These contributions are an explicit part of the process, such as where the resulting model was brought to a participant focus group for validation.

Participants

Recruitment sources. Participants were recruited from Forensic departments of two NHS mental health trusts. In Trust A, participants resided in low-secure and recovery wards (n=9) or were living in a community forensic hostel (n=1). In Trust B, participants resided in a low-secure pre-discharge ward (n=4) and in the community (n=2).

Participant numbers. The study aimed to reach ‘theoretical sufficiency’ (Dey, 1999); this is the stage where categories can cope adequately with new data without requiring extensions or changes and no new themes are emerging (Dey, 1999). Between eight and sixteen participants are usually required to reach saturation (Guest, Bunce & Johnson, 2006). This study had sixteen participants.

Inclusion and exclusion criteria.

Table 1.

Inclusion and exclusion criteria.

Inclusion	Exclusion
<ul style="list-style-type: none"> • Detained or have been detained under the Mental Health Act (2007) • History of offending • Clinical team have agreed suitability for the research and capacity to consent • Age range: 18-65 • Any sex or gender • Residing in lower security accommodation or in the community. This suggests they have moved through forensic services to a certain degree. 	<ul style="list-style-type: none"> • English as a second language is not an automatic exclusion. Rather efforts are made to use an interpreter if required, in discussion with the participant and their clinical team • Acute symptoms of psychosis

Sampling strategy. A purposive theoretical sampling strategy was adopted to achieve heterogeneity in experiences drawn upon (Corbin & Strauss, 1990). Using this strategy, participants were selected based on experiences and qualities they possessed, seeking a range of experiences rather than a numerically proportional representation (Tongco, 2007). This was conducted concurrently with data analysis, so participants with particular experiences could be sought if found relevant during analysis

Participant demographics.

Table 2.

Participant characteristics.

Characteristic	Participant information
Age:	Range: 23-57; Median: 38; Mean: 41
Gender	Men: 12; Women: 4
Ethnicity	Black-British: 8; White-British: 6; White-European: 1; Iranian: 1
Section	Section 37/41: 10; Section 3: 3; Section 45A: 1; Section 41: 1; Section 117: 1
Primary diagnosis	Paranoid schizophrenia: 9; Schizo-affective disorder: 5; Emotionally Unstable Personality Disorder: 2
History of substance misuse	Yes: 13; No: 3
Index offence	Common Assault: 3; Actual Bodily Harm [ABH]: 3; Arson: 2; Murder: 1; Manslaughter: 1; Grievous Bodily Harm [GBH] with intent: 2; Rape: 1; Battery: 1; Sexual assault: 1; Trespass with intent to commit a sexual offence and assault by penetration: 1
Range of other offences	Threats to kill; Assault; Attempted strangulation; Wounding; Indecent exposure; Rape; Sexual assault; Theft; Destroying or damaging property; ABH; Possession of a weapon; Affray; Arson
Range of length of time in hospital on current admission	9 months – 11 years
For those discharged from hospital, range of length of time in the community	2 – 5 years
Interpreter required	No interpreters were needed

Procedure

Recruitment. The researcher attended multi-disciplinary team meetings, presenting the research to recruit participants. Staff were emailed information (Appendix 13), including the information sheets (Appendices 14 & 15), and consent forms (Appendix 16). The

researcher attended community meetings to present the research to service users. Service users expressing an interest were discussed with clinical teams about suitability and capacity to consent, in line with the Mental Capacity Act (Department of Health [DoH], 2014). Following team approval, the researcher met with potential participants to obtain informed consent. There was a possibility selection bias could occur through the team approval process; staff were reminded as long as the individual met the inclusion criteria then they were suitable to participate.

Interviews. The interviews aimed to explore participants' unique experience and understanding of their recovery as fully as possible. The interviews were semi-structured, structured around the research aims but also flexible, allowing more spontaneous descriptions and narratives (Brinkmann, 2014). This shifts control towards the participant (Corbin & Morse, 2003).

An initial interview schedule was generated (Appendix 17) following research supervision, informed by principles outlined by Charmaz (2014). In later interviews, the interviewer assumed a more active role and asked more direct questions to inform theory generation (Charmaz, 2014) (Appendix 18). Interviews were audio-recorded. Interview length ranged between 39 and 55 minutes. The interviews were transcribed by the researcher and coded by hand initially and later using NVivo software.

Background information data collection. An information sheet was completed by staff (Appendix 19) to obtain participant demographic information. The most recent violence risk assessment (HCR-20v3, Douglas, Hart, Webster, & Belfrage, 2013) was provided by staff.

Data analysis. Analysis was conducted concurrently with data collection. This allowed theoretical sampling to take place. The first three interview transcripts were

analysed with Initial Coding, a line-by-line process to identify simple descriptive codes, remaining close to the data (Appendix 22). Then the most common or significant codes were considered, and Focused Codes were developed (Appendix 23). Codes moved from description to conceptualisation, using terms that are directed, selective and conceptual (Glaser, 1978). Further interviews were conducted and focused codes held in mind; participants spontaneously brought content that could be coded under these codes and direct questions about the focused codes were asked if not. Larger segments of data were coded with the discovered categories (Appendix 23). Categories aimed to be 'in vivo', in that they utilised words and phrases used by participants. As the process of interviewing and analysis progressed, coding moved to Theoretical Coding, where analytic categories were developed starting to encapsulate and explain the data, as well as relationships between the analytic categories (Appendices 24, 25 & 26); Theoretical Codes conceptualise how the Focused Codes and Categories may relate to each other as hypotheses to be integrated into the theory (Glaser, 1978). Throughout the analysis, constant comparison (Glaser & Strauss, 1967) was employed; data were constantly compared to find similarities and differences both within the same interview transcript and across interview transcripts. Memo-writing took place throughout (Appendix 28); these kept a record of the interactive process between the earlier codes and later analytic categories, as well as being a quality assurance process.

Quality assurance checks. A number of strategies were employed to ensure quality throughout.

Reflexivity. Social constructivist approaches to GT highlight the importance and impact of researchers' pre-existing knowledge, ideas and beliefs (Cutcliffe, 2000; Charmaz, 2006). Reflexivity examines how researchers' positions and assumptions influence their decisions and interpretations (Charmaz, 2014) and attempts to make this explicit and take this into account. Five strategies were used to enhance reflexivity: 1) A positioning statement

(Appendix 20); 2) A bracketing interview (Tufford & Newman, 2010), where the researcher was interviewed about their values, assumptions and beliefs about the research prior to data analysis (Appendix 21); 3) Supervision, to draw attention to potential biases and staying true to the data; 4) Memo-writing, mapping and documentation of the coding process to provide an open account of theory development; 5) A reflective diary, commenting on personal reactions to the interviews and research (Appendix 29).

Inter-rater reliability. While the interviews were coded and analysed by the researcher, meetings were held with supervisors to discuss and evaluate data and theory development; this enabled the researcher to be open to differing interpretations and ensured categories and theory development corresponded to the data.

Theory checking and respondent validation. Participants were invited to attend a focus group to provide feedback on the initial model to validate whether they felt it reflected what they had spoken about in the interview (Appendix 30) (Bryman, 2004). Four participants attended. This is in line with a constructivist approach of GT, as it allowed participants to provide feedback and co-construct the theory, balancing the perspective of the researcher. The feedback was incorporated into the final theory.

Ethical Considerations

Approval. Ethical approval was granted by an NHS ethics committee (Appendix 9), the Health Research Authority [HRA] (Appendix 10) and the Research and Development departments for the NHS trusts (Appendices 11 and 12).

Informed consent. Participants and the clinical team were provided with verbal and written information about the research. The clinical team assessed capacity. Participants signed consent forms at least 24 hours before their interview and were reminded they had the right to withdraw at any time.

Confidentiality and data protection. Only the researcher had access to the recordings, which were deleted once transcribed. Identifying information was anonymised in the transcripts. The supervisor accessed anonymised transcripts for inter-rater reliability purposes. Participants were reminded of limits of confidentiality at the beginning of interviews.

Managing potential harm to participants. Participants were offered a debrief and were provided with work contact details for the researcher if they had any concerns.

Feedback to stakeholders

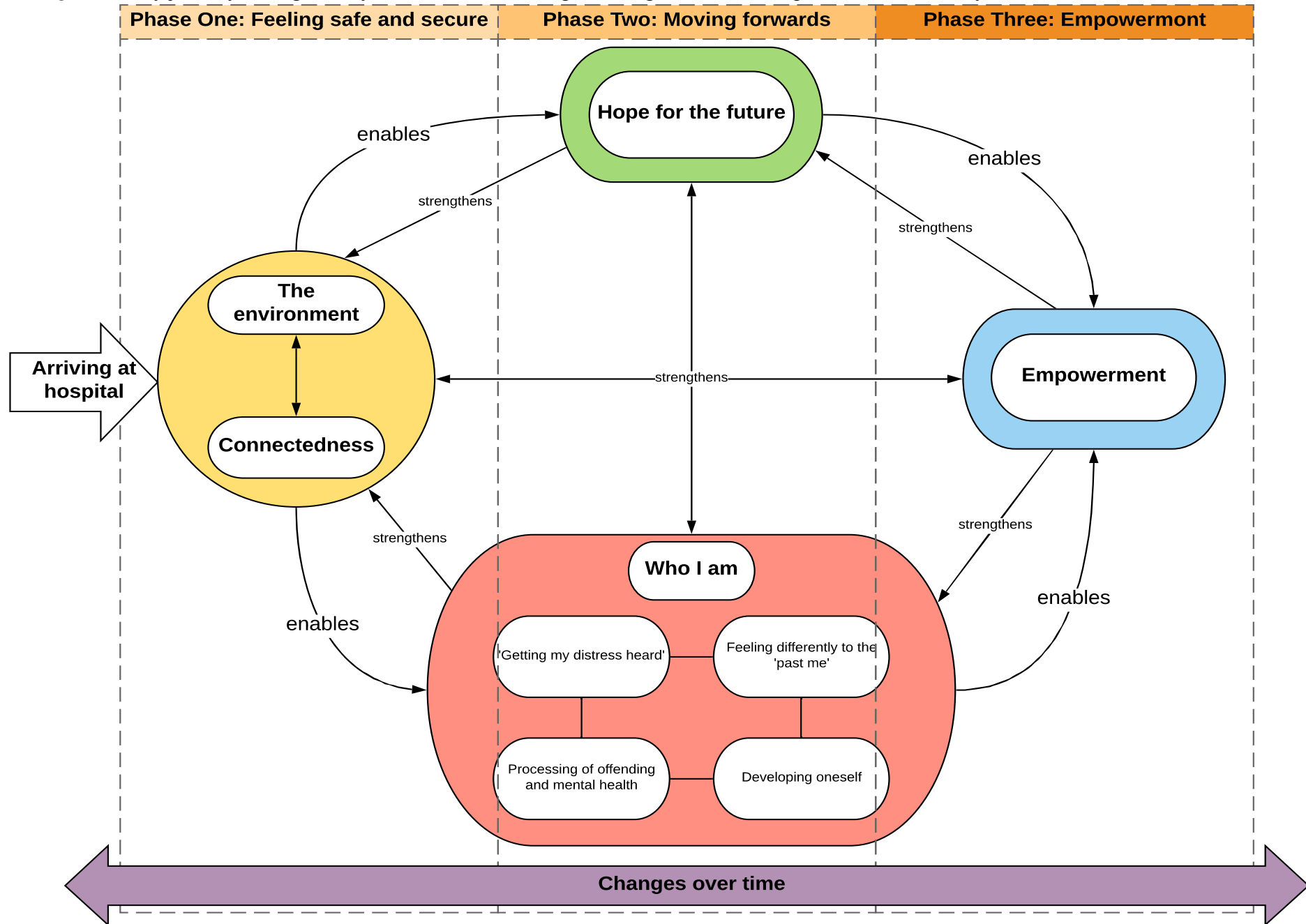
The results were fed back to relevant stakeholders: NHS ethics panel; HRA; relevant R&D departments (Appendix 32); all participants (Appendix 33); and relevant teams and conferences where the research was carried out.

Results

Grounded Theory Model

A cyclical model was constructed representing service user experiences of recovery in forensic mental health settings. An overview of the model as a whole is presented in Figure 1, followed by a detailed account of categories and how they are related. Illustrative quotations are italicised in the text. Participants are referred to as P1, P2 and so on. See Appendix 27 for additional quotations.

Figure 1. 'My journey through the system': a GT model representing service user experiences of recovery in forensic mental health services



Model Summary

The model is called “*My Journey through the System*” (P16) and contains five superordinate categories: the environment; connectedness; hope for the future; who I am; and empowerment. These were described as occurring in three phases of 1) feeling safe and secure, 2) moving forwards and 3) empowerment. Categories strengthened and reinforced each other in a cyclical process, which suggests participants’ perceived recovery as an on-going phenomenon. No one category was sufficient to facilitate recovery, without the aid of other processes. Two additional categories were found encompassing the process, which were ‘arriving at hospital’ and ‘changes over time’. The temporal dimension of the model was important, to enhance potential for change. The lines separating the phases are broken to signify the porous divisions between phases. See Table 3 for an outline of each of the categories.

Participants portrayed what it was like arriving at hospital, providing a context of their state of mind. ‘Feeling safe and secure’, the first phase in the process, was described as a reciprocal relationship between two superordinate categories, ‘the environment’ and ‘connectedness’; this provided a necessary basis for other recovery processes to occur. ‘Feeling safe and secure’ enabled participants to move onto a second phase: ‘moving forwards’. Participants described building ‘hope for the future’, alongside processing and developing ‘who I am’. These two superordinate categories strengthened and worked alongside one another. Thinking about ‘who I am’ was portrayed as a complex process of “getting my distress heard”, processing of offending and mental health, feeling differently to the “past me” and developing oneself. Having hope and developing a greater sense of ‘who I am’ helped empower individuals, moving to a third phase of ‘empowerment’. This reinforced people feeling safe and secure, not only in their external world but also within themselves, which they described not feeling on arrival to hospital.

Respondent validation

Participants in the focus group stated the model represented their experiences, although one participant highlighted “*we are all different*” (P14), demonstrating although there are core recovery processes, each individual and their experience is truly unique. Participants chose the colours of superordinate categories: yellow for ‘feeling safe and secure’, signifying a possible “*danger zone*” (P12); red for ‘who I am’ representing the more difficult aspects of recovery in terms of thinking about one’s past, offending and mental health; green for ‘hope for the future’, expressing “*being free*” and “*renewal*” (P15).; and blue for ‘empowerment’ to embody an inner peace within themselves. Other feedback is interweaved in the below results.

Table 3.

Summary of categories and sub-categories.

Phases	Categories	Sub-categories
One: Feeling safe and secure	The environment	Having boundaries and routine Pharmacological interventions
	Connectedness	Trust between staff and service users Acceptance and belonging Others believing in me
Two: Moving forwards	Hope for the future	Having and achieving goals Envisaging the future Having faith
	Who I am	‘Getting my distress heard’ Processing of offending and mental health Developing oneself Feeling different to the ‘past me’
Three: Empowerment	Empowerment	N/A
Additional categories	Arriving at hospital Changes over time	N/A

Arriving at Hospital

Participants reflected on experiences of arriving at hospital as feeling chaotic and out of control:

“I didn’t have any control over my life” (P9);

“I did not know where I was, I did not know what was happening... I did not trust where I was” (P16);

“I was all over the place” (P15).

At this point, service users felt diminished in both internal and external resources. It was described as *“walking into oblivion”* (P6). This feeling was temporary and being in hospital helped to change this fragmented state of being.

Phase One: Feeling Safe and Secure

Participants described a need to feel safe and secure. There were two core aspects of this: ‘the environment’ and ‘connectedness’. These were portrayed as having a reinforcing reciprocal relationship. Participants shared in the focus group they believed this provided a necessary base for other aspects of recovery to ensue.

The environment. There were two sub-aspects of being in hospital that helped participants feel safe and secure: having boundaries and routine; and pharmacological interventions. They spoke about the impact this had on them:

“I feel safe and I have been here two years and I have been out 60, 70 times and I have never bothered to go AWOL because I don’t feel like I need to” (P9).

Participants reflected on what their life might be like if they had not been ‘put’ in hospital:

“If I hadn’t been put on a restriction hospital order, I would be doing drugs I think” (P5).

This demonstrates the protection the hospital environment offered them.

Having boundaries and routine. The boundaries and routine of the hospital environment were contrasted with the lack of these and resultant chaos in the community:

“When I was in the community, I did not have so much structure” (P4).

Introduction of boundaries and routine enhanced a sense of safety and security. This included meeting basic physiological needs:

“Now I am not naked, I am not hungry, I am not homeless” (P11); “I like the regularity, of things being in order... the regularity of eating and sleeping, like having a routine” (P7).

Initially the boundaries and routine are described as being imposed by staff:

“You have to wake up at a certain time” (P12);

“I tried to comply with the rules and regulations and the way they operate” (P13).

It was described as important to *“not be done in an oppressive way” (P8)*. Participants described transitioning to an internalisation of this:

“I make sure I get sleep every night, take my medication on times and just occupy myself” (P5);

“I think I know more so now that routine is important” (P4).

Engaging in activities added to the routine of peoples’ days, which were experienced as respite from their own minds:

“When I go there [art group] I am distracted from everything and I am doing something that is like escapism” (P15).

Participants felt the activity engagement was unhelpful if it was coercive:

“I would have to go otherwise I wouldn’t get something like shop run or whatever... I used to hide in my bedroom, it made me hate it even more” (p3).

Inconsistent boundary setting was described as being detrimental to participants and their recovery:

“The staff are quite inconsistent. Like when you go on your leave some of them will let you smoke but some of them will come back and say we are stopping your leave now because I smoked but the day before they didn’t say anything about it” (P7).

Environments that were “noisy” (P2) or “had lots of violence” (P6) were described as making it more difficult for people to engage with structure and boundaries of the ward.

Pharmacological interventions. Medication was experienced as helping participants to feel safe in their environment. One participant commented, “if anyone took it [clozapine] away from me, I would be a mess” (P2). It was described as lessening distressing experiences, such as voice hearing:

“The illness is always there but the medication relieves the symptoms. It helps me to function properly, to think properly” (P13).

It helped peoples’ minds feel clearer, “turning down the volume” (P14) on any voices and paranoia. The alleviation of distressing experiences helped participants feel safer in their own mind, “feeling a lot better in myself” (P15) and see the staff as safe, giving patients “an opportunity to start their relationships with staff” (P16).

Participants mentioned the balance between being given medication to help with difficulties combined with having staff support:

“They help me not just in the way of taking PRN but by talking to me” (P2).

Participants spoke of experiences where they had not complied with medication, which one person related to *“experiencing abuse while I was in prison, which made me resist the medication all the more”* (P16). Participants thought they were more likely to comply with prescribed medication when they trusted the person encouraging the idea:

“He was a good friend and he said even if I have a shorter-term life on medication, it will be a life of good quality rather than being ill all the time”
(P15).

This demonstrates the complex decision-making processes service users engage in.

Connectedness. This category has three sub-themes: trust between staff and service users; acceptance and belonging; and others believing in me. Different aspects of these sub-categories were described as having differing importance to individuals. Aspects of ‘connectedness’ merge with some of ‘the environment’ sub-categories, such as staff implementing boundaries and structure.

Trust between staff and service users. A mutual relationship of trust was talked about as necessary for meaningful relationships to develop. Participants described trust being created through staff being compassionate and caring:

“Just a gentleness to them and a sincerity about their work” (P4).

Participants believed how they were treated, impacted their feelings and behaviour:

“When people treat you well when you are unwell, it reflects on your whole recovery, because you feel like a human and that you can do what they [staff]

expect of you. It means I do not have a desire to go and get high and forget about everything” (P8);

“...that really helped because they were putting their trust in me and I didn’t want to break that” (P2).

This enabled service users to feel like they could trust staff, and could start talking to them about their personal issues:

“I could come with anything that I really wanted to say and I knew I wouldn’t be penalised just for talking” (P9);

“They make me feel safe, which is important to me because in my past I haven’t felt safe” (P2).

Trust was demonstrated through small, yet significant acts such as, *“doing simple things like letting me go to make my own cup of tea” (P2)* or being trusted with certain equipment:

“I would go gardening and one staff member would give me a plastic trowel and then they next day they would give me a pitch fork” (P1).

This enabled the participant to feel like they *“had achieved something” (P1).*

Not all experiences of staff were positive, as highlighted in the ‘having boundaries and routine’ sub-category. Participants had experiences of staff being *“on a power trip” (P7)*, which made it difficult to develop genuine relationships.

Acceptance and belonging. Belonging and being accepted created a sense of connectedness for participants. It was important for participants to feel like there were people who truly knew them outside of hospital:

“It is nice to talk to someone who knows me” (P15).

Participants found being treated the same as they always had been important:

“Mum treats me the same when I am here as if I was at home” (P8).

The maintenance of these relationships was enabled through visits and telephone calls:

“I talk to my friend on the phone and we just have a laugh” (P3);

“My mum has been really supportive; she comes at least twice a week” (P6).

This made participants feel that people do care about them:

“She is caring and that is something I have not had in a long time” (P3);

“Having someone who wants to look out for you and not bring you down” (P7).

Participants felt these relationships provided them with motivation and hope of change:

“I don’t want to mess up or let people down” (P14);

“Every time I talk to my mum, she says make sure you don’t do any of that [drug taking]” (P5);

“Having decent people around me makes me feel like there is something worth changing for” (P7).

A sense of belonging was described as important:

“Just a lot of my life I have been bullied and felt that I have not been wanted but knowing my family keep coming back makes me feel wanted and a part of something” (P1).

Having a sense of belonging to a group in the community, enabled participants to envisage being a part of that upon leaving hospital and being socially included in wider society:

“I never had a sense of community in the past, it is one where I can belong to, they have welcomed me fully” (P10).

People had experiences that juxtaposed this, where they felt “*marginalised and just treated in an unsatisfactory way by the people I have been around*” (P8), which was described as being “*very painful*” (P8). One participant questioned, “*if your own family do not care about you, who is going to?*” (p9), leaving them feeling alone and disconnected from others, which was described as a hindrance to recovery.

Others believing in me. Having other people believe in participants enhanced their belief in themselves:

“*A lot of the days I couldn’t see the good parts of me and even now when someone says, ‘well done, you have done really well’, I think, yeah alright*” (P1).

The faith of others encouraged participants to achieve things they otherwise would not have thought possible. One participant, when thinking about their role as an ‘expert-by-experience’, attributed this to “*other people seeing something in me that I did not necessarily see in myself*” (P16). Some participants described the emotional pain of not having others believe in them:

“*It broke my heart and really set me back*” (P15).

Phase Two: Moving Forwards

This phase was described as being enabled through ‘feeling safe and secure’ and is characterised by the development of hope for the future and of “*who I am*” (P7). Both superordinate categories were portrayed as occurring alongside one another, and both strengthening the other; the more someone felt they were developing who they were, the more hopefulness they had for their future. The processes associated to ‘moving forwards’, strengthened participants’ safety and security.

Hope for the future. Participants believed having hope counteracted feelings of despair. They felt it offered them an opportunity to see how life could be different and have belief this new way of being is worthwhile. Participants in the focus group expressed this category as “*very important*” (P11). There were three sub-categories: having and achieving goals; envisaging the future; and having faith.

Having and achieving goals. This enhanced participants’ hopefulness. Short-term goals that were realistic and attainable, helped individuals see their longer-term goals were achievable:

“Because I have been getting my escorted leaves, I have started to feel like I am moving on” (P3).

This kept participants motivated and focused, feeling like they have something to work towards:

“Having goals helps me navigate my way through the system. Originally my goal was to get out of hospital and then once I had got out of hospital, I was hearing there was a possibility I could step down into independent living, so I thought, okay, let’s make that my goal” (P16).

Envisaging the future. Achieving goals helped participants envisage their future:

“I can see the future more clearly. When I was young it was always about today and tomorrow but now, I can see more than that. I can see myself getting a job. I feel more confident” (P10).

Participants were hopeful about their future, and a new way of being, from achieving goals:

“I started going out more and I started to think that, yeah, there is a life outside of hospital” (P3);

Participants struggled to see a hopeful future when they received negative messages from others, about what they thought their future would look like:

“Everybody said that I would be in high-secure until I am old. If someone tells you enough times that wall is black, you will start to believe it” (P1).

This demonstrates the profound damaging impact others’ comments can have on a person’s hopefulness.

Having faith. For some, having a faith in a spiritual or religious sense provided them with hope for better things to come:

“It is nice to think that there is a plan behind everything. Even though it is painful and there is pain you have to go through at times, there is always a reason for it” (P9);

“I just have a faith in God that I can put myself through anything and I will come out strong the other end” (p8).

Some participants described the importance of what their faith gives them, in the absence of close relationships.

Who I am. Processing and developing ‘who I am’ was depicted as a multifaceted process and a complex interplay between a past and possible future self. This involved four sub-components: getting my distress heard, processing of offending and mental health, developing oneself and feeling different to the ‘past me’.

‘Getting my distress heard’. Participants’ pasts were described as being characterised by trauma and difficult childhood experiences, which had a profound impact on their life. Participants believed these experiences had not been addressed, with them holding unresolved emotion relating to this:

“She said it was a space where I could get my distress heard and that was really helpful for me because sometimes you want to speak but you feel like it is not always going to be received well” (P4).

Having a space to talk about this distress helped:

“To have the ability to put everything on paper, rather than it going around in your mind, spinning like a washing machine, going out of control. It is good to have something you can look at rather than be confused by” (P15);

“It helps me release my feelings instead of bottling it all up and taking it out on myself” (P3);

“For me it is like off-loading and airing it out really, getting it out of me, physically out of me, for someone else to share it” (P4).

Participants found it more challenging to talk about their distress when they felt the therapist had a different agenda, which was seen as a barrier to recovery:

“I wanted to talk about the emotional stuff, and she wanted to talk about the practical stuff” (P6).

A focus group participant did not think this sub-category was important:

“I don’t talk about things, I just get on with it” (P14).

This reflects different processes will be more pertinent to different individuals.

Processing of offending and mental health. Participants struggled to talk about their offending and some named the shame they felt around this, which may partly explain their difficulties in discussing it:

“It scares me thinking about these things [offending]. The shame and guilt comes in and starts to play on your mind. It is like it is always going to be there, like a bag on my shoulder. It is always there” (P8).

Participants spoke about how various groups had helped them to learn different ways of managing:

“I did a violent treatment programme for two years, I think it made a massive difference” (P1);

“Because I did the group and they gave me the tools of how to manage anger” (P13);

“Learning is empowering. It gives you the tools to move forwards” (P15).

From engaging in some of this work, participants felt they could take responsibility for their actions and understand the potentially devastating impact they can have:

“At the end of the day the decision is yours. When you start to recover you start to realise the wrongs you have done and the ripple effects it causes to your family, friends, neighbours and community” (P11).

Some participants viewed offending as a secondary to other difficulties such as substance misuse and mental health, seeming to move away from taking responsibility of offending:

“Any offence I have ever committed has been when I have been so unwell that I genuinely cannot even remember doing it” (P9).

A few participants said making sense of offending, did not fit with their recovery.

People talked about their mental health as if it was something of the past they no longer connected to:

“I was diminishing a few years before hospital, you know when you get a virus on your computer, I felt like that. But I don’t feel like that now” (P8).

“I am a lot more stable now” (P16).

Various participants spoke about the decline in their mental health being associated to substance misuse:

“I smoked weed at the time and I started developing weird symptoms” (P9).

Participants reflected on the importance of learning about the effects of drug taking:

“I have listened to the doctors and they taught me that it causes mental illness, that your behaviour can change, and you don’t think the same” (P12).

Increasing understanding and knowledge of one’s experiences added to the individuals’ sense of self, describing it as *“helping put the pieces of the jigsaw together” (P14).*

Developing oneself. Alongside processing past experiences and understanding themselves, participants described putting time into developing new and different parts of who they are. This was partly achieved through people engaging in meaningful activities:

“I put a lot more time into my personal self. I invest a lot of time into myself. I do paintings and draw all the time” (P9);

“I am on a mechanics course... I am so happy about this... I want something big like this in my life, I need it... It gives me strength and it gives me power. It shows me that I am able to do something positive in the world. And that feels great” (P8).

Some participants connected this to no longer needing to engage in more negatively perceived behaviours such as drug taking:

“I didn’t really need the drugs as I was so busy with work” (P7).

Engaging in these activities was depicted as becoming incorporated into participants' preferred sense of who they are, reinforcing the belief they are moving on:

"The facilitating groups is one step forward because I am moving on" (P13).

Even though participants were able to develop themselves through occupation and activities, they described experiencing a societal stigma surrounding their mental health and offending, which impacted this:

"Another barrier is the criminal record I end up with. This causes a lot of difficulties in terms of getting a proper full-time job" (P13).

Feeling different to the 'past me'. Participants distanced themselves from the "*past me*" (P3), which was resultant from the above categories:

"I feel separate from the past. Me fifteen years ago when I committed the index offence, is different to me now, in 2018" (P13).

Participants struggled to incorporate aspects of how they had been in the past, with their new, more desirable sense of self:

"I mean I was proper nasty. I used to be very nasty" (P3);

"In the past I was a hooligan, horrible, violent, a nasty piece of work" (P1).

At times, participants questioned their new idea of themselves, stating, "*is this how I am?*" (P4).

Phase Three: Empowerment

'Empowerment' was described as being enabled from categories in phases one and two, with participants feeling empowered, having more autonomy and self-determinism:

“I am more able to ride the highs and lows and make positive decisions” (P8);

“I feel more confident because I have learnt from the mistakes I did. I can make judgements for myself” (P13).

There was a narrative that participants recognised their past cannot be changed but they had the power to change their future:

“You can’t change your past but you can change your future and you can make whatever steps you need to make to get what you want in life” (P1);

Participants described no longer needing to engage in behaviours such as drug taking, self-harm and violence, which characterised their lives before entering hospital, and these features had less power had over them. This sense of empowerment reinforced individuals’ belief about feeling safe and secure, not only externally in their environment and with others but feeling safe and secure within themselves and their own minds:

“I feel free. It is beautiful, so beautiful” (P13).

Focus group participants agreed with this:

“Yeah I am now secure in myself and I feel safe, I don’t need hospital anymore” (P12).

Changes over Time

The passage of time was important for the above categories to occur. One participant commented they needed *“time to recover really. Time to take things in and digest things and mould myself into a better person”* (P8) and that *“it is a gradual process”* (P15). The time in hospital created a space for people to have some distance from potentially harmful behaviours that they had engaged with previously and had time to think about the effects of this:

“Being able to be away from the environment where I can easily get it [cannabis], and having the time to think about what it does to me” (P9).

People found time in hospital helped prepare them for their future and living in the wider society again, which is something they may not have had the opportunity to do previously:

“It kind of prepares you for society. I didn’t have that time to prepare myself for society in that way before” (P8).

Discussion

The aim of this research was to develop a model of service user experiences of recovery in forensic mental health services. Although recovery is a uniquely personal experience, core categories of recovery experiences, and an understanding of how these come about and relate to each other, were found. This is the first study of its kind.

While the proposed model is unique in its own right, it shares traits with Maslow’s hierarchy of needs (1943), a model depicting five-tiers of human needs. This theory articulates how humans are motivated by a hierarchy of needs; basic needs (e.g. physiological) more or less need to be met prior to higher needs (e.g. self-actualisation) being achieved. This maps onto the proposed model, in that participants described needing to feel safe and secure enough in their environment and relationships before being able to engage with processes around their psychological needs (i.e. the superordinate category ‘who I am’).

The concept of feeling safe and secure can be linked to the idea of psychological containment (Bion, 1962). Applying this to forensic services, the hospital and the staff act as the ‘container’ and the service user is the ‘contained’ (Clarke et al., 2008). The service user is seeking in the staff and hospital, someone who can hold them in mind, be consistent, present with them, and can understand them, even if the service user is unable to tolerate understanding parts of the self (Clarke et al., 2008). The boundaries and routine spoken

about add to the hospital being thought of as a 'holding environment' (Abram, 1996). This 'containment' being met to a 'good enough' standard (Winnicott, 1953) enables learning, change and maturation to take place. This demonstrates the need to feel safe and secure (i.e. contained) to enable future processes.

The importance participants placed on relationships in their recovery can be thought about in terms of attachment theory (e.g. Bowlby, 1988); this provides a model of the development of the self and how individuals relate to others. For the development of an autonomous self, the experience of safety within an emotional relationship is essential. Many participants described having impoverished pasts with insecure attachments, which threatens the development of the autonomous self. Participants spoke about the considerable positive impact developing trusting relationships had on other recovery processes (e.g. being able to process past experiences and feel like they can achieve things). Adshead (1998) suggests staff in forensic settings can be positive attachment figures, particularly for those who were deprived of this in early years.

Participants articulated how the more they engaged in recovery processes the less they needed to engage in behaviours such as self-harm, drug use or violent behaviour. This links to ideas in positive psychology (Seligman, 2002) and strengths-based approaches (e.g. Wade, 1997). Much like the 'Good Lives Model' [GLM] of offender rehabilitation (Ward and Brown, 2004), this reflects the idea that all meaningful human action reflects attempts to achieve primary human 'goods' (i.e. particular interests, abilities and aspirations) (Emmons, 1999); if primary goods become difficult to attain, a person may seek other ways of achieving this (e.g. achieving 'relatedness' by socialising with peers who use drugs). Therefore, when participants in this study were able to meet primary needs in more positive and pro-social ways, they described no longer engaging in violence, self-harm or take drugs to fulfil these needs.

The concept of the 'past me' and 'new me' was highlighted in the 'who I am' category. Many participants' descriptions sought to externalise and separate mental health difficulties and violent behaviour from their 'new' version of who they are. This demonstrates service user perspectives of what has occurred, but it may be that they are consciously and unconsciously using avoidance coping strategies in 'sealing-over' rather than 'integrating' the more intolerable parts of their identity (e.g. McGlashan, 1987). This is something that is common within recovery narratives of psychosis (Tait, Birchwood & Trower, 2004).

Limitations

Participants may have felt they needed to present themselves in a favourable light and provide socially desirable responses (Tan & Grace, 2008); they may have been reluctant to respond in ways they felt could jeopardise aspects of their care pathway. This could be seen through descriptions of any barriers of recovery being externalised (e.g. to staff members) or associated with the 'past me'. It is not possible to ascertain whether participants were able to present a true presentation of themselves in interviews or whether they had not psychologically reached a place of ambivalence, integrating the 'good' and 'bad' parts of themselves. The researcher was independent to participants' care and it was explicitly stated participation would not influence treatment. Having a service user researcher interviewer may have helped with this, as well as adopting recovery principles via the research. This connects to another limitation of lacking service user input into the research design; this is problematic as the power and interpretation remains with the researcher. However, respondent validation lessened this somewhat.

It is possible for recruitment bias to have occurred. While it was necessary for staff to act as 'gate-keepers', service users who were deemed unwell, 'insightless' or non-compliant were less likely to be thought about to participate. Those who were interviewed were likely

to be in a 'better place' and have a greater capacity to reflect and be forthcoming about their experiences. Therefore, the proposed model may not be a true representation of service user experiences of recovery in forensic settings.

The interviews and analysis were conducted by a single researcher. This has an advantage of homogeneity in interviewer characteristics but has receiver bias implications. Attempts were made to minimise this through quality assurance checks.

Clinical Implications

With the limitations in mind, the model provides a clear presentation of the recovery process from service user experiences in forensic mental health settings. These processes can be implemented across all areas from an organisational level to the ground and be located at the heart of service delivery; it helps articulate 'the task' forensic services are currently working towards, and the model provides services with a frame of reference for what they are trying to achieve in terms of recovery. The below implications are not exhaustive but some key ideas of how the model can be applied.

In terms of 'on the ground' staff, the model can be implemented in a range of interactions with service users, from how a ward round is conducted to one-to-one engagement between primary nurses and their patient. It would be important for services to consider whether their current approaches are underpinned by recovery principles. For example, routine and structure being used as a tool to help patients feel safe and secure, as opposed to implementing an oppressive regime, in which the service users are passive recipients.

The model can be used to assess at what point staff and service users think the service user may be at with their recovery, informing their care pathway. This would aim to help identify areas that may need further work, as well as being thoughtful about the appropriate

time for this to happen. For example, using psychological therapy to process difficult experiences, may not be suitable if they do not have a sense of safety in their relationships and environment at that point in time.

For the model to be applied usefully in these ways, it is important it is disseminated in staff training at all levels. It would be helpful to relate the proposed model to management of risk, which is a key concern in forensic settings (Pouncey & Lukens, 2010). This could be linked to the GLM (Ward & Brown, 2004), demonstrating the cross-over between recovery and rehabilitation. Promoting this model in training, as well as reflective practice spaces, would hope to enhance staff compassion towards service users, thus fostering recovery-orientated relationships (Gudjonsson, Webster & Green, 2010).

The model may help organisations think outside of the usual and known structures, such as engaging with Restorative Justice services (Cook, Drennan & Callanan, 2015) and forensic service user involvement practice. These ideas are aligned to the recovery processes the model proposes.

Research Implications

This study concentrates on how recovery processes are enabled. While participants commented on perceived barriers to recovery, this was not the focus. It would be helpful for a qualitative study to be carried out explicitly exploring barriers to implementing recovery in forensic services. This would hope to direct where changes may need to be made.

While this study's participants were service users, which is in line with recovery principles, it may be helpful to conduct research ascertaining staff and support network perspectives of recovery in forensic services. This would help to see how aligned staff, support networks and service users' views are. Understanding of where the differences and similarities lie would aim to raise important conversations about how to bring these together, thus facilitating power-sharing (Livingston et al., 2012).

With regard to the 'past me' and 'new me' concept, future qualitative research could explore narratives of recalled service users and how they accommodate this concept, having been discharged to the community and return to hospital. This could be done via Discourse Analysis (Parker, 1998).

Conclusion

This study is the first to provide a clear model of recovery processes from service user perspectives in forensic mental health services. The emerging model captures the view of service users that the environment, connectedness, hope for the future, 'who I am' and empowerment, are key recovery processes one engages in, and articulates how these aspects relate to each other. While the study has limitations, there are important clinical implications, generally regarding how the model can be applied to services at all levels. Future research would benefit from specifically exploring barriers to recovery, other perspectives on recovery and understanding some sub-categories further.

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Section C: Appendices and supporting material

Appendix 1: Reviewed studies and their titles

<i>Reviewed studies and their titles.</i>	
<u>Study</u>	<u>Title</u>
Barsky & West (2007)	Secure settings and the scope for recovery: service users' perspectives on a new tier of care
Mezey, Kavuma, Turton, Demetriou & Wright (2010)	Perceptions, experiences and meanings of recovery in forensic psychiatric patients
Cook, Phillips & Sadler (2005)	The tidal model as experienced by patients and nurses in a regional forensic unit
Laithwaite & Gumley (2007)	Sense of self, adaptation and recovery in patients with psychosis in a forensic NHS setting
Stanton & Simpson (2006)	The aftermath: aspects of recovery described by perpetrators of maternal filicide committed in the context of severe mental illness
Ferrito, Vetere, Adshead & Moore (2012)	Life after homicide: accounts of recovery and redemption of offender patients in a high security hospital – a qualitative study
O'Sullivan, Boulter & Black (2013)	Lived experiences of recalled mentally disordered offenders with dual diagnosis: a qualitative phenomenological study
Walker, Farnwoth & Lapinski (2013)	A recovery perspective on community day leaves
Skinner, Heasley, Stenney & Braham (2014)	Can motivational groups promote recovery in forensic settings?
Nijdam-Jones, Livingston, Verdun-Jones & Brink (2015)	Using social bonding theory to examine 'recovery' in a forensic mental health hospital: a qualitative study
Colquhoun, Lord & Bacon (2018)	A qualitative evaluation of recovery processes experienced by mentally disordered offenders following a group treatment programme
Shepherd, Sanders & Shaw (2017)	Seeking to understand lived experiences of personal recovery in personality disorder in community and forensic settings – a qualitative methods investigation
McKeown, Jones, Foy, Wright, Paxton & Blackman (2016)	Looking back, looking forward: recovery journeys in high secure hospital
Adshead, Ferrito & Bose (2015)	Recovery after homicide: narrative shifts in therapy with homicide perpetrators
Olsson, Strand & Kristiansen (2014)	Reaching a turning point – how patients in forensic care describe trajectories of recovery
Williams, Moore, Adshead, mcdowell & Tapp (2011)	Including the excluded: high security hospital user perspectives on stigma, discrimination, and recovery
Pollak, Palmstierna, Kald & Ekstrand (2018)	It had only been a matter of time before I had relapsed into crime: aspects of care and personal recovery in forensic mental health
Aga, Vander Laenen,	Recovery of offenders formerly labelled as not criminally

Vandavelde, Vermeersch & Vanderplasschen (2017)	responsible: uncovering the ambiguity from first-person narratives
Adshead, Pyszora & Thomas (2013)	‘The waiting room’: narratives of recovery and departure in men leaving high secure psychiatric care
Chandley & Rouski (2014)	Recovery, turning points and forensics: views from the ward in an English high secure facility
McKenna, Furness, Dhital, Parl & Connally (2014)	Recovery-orientated care in a secure mental health setting: ‘striving for a good life’
Stuart, Tamsey & Quayle (2017)	What are the barriers to recovery perceived by people discharged from a medium-secure forensic mental health unit? An interpretative phenomenological analysis

Appendix 2: Kmet et al. (2004) quality assessment scoring system**Quality Scoring of Qualitative Studies**

“Total sum = (number of “yes” * 2) + (number of “partials” * 1)

Total possible sum = 20

Summary score: total sum / total possible sum”

(p20; Kmet et al., 2004).

Appendix 3: Quality assessment score, guided by Kmet et al.'s (2004) quality assessment tool

<i>Quality assessment score, guided by Kmet, Lee, and Cook's (2004) quality assessment tool.</i>											
	<u>1. Question / objective sufficiently described?</u>	<u>2. Study design evident and appropriate?</u>	<u>3. Context for the study clear?</u>	<u>4. Connection to a theoretical framework / wider body of knowledge?</u>	<u>5. Sampling strategy described, relevant and justified?</u>	<u>6. Data collection methods clearly described and systematic?</u>	<u>7. Data analysis clearly described and systematic?</u>	<u>8. Use of verification procedure(s) to establish credibility?</u>	<u>9. Conclusions supported by the results?</u>	<u>10. Reflexivity of the account?</u>	<u>Total (%)</u>
Barsky & West (2007)	2	2	2	2	1	1	1	2	2	0	75
Mezey, Kavuma, Turton, Demetriou & Wright (2010)	2	2	2	2	1	2	2	2	2	1	90
Cook, Phillips & Sadler (2005)	2	2	1	1	0	1	1	2	2	0	60
Laithwaite & Gumley (2007)	2	2	2	1	1	2	2	2	2	2	90
Stanton & Simpson (2006)	2	2	0	1	2	2	1	0	2	0	60
Ferrito, Vetere, Adshead & Moore (2012)	2	2	2	2	1	2	2	2	2	0	85
O'Sullivan, Boulter & Black (2013)	2	1	1	2	1	2	1	2	2	0	70
Walker, Farnwoth & Lapinski (2013)	2	1	2	1	2	2	2	0	0	1	75
Skinner, Heasley, Stenney & Braham (2014)	2	2	1	1	1	2	2	2	1	0	70
Nijdam-Jones, Livingston, Verdun-Jones & Brink (2015)	2	2	2	2	1	2	2	2	1	1	85
Colquhoun, Lord & Bacon (2018)	2	2	2	2	1	2	2	2	2	1	90
Shepherd, Sanders & Shaw (2017)	2	2	1	1	1	1	1	2	2	2	75

McKeown, Jones, Foy, Wright, Paxton & Blackman (2016)	2	1	1	2	1	2	1	2	2	0	70
Adshead, Ferrito & Bose (2015)	2	1	2	2	1	1	1	0	1	0	55
Olsson, Strand & Kristiansen (2014)	2	2	2	1	2	2	1	2	2	0	80
Williams, Moore, Adshead, mcdowell & Tapp (2011)	1	2	1	1	1	1	1	2	1	0	55
Pollak, Palmstierna, Kald & Ekstrand (2018)	2	2	2	1	2	2	2	2	2	0	85
Aga, Vander Laenen, Vandeveld, Vermeersch & Vanderplassche n (2017)	2	2	1	2	1	2	1	2	2	0	75
Adshead, Pyszora & Thomas (2013)	1	2	2	1	1	1	1	2	2	0	65
Chandley & Rouski (2014)	2	2	2	1	0	0	2	0	2	0	55
McKenna, Furness, Dhital, Parl & Connally (2014)	2	2	2	2	1	1	2	2	1	0	75
Stuart, Tamsey & Quayle (2017)	2	2	1	2	1	2	2	2	2	1	85

Appendix 4: Original themes related to reported accounts of service user' experiences of recovery in forensic mental health settings, extracted from studies

<i>Original themes relating to reported accounts of service users' experiences of recovery in forensic mental health services.</i>											
<u>Study no.</u>	<u>Study</u>	<u>Theme</u>	<u>Theme</u>	<u>Theme</u>	<u>Theme</u>	<u>Theme</u>	<u>Theme</u>	<u>Theme</u>	<u>Theme</u>	<u>Theme</u>	<u>Theme</u>
1	Barsky & West (2007)	Activities	Freedom on the ward	Access off the wards and the security wall	Atmosphere on the wards: more stable environment, encouragement of social relationships between patients.	Staff	Access to therapies				
2	Mezey, Kavuma, Turton, Demetriou & Wright (2010)	Definitions and understandings of recovery	What helps to bring about recovery: Diagnosis, psycho-education and medication; Secure detention as a route to recovery; Security vs sanctuary; Time; Positive relationships and attachments.	Impediments to recovery: Physical environment/atmosphere; Negative relationships and interactions.							
3	Cook, Phillips & Sadler (2005)	Hope	Levelling	Relationships	Working together	Human face					
4	Laithwaite & Gumley (2007)	Past experiences of adversity: Parental break-up and	Recovery in the context of being in hospital: Frightening vs	Relationships and a changing sense of self							


		loss; Feeling rejected and worthless; Relationships with significant others; Perspectives on past selves	safety; Feeling entrapped; The importance of relationships; Development of trust; Coping; Valued outcomes								
5	Stanton & Simpson (2006)	Managing the horror of the memories	Language used to describe the event	Forgiving themselves	Role as a mother	Support	Managing illness				
6	Ferrito, Vetere, Adshead & Moore (2012)	The role of past experiences: Early-life trauma	Impact on personal development: Mistrust; Social isolation; Perceived helplessness	Periods of 'loss of grip on reality': Loss of control over feelings; Confusion; Emotional release	Reframing: events via therapeutic intervention	Internal integration: Confronting existential issues and discovering meaning; Forms of repayment; hope	Roadblocks to the process of recovery: Communication breakdown with professionals: Stigmatisation				
7	O'Sullivan, Boulter & Black (2013)	I can be me rather than some crazy whatever': Self and other	I wasn't really an addict': Transition of the self as substance user	I have got no choice': Disempowerment	You can't be forced into doing something': Self-determinism	I can do nothing sober or I can do nothing high': Recovery					
8	Walker, Farnwoth & Lapinski (2013)	Purpose of the day leave	Facilitation of recovery: I was very conscious of listening to what was being said	Having a scooter to get me to and from work;	He did not buy a train ticket						
9	Skinner, Hearsley,	Gaining confidence:	Hope: Moving on; Living a	Gaining control and	Identifying strengths	Social support					

	Stenney & Braham (2014)	Preparation for future groups ; confidence to achieve goals	meaningful life	taking responsibility: Responsibility for past behaviour; Control of current decisions							
10	Nijdam-Jones, Livingston, Verdun-Jones & Brink (2015)	Involvement	Belief and adherence to social norms and rules	Attachment to supporting individuals: staff, friends and family	Commitment	Length of stay					
11	Colquhoun, Lord & Bacon (2018)	Not being the person I was	Gaining new perspectives	Social relationships: The problem with groups: The goldfish bowl	Barriers: Poor memory; Impression management; Disconnection						
12	Shepherd, Sanders & Shaw (2017)	Developing emotional regulation	Diagnosis as linking understanding and hope for change	The role of mental health services							
13	McKeown, Jones, Foy, Wright, Paxton & Blackman (2016)	The importance of meaningful occupation	Valuing relationships	Recovery journeys and dialogue with the past	Recovery as personal responsibility						
14	Adshead, Ferrito & Bose (2015)	Coming to terms with having offended: Identity change	Abnormal mental states and identity	Therapist roles in facilitating narrative change							
15	Olsson, Strand & Kristiansen (2014)	The high-risk phase: Facing intense negative emotions and feelings	The turning point phase: Reflecting on and approaching oneself and life in a new way	Recovery phase: Recognising, accepting and maturing							

16	Williams, Moore, Adshead, mcdowell & Tapp (2011)	Detention in hospital and the passage of time widens the gap between the person and their community of origin	Emergent recovery styles: How do I include illness and offending in my life?	Loss of status associated with enduring illness: 'You are treated as if you are too ill to be somebody'							
17	Pollak, Palmstierna, Kald & Ekstrand (2018)	Time: Opportunity for change	Trust: Creating a context with meaningful relations	Hope: To reach a future goal	Toolbox: Tools needed for recovery						
18	Aga, Vander Laenen, Vandevelde, Vermeersch & Vanderplasschen (2017)	Clinical recovery resources: Medication; Residential treatment services; Formal healthcare	Functional recovery resources: Financial situation; Daily activities; Practical resources	Social recovery resources; Helping others; Social network; A sense of belonging	Personal recovery resources: Personal development; Acceptance; Autonomy						
19	Adshead, Pyszora & Thomas (2013)	Why are they leaving? Facts (NOT REPORTED SU); Narrative - asylum, bad habits, the old me	What is their challenge: Fact; Narrative	Technical issues for therapists							
20	Chandley & Rouski (2014)	Things that have happened on Croft Ward	Relationships	Qualities in other that have helped	Turning points	Hope and future plans	How I contribute	What recovery means to me	Thing I would change	After here	
21	McKenna, Furness, Dhital, Parl & Connally (2014)	A common vision: A journey toward 'a life worth living'	Promoting hope	Promoting autonomy and self-determination	Meaningful engagement	Focusing on strengths	Holistic and personalised care	Community participation and citizenship	Managing risks by taking calculated risks		
22	Stuart, Tamsey	Living in the	Power	Security and	Reconfigured	Recovery' as					

	& Quayle (2017)	shadow of the past: Dominance of the events that brought me into secure care; Trying to make sense of what's happened to me; becoming something other than my past	imbalances: Dominance of services and systems; Not having a say in my own life; Being on the edge of society; Finding empowerment and trying to fit back in	care: Wanting to feel safe and secure; Wanting to care	relationships: relationships with others are different now; Relationships with others are more difficult now; Building new relationships with others and myself	a barrier to recovery: Who decides who's recovering?; Recovery vs cure					
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Highlighted in green if not relevant or not reported service user experience



Appendix 5: Translation of studies' concepts into one another

N.B. The numbers relate to the study number as seen in the table in Appendix 3.

SAFETY AND SECURITY

- (1) Atmosphere on the wards
- (2) What helps to bring about recovery – Secure detention as a route to recovery
- (2) Impediments to recovery – Physical environment/atmosphere
- (4) Recovery in the context of being in hospital – frightening vs safety
- (10) Belief and adherence to social norms and rules
- (15) The high-risk phase: facing intense negative emotions and feelings
- (15) The turning point phase: Reflecting on and approaching oneself and life in a new way
- (17) Toolbox: tools needed for recovery
- (19) Why are they leaving – Asylum
- (21) Holistic and personalised care
- (22) Security and care – wanting to feel safe and secure – trying to make sense of what's happened to me

TIME

- (2) Secure detention as a route to recovery
- (15) The turning point phase: Reflecting on and approaching oneself and life in a new way
- (16) Detention in hospital and the passage of time
- (17) Opportunity for change
- (19) What is their challenge?

RELATIONSHIPS

- With staff and patients
- With family and friends
- (1) Staff,
- (2) What helps to bring about recovery – Positive relationships and attachments
- (2) Impediments to recovery – Negative relationships and interactions,
- (2) Levelling
- (3) Relationships,
- (3) Working together,
- (3) Human face,
- (4) Recovery in the context of being in hospital – the importance of relationships – the development of trust
- (4) Relationships,
- (5) Support,
- (5) Role as Mother
- (6) Roadblocks to the process of recovery – communication breakdown with professionals
- (7) 'I have got no choice': disempowerment
- (8) Having a scooter to get me to and from work
- (9) Social support,
- (10) Attachment to supportive individuals: staff, friends and family,
- (11) Social relationships,
- (12) The role of mental health services,
- (13) Valuing relationships,
- (16) Loss of status associated with enduring illness
- (17) Trust: creating a context with meaningful relations,

- (18)Clinical recovery resources – Formal healthcare,
- (18)Social recovery resources –social network,
- (18)Social recovery resources – belonging,
- (18)Functional recovery resources – Practical resources,
- (20)Things that have happened on Croft Ward,
- (20)Relationships,
- (20)Qualities in others that have helped,
- (20)Turning points
- (20)How I contribute
- (21)Meaningful engagement,
- (22)Reconfigured relationships – relationships with others are different now – relationships with others are more difficult now – building new relationships with others (and myself)
- (22)Power imbalances – dominance of services and systems – not having a say in my own life – finding empowerment and trying to fit back in

PROCESSING THE PAST

- **Acknowledging difficult past experiences and their impact**
- **Coming to terms with having offended and having a mental illness**
- (2) Definitions and understandings of recovery
- (4)Past experiences of adversity
- (5)Managing the horror of the memories
- (5)Language used to describe the event
- (5)Managing illness
- (5)Forgiving themselves
- (6)Roadblocks to the process of recovery – stigmatisation
- (6)The role of past experiences – Early-life trauma
- (6)Periods of ‘loss of grip on reality’ – loss of control over feelings – confusion – emotional release
- (6)Reframing: events via therapeutic intervention
- (6)Impact on personal development – mistrust
- (6) Internal integration – forms of repayment
- (7)‘I wasn’t really an addict’: transition of the self as substance user
- (7)‘You can not be forced into doing something’: self-determinism
- (9)Gaining control and taking responsibility – responsibility for past behaviours – control of other decisions
- (11)Not being the person I was
- (13)Recovery journeys and dialogue with the past
- (13)Recovery as personal responsibility
- (14)Abnormal mental states and identity
- (14)Coming to terms with having offended
- (14)Abnormal mental states and identity
- (15)Recovery phase: recognising, accepting and maturing
- (16)Emergent recovery styles: How do I include my illness and offending in my life?
- (17)Toolbox: tools needed for recovery
- (18)Personal recovery resources – acceptance
- (20)Turning points
- (22)Living in the shadow of the past – dominance of the events that brought me into secure care – trying to make sense of what’s happened to me
- (22)Security and care – wanting to feel safe and secure
- (22) Power imbalances – being on the edge of society

(22) Recovery as a barrier to recovery – recovery vs cure

SENSE OF SELF

- (2) Definitions and understandings of recovery
- (3) Hope
- (4) Sense of self
- (6) Internal integration – confronting existential issues and discovering meaning
- (7) 'I can be me rather than some crazy whatever': self and other
- (7) 'I can do nothing sober or I can do nothing high': recovery
- (8) Having a scooter to get me to and from work
- (9) Identifying strengths
- (11) Not being the person I was
- (11) Barriers – Disconnection
- (12) Developing emotional regulation
- (14) Abnormal mental states and identity
- (19) Why are they leaving? – The 'old me'
- (20) What recovery means to me
- (21) Focusing on strengths
- (22) Living in the shadow of my past – becoming something other than my past

MEANINGFUL ACTIVITIES

- (1) Activities
- (4) Recovery in the context of being in hospital – coping
- (4) Recovery in the context of being in hospital – valued outcomes
- (6) Internal integration – forms of repayment
- (9) Gaining confidence-preparation for future groups – confidence to achieve goals
- (10) Involvement
- (11) Gaining new perspectives
- (12) Developing emotional regulation
- (13) The importance of meaningful occupation
- (17) Toolbox: tools needed for recovery
- (18) Social recovery resources – helping others
- (20) How I contribute
- (20) Things I would change
- (22) Security and care – wanting to care
- (22) Finding empowerment

INTERVENTION

Medication

- (2) Definitions and understandings of recovery
- What helps to bring about recovery – diagnosis, psycho-education and medication
- (6) Reframing: events via therapeutic intervention
- (12) Diagnosis as linking understanding and hope for change
- (16) Loss of status associated with enduring illness
- (18) Clinical recovery resources – medication

Talking

- (1) Access to therapies
- (2) What helps to bring about recovery – diagnosis, psycho-education and medication
- (4) Recovery in the context of being in hospital – valued outcomes

- (6) Reframing: events via therapeutic intervention
- (10) Commitment
- (11) Barriers – Poor memory
- (18) Clinical recovery resources – residential treatment services
- (20) Things I would change

AUTONOMY AND FREEDOM

- (1) Freedom on the ward
- (1) Access off the wards and the security wall
- (4) Recovery in the context of being in hospital – feeling entrapped
- (6) Impact on personal development – perceived helplessness
- (8) Purpose of day leaves
- (8) Facilitation of recovery – having a scooter to get me to and from work
- (18) Functional recovery resources – financial situation
- (18) Personal recovery resources – autonomy
- 21) Promoting autonomy and self-determination

HOPE

- (1) Access off wards
- (2) Definitions and understandings of recovery
- (3) Hope
- (6) Internal integration – hope
- (8) Having a scooter to get me to and from work
- (9) Hope – Moving on – Living a meaningful life
- (10) Length of stay
- (16) Loss of status associated with enduring illness
- (17) Hope: to reach a future goal
- (20) Hope and future plans
- (20) Hope and future plans
- (20) After here
- (21) Promoting hope
- (21) Community participation and citizenship
- (21) A common vision: A journey toward ‘a life worth living’

Appendix 6: Contribution of studies to summary themes

<i>Contribution of studies to summary themes.</i>										
<u>Study number</u>	<u>Study</u>	<u>Safety and security</u>	<u>Time</u>	<u>Relationships</u>	<u>Processing the past</u>	<u>Sense of self</u>	<u>Meaningful activities</u>	<u>Intervention</u>	<u>Autonomy and freedom</u>	<u>Hope</u>
1	Barsky & West (2007)	X		X			X	X	X	X
2	Mezey, Kavuma, Turton, Demetriou & Wright (2010)	X	X	X	X	X		X		X
3	Cook, Phillips & Sadler (2005)			X		X				X
4	Laithwaite & Gumley (2007)	X		X	X	X	X	X	X	
5	Stanton & Simpson (2006)			X	X					
6	Ferrito, Vetere, Adshead & Moore (2012)			X	X	X	X	X	X	X
7	O'Sullivan, Boulter & Black (2013)			X	X	X				
8	Walker, Farnwoth & Lapinski (2013)			X		X			X	X
9	Skinner, Heasley, Stenney & Braham (2014)			X	X	X	X			X
10	Nijdam-Jones, Livingston, Verdun-Jones & Brink (2015)	X		X			X			X
11	Colquhoun, Lord & Bacon			X	X	X		X		

	(2018)									
12	Shepherd, Sanders & Shaw (2017)			X	X	X	X			
13	McKeown, Jones, Foy, Wright, Paxton & Blackman (2016)			X	X		X			
14	Adshead, Ferrito & Bose (2015)				X	X				
15	Olsson, Strand & Kristiansen (2014)	X	X		X			X		
16	Williams, Moore, Adshead, mcdowell & Tapp (2011)		X	X	X			X		X
17	Pollak, Palmstierna, Kald & Ekstrand (2018)	X	X	X	X		X			X
18	Aga, Vander Laenen, Vandevelde, Vermeersch & Vanderplasschen (2017)			X	X		X	X	X	
19	Adshead, Pyszora & Thomas (2013)	X	X			X				
20	Chandley & Rouski (2014)			X	X	X	X	X		X
21	McKenna, Furness, Dhital, Parl & Connally (2014)	X		X		X			X	X

22	Stuart, Tamsey & Quayle (2017)	X		X	X		X			
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Appendix 7: Synthesising translations

<i>Synthesising translations.</i>	
<u>Summary theme (translation)</u>	<u>New interpretation: Third order theme</u>
Safety and security	Safety and security helping to provide a secure base
Time	The passage of time allowing for reflection and change to occur
Relationships	Relationships enabling connectedness and belonging: C) With staff and other patients D) With family and friends
Processing the past	Processing the past: C) Acknowledging difficult past experiences and their impact D) Coming to terms with having offended and understanding mental health difficulties
Sense of self	Self-reflection aiding the development of a sense of self
Meaningful activities	Engaging in meaningful activities
Intervention: C) Medication D) Talking therapies	Psycho-pharmacological interventions: C) Taking medication D) Talking therapies
Autonomy and freedom	Enhancing freedom through increased autonomy
Hope	Developing a sense of hope for the future

Appendix 8: Timeline of study

<i>Timeline of study.</i>	
<u>Date</u>	<u>Event</u>
06/07/2017	Salomons MRP proposal approval
21/11/2017	NHS ethics approval
21/11/2017	HRA approval
14/12/2017	R&D approval NHS trust 1
15/02/2018	R&D approval NHS trust 2
01/03/2018 – 14/03//2019	Participant recruitment, data collection and data analysis
01/03/2019	Theory checking and focus group validation

Appendix 9: NHS Ethics approval

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Appendix 10: HRA approval

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Appendix 11: Research and Development approval 1

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Appendix 12: Research and Development approval 2

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Appendix 13: Recruitment email to staff

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Appendix 14: Participant information sheet 1**Salomons**

07/11/2017

Participant information sheet**Developing a model of service users' perspectives of recovery in forensic mental health services.**

Hello. My name is Tamsin and I am a trainee clinical psychologist at Canterbury Christ Church University. I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

Talk to others about the study if you wish. Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more detailed information about the conduct of the study. Please ask me if there is anything that is unclear.

Part 1**What is the purpose of the study?**

The aim of the study is to explore your perspective of your recovery in secure services. It is hoped that this will help us understand the process of an individual's recovery in forensic settings and help to develop forensic services to enhance the service users' experience.

Why have I been invited?

You have been invited because you are someone who has been identified as being on a journey of recovery. Therefore, your view point will be greatly valued to help understand the process of recovery in and from secure services.

Do I have to take part?

It is up to you to decide to join the study. If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive.

What will happen to me if I take part?

If you agree to take part, you will be asked to sign a consent form that state you are happy to take part in the study, involving an interview and later telephone call/focus group. You will be given a signed copy of this. Following this, you will be interviewed about your experience for approximately an hour. It may be less or could last up to two hours. All interviews will be held at [REDACTED] unless you are currently based at [REDACTED] and I can travel to you. The interview will be transcribed. The discussion we have will be audio recorded and all recordings will be anonymised. I will later invite you to join a focus group or to have a telephone conversation to discuss initial findings from the discussions. These comments will be used in the final refinement of the analysis. If English is your second language, you will be asked if you would like an interpreter to join you for the interview. They will sign a consent form, ensuring what is discussed in the interview is confidential.

Expenses and payments

You will be given a £10 shopping voucher for taking part in the research. This is an acknowledgement of appreciation for participating in the research.

What are the possible risks and benefits of taking part?

There are few risks to taking part in this study. I will ask you questions about your journey in secure services. This may bring up sensitive and emotional topics for you, which could be potentially difficult. However, I will not ask you to talk about anything that you do not feel comfortable talking about. The benefit of taking part is that you will be contributing to research that aims to help improve aspects of secure services and how they think about and implement recovery values. You may also gain personal benefit from discussing your journey with another person.

What if there is a problem? :

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in Part 2.

Will information from or about me from taking part in the study be kept confidential?

Yes everything will be kept confidential unless it arises that there is risk of harm to yourself or others, in which case this will be passed onto the clinical team whose care you are under. Anonymised transcripts will be discussed and shared with the lead supervisor. We will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

Part 2**What will happen if I don't want to carry on with the study?**

You can withdraw from the study at any time, without giving a reason.

Complaints

If you have a concern about any aspect of this study, you should ask to speak to me and I will do my best to address your concerns. If you remain unhappy and wish to complain formally, you can do this by contacting Professor Paul Camic, Research Director, Salomons Centre for Applied Psychology – paul.camic@canterbury.ac.uk, tel: 01227927073

Will information from or about me from taking part in the study be kept confidential?

Yes. Both your participation in the study, and the data collected from you will be kept confidential. Only Tamsin Lovell and her supervisors (Dr. Catherine Gardner-Elahi and Prof. Margie Callanan) will have access to your anonymised audio recording and the anonymised transcript. The audio recording will be deleted as soon as it has been transcribed. Until then, it will be stored securely on an encrypted USB. As previously mentioned, if you require the support of an interpreter, they will sign a consent form adhering to the confidentiality agreement.

However, if anything arises that puts yourself or others at harm; it will be my duty to pass this information on to relevant parties. E.g., if you disclosed thoughts or harming yourself I would pass this onto the clinical team whose care you are under.

Access to clinical records

Either, I will require access to your clinical records to read your risk assessment or a member of the clinical team will pass this information on to me. Access will also be necessary so that myself, my clinical supervisor (Dr Catherine Gardner-Elahi) or a member of the clinical team can write a note on the electronic system about your participation in the study. A member of your clinical team will access records for relevant background information.

What will happen to the results of the research study?

The initial results of the study will be written up. I will then hold a focus group that you will be invited to, to discuss findings and provide comments and feedback. The final results of the study will be written up into a report, and then published in a scientific journal. They will also be presented within the service, and you will be able to attend this presentation if you wish. The report will include anonymised quotes from the interviews. No one will be able to identify you in the write up of the report and you are welcome to receive a copy of the final report. A brief summary of the report will be written and available for interested participants.

Data protection:

Interviews will be audio-recorded onto a dictaphone on one of the NHS host sites. No names will be stored and they will be coded with a number. Interviews will be transcribed anonymously and stored on an encrypted USB. All identifiable information (e.g., names, addresses) will be changed to protect your personal data. All data will be transferred to a password protected CD, where it will be stored at the Salomons Centre in a locked cabinet for ten years and destroyed. The researcher will keep the data in their possession on an encrypted USB for ten years after the study is completed, then will be destroyed. Data stored is kept in a locked cabinet and is accessible only to the research supervisor and administrative assistant.

Who is organising and funding the research?

Salomons Centre for Applied Psychology, Canterbury Christ Church University are supporting the organisation of and funding of the research.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by HRA Research Ethics Committee.

What happens if you would like more information about the study?

You will be able to contact me, or my supervisor, to discuss the study during its duration. If you would like to ask any questions or receive more information about the study then please contact one of us on. You can leave a message for me on a 24 hour voicemail phone line. Please say that the message is for me [Tamsin Lovell] and leave a contact number so that I can get back to you:

Researcher

Tamsin Lovell (Tel: 01227927073)
Salomons Centre for Applied Psychology
Canterbury Christ Church University
1 Meadow Road
Tunbridge Wells
Kent, TN1 2YG

Lead Supervisor

Catherine Gardner-Elahi



Appendix 15: Easy to read participant information sheet**Salomons**

07/11/2017

Participant information sheet**Developing a model of patients' perspectives of recovery in secure services**

Hello. My name is Tamsin, I am a trainee clinical psychologist and I would like to invite you to take part in a research study. Before you decide it is important that you understand why the research is being done and what it would involve for you.

What is the purpose of the study?

I want to find out about your opinion on your recovery in secure services. I hope that this will help to understand how recovery can happen for someone and to help make changes to services that make it a better experience for service users.

Do I have to take part?

It is up to you to decide to join the study and you can stop being involved in the study at any time without giving a reason.

What will happen to me if I take part?

I will interview you about your experiences for about an hour but it may be a bit shorter or longer. This will be at [REDACTED] or if you are at [REDACTED], I can travel there. The interview will be audio recorded. I will later invite you to a focus group or talk with you on the phone to discuss what I have found so far. If English is your second language, you will be asked if you would like an interpreter to join you for the interview.

Expenses and payments

You will be given a £10 shopping voucher for taking part in the research. This is to say thank you for participating in the research.

What are the possible risks and benefits of taking part?

During the interview I will ask you questions about your journey in secure services. This could bring up emotional topics for you. But you do not have to talk about anything that you don't want to. Hopefully you will gain benefits from taking part, contributing to research that aims to help improve secure services. You may also find it beneficial discussing your journey with another person.

Will information from or about me from taking part in the study be kept confidential?

Yes. Both your involvement in the study, and the data collected from you will be kept confidential. Only Tamsin Lovell and her supervisors (Dr. Catherine Gardner-Elahi and

Prof. Margie Callanan) will have access to the transcript. The audio recording will be deleted as soon as it has been transcribed by Tamsin Lovell.

However, if anything arises that puts yourself or others at harm; it will be my duty to pass this information on to relevant parties. E.g., if you disclosed thoughts or harming yourself I would pass this onto the clinical team whose care you are under.

Complaints

If you have any concern about the study I will speak with you and do my best to answer your concerns. If you remain unhappy and wish to complain formally, you can do this by contacting Professor Paul Camic, Research Director, Salomons Centre for Applied Psychology - paul.camic@canterbury.ac.uk, tel: 01227927073

Access to clinical records

Either I will require access to your clinical records to read your risk assessment or a member of the clinical team will pass the information to me. Access will also be necessary so that a note can be written saying that you have taken part and for relevant background information.

What will happen to the results of the research study?

I will write the results up and then hold a focus group that you will be invited to, to discuss findings. The report will include anonymised quotes from the interviews. No one will be able to identify you in the write up of the report and you are welcome to receive a copy of the final report. A brief summary of the report will be written and available for interested participants.

What happens with the data?

All data (anonymised interview transcripts) will be transferred onto a password protected CD. This will be stored at the university in a locked cabinet for 10 years then destroyed. Only the research supervisor and administrative assistant can access this. I will keep the data safely with me on a password protected USB for ten years, then it will be destroyed.

What happens if you would like more information about the study?

Please feel free to contact me or my supervisor, Dr Catherine Gardner-Elahi. You can leave a message for me on a voicemail phone line [01227927073], saying that the message is for Tamsin Lovell and leave a contact number so I can get back to you.

Thank you for your time!

Tamsin Lovell (Tel: 01227927073)
Salomons Centre for Applied Psychology
Canterbury Christ Church University
1 Meadow Road, Tunbridge Wells, Kent, TN1 2YG

Appendix 16: Consent form

Consent form for participants



Salomons

Consent Form

Participant Identification Number: _____

Title of Project: Developing a model of patients’ perspectives of their recovery in secure services.

- 1. I confirm that I have read and understand the information sheet dated _____ for the above study. I have had the opportunity to ask the researcher questions and have had these answered satisfactorily.
- 2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.
- 3. I agree to take part in an interview, as explained in the information sheet.
- 4. I agree to be contacted about being involved in a focus group/telephone conversation to discuss findings.
- 5. I understand that relevant sections (e.g., risk summary) from my clinical notes will be looked at by the researcher/s of the study. I give permission for these individuals to have access to my records.
- 6. I agree for my interview to be audio recorded and understand the recording will be destroyed as soon as the interview is typed up.
- 7. I agree that the anonymised findings from this study will be published as a doctoral thesis and possibly published in a research journal.

I would like to receive a copy of the summary of findings of the research

Name of Participant	Date	Signature

Name of Researcher	Date	Signature

Appendix 17: Initial interview schedule

Interview schedule.



Salomons

The interview will be semi-structured, aiming to elicit participants' experience of their process of recovery. Questions will aim to follow the participants' line of thinking and may not be asked in the exact order below (see 'core questions'). The overall aim is to ensure these questions have been answered by the end of the interview.

Introduction

- Introduction of the researcher
- Go through the information sheet with participant to provide an explanation and overview of the research
- Work through the consent form, reminding the participant that they can withdraw at any time
- Discuss the boundaries of confidentiality
- Check contact details
- Give opportunity for participant to ask questions

Background information

- Go through the 'background information' sheet with the participant and explain that staff will provide the researcher with this information, as well as their risk assessment, as stated on the consent form.

Core questions

1. How did you being in forensic services come about?
2. Do you feel like you have moved forward from where you once were?
3. Do you feel like you needed to move on from where you once were?
4. What are the differences to where you once were and where you are now?
 - Internal and external
 - What made you notice the change?
 - When did you notice the change?
5. What has been important for you in your journey of moving forward?
6. What has been able to 'keep you going'?
7. Are there times when you feel you are back to where you once were?
 - What contributes to you feeling like this?
 - What helps you stop feeling like this?
8. What has changed for you over the years? / How have things changed for you over the years?
 - Attitudes
 - Values

- Feelings
 - Skills
 - Goals
9. How do you understand these changes?
- How do you think X links to Y?
 - Did you notice the experience of X before Y?
10. What do you think will help you maintain these changes?
11. Is there anything else you think I should know to understand what we have been discussing better?

Examples of other general prompts

- Can you tell me more about that?
- Does that feel important?
- What makes that important?
- Why is that?
- What are your thoughts/feelings about that?
- What was that like?
- How is X connected to Y?
- How is X related to Y?

Ending

- Thank participant for their time and contribution
- Offer a debrief
- Encourage participant to talk to their key nurse/someone close to them if any concerns/difficulties arose as a result of the interview
- Let participant know next stages of the process
- Explain that will be in touch regarding the focus group with initial results of the research.

Appendix 18: Final interview schedule

Interview schedule.



Salomons

The interview will be semi-structured, aiming to elicit participants' experience of their process of recovery. Questions will aim to follow the participants' line of thinking and may not be asked in the exact order below (see 'core questions'). Not all 'core questions' are expected to be answered by the end of the interview.

Introduction

- Introduction of the researcher
- Go through the information sheet with participant to provide an explanation and overview of the research
- Work through the consent form, reminding the participant that they can withdraw at any time
- Discuss the boundaries of confidentiality
- Check contact details
- Give opportunity for participant to ask questions

Background information

- Go through the 'background information' sheet with the participant and explain that staff will provide the researcher with this information, as well as their risk assessment, as stated on the consent form.

Core questions

1. How did you being in forensic mental health services come about?
2. What was it like for you when you first arrived at hospital?
3. Do you feel like you have moved forward from where you once were?
 - How do you think you have moved forward?
4. What are the differences to where you once were and where you are now?
 - Internal and external
 - What made you notice the change?
 - When did you notice the change?
 - How did you notice this change?
 - How do understand how these differences came about?
5. How have things changed over the years?
 - How do you understand these changes?
 - How do you think X links to Y?
 - Did you notice the experience of X before Y?
 - How do you understand how these changes came about?
6. What do you think made the difference in your recovery?
7. How would you describe yourself now and yourself in the past?
8. What has been important for you in your journey of moving forward?

9. What differences and changes have you noticed in your mental health since being in hospital?
 - How did these changes come about?
 - How do you understand these changes?
 - How has this influenced your journey?
10. How has making sense of any offending fitted with your recovery?
 - How has it influenced how you think about yourself or has it not?
11. What has been able to 'keep you going'?
12. Are there times when you feel you are back to where you once were?
 - What contributes to you feeling like this?
 - What helps you stop feeling like this?
13. What barriers have you experienced to your recovery?
 - How did you manage/overcome these?
 - What helped?
14. What do you think helps you or will help you maintain some of these changes you have spoken about?
15. Is there anything else you think I should know to understand what we have been discussing better?

Questions for participants living in the community

1. What was it like moving from hospital settings to the community?
2. Have there been challenges living in the community?
 - [If yes]
 - What were the challenges?
 - How did you manage/cope with these challenges?
 - What?
3. What has it been like living in the community?
4. Have you noticed and changes since living in the community?

Examples of other general prompts

- Can you tell me more about that?
- Does that feel important?
- What makes that important?
- Why is that?
- What are your thoughts/feelings about that?
- What was that like?
- How is X connected to Y?
- How is X related to Y?

Ending

- Thank participant for their time and contribution
- Offer a debrief
- Encourage participant to talk to their key nurse/someone close to them if any concerns/difficulties arose as a result of the interview
- Let participant know next stages of the process
- Explain that will be in touch regarding the focus group with initial results of the research.

Appendix 19: Background information sheet

Background information.



Salomons

Name:

DOB:

Gender:

Ethnicity:

Section currently on:

Diagnoses:

Appendix 20: Positioning statement

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Appendix 21: Bracketing interview extract and mind map

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Appendix 22: Example of initial coding transcript

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Appendix 23: Table showing development of loose categories from focused codes

NB: The below table shows loose categories that were formed from the focused codes.

<u>Loose initial categories</u>	<u>Focused codes</u>
Acceptance	Accepting who I am Accepting things Being accepted Feeling okay within myself
Activities	Activities alleviating boredom Activities distracting me and giving me a release Activities stopping me from being with my thoughts Distracting myself if I have urges Doing activities I enjoy Doing different activities Doing exercise Having activities to do Looking forward to doing activities
Psychology	Applying what I am learning in psychology Attending groups Being given the chance to speak to a psychologist Being given the space to think about my distress Completing the violence reduction programme Engaging in psychology Changing how I use psychology Doing groups Learning how to manage things through groups and psychology Psychology developing my understanding of why things have happened Psychology helping address issues in my life
Understanding myself	Developing insight into how I manage emotions Developing understanding of mental health difficulties Developing understanding of my past and myself Feeling scared about what I have done Getting somewhere in your head Having a better understanding of myself Impact of managing things differently Learning from mistakes Learning to control myself Learning to deal with problems better Looking into and addressing my problems Managing anger differently Not hitting others Recognising I punish myself through ruminating Recognising there was an issue Recognising urges to hit people Recognising what has held me back Recognising when I need my own space Reflecting on not having the right support in the past

	<p>Reflecting on past difficult experiences</p> <p>Reflecting on violent and aggressive behaviour in the past</p> <p>Reflecting on change in behaviour</p> <p>Reflecting on differences in the past and now</p> <p>Reflecting on drug use</p> <p>Reflecting on fears of being rejected</p> <p>Reflecting on having issues from a young age</p> <p>Reflecting on how I used to be</p> <p>Reflecting on past impulsivity</p> <p>Reflecting on past mental state</p> <p>Resolving issues</p> <p>Thinking about the consequences of my actions</p> <p>Thinking about negative comments towards me throughout my life</p> <p>Thinking about how the process of managing things better</p> <p>Thinking about what I have done</p> <p>Understanding what makes me tick</p> <p>Looking into and addressing problems</p> <p>Thinking about the consequences</p> <p>Developing self-control</p> <p>Impact of taking drugs</p> <p>Processing the past</p> <p>Being able to stop and think</p> <p>Being able to explain myself</p>
Talking	<p>Feeling listened to</p> <p>Feeling a relief and release from talking</p> <p>Being able to talk about what is troubling me</p> <p>Being able to talk to someone</p> <p>Getting my distress heard</p> <p>Having someone to talk to and listen</p> <p>Impact of talking</p> <p>Impact of talking about my distress</p> <p>Getting 'it' out of my system</p> <p>Needing to talk about emotional stuff</p> <p>Offloading</p> <p>Physically getting my distress out of me by talking</p> <p>Someone listening to me</p> <p>Talking about my feelings when I am upset</p> <p>Talking being like a release</p> <p>Talking instead of self-harming</p> <p>Talking to friends about how I am feeling</p> <p>Talking to people</p> <p>Talking with staff</p> <p>Thinking about finding it hard to talk</p>
Changes in who I am	<p>Being able to better myself</p> <p>Being stronger than I thought I was</p> <p>Changing behaviour</p> <p>Changing emotionally</p> <p>Dealing with things in a better way</p> <p>Discovering things about myself</p> <p>Doing things 'normal people' do</p>

	<p>Putting myself down when someone praises me Questioning, is this me? Recognising the strength I have Thinking about how I used to be a 'bad person' Thinking about what might have happened if I hadn't changed Changing how I view myself Growing up and maturing</p>
Being a part of something	<p>Being included Feeling a part of something Not wanting to be different Seeing other people go through the same thing Thinking about feelings of not being wanted Wanting to fit in</p>
Feeling safe	<p>Being kept safe Feeling safe Not being able to trust people if I didn't feel safe Not having the support I needed in the community</p>
The environment	<p>The environment Feeling safe in my environment Settling into the unit</p>
Relationships with staff	<p>Building up relationship with staff Change in relationship with staff Developing trust with staff Feeling like someone wants to genuinely spend time with me Feeling like someone is caring Feeling respected Feeling supported on the ward Finding common ground with staff Getting encouragement from staff Having good staff Impact of being encouraged by staff Impact of staff trusting me Not feeling pressured by staff Not wanting to lose the staffs' trust in me People being non-judgemental Staff being kind, gentle and sincere Staff being non-judgemental Staff believing in me Staff helping me with my voices Staff helping me to feel safe Staff helping me with my needs and worries Staff listening Staff not making assumptions Staff noticing me doing well Staff reminding me of the positive steps I have made Staff supporting me Staff using humour Support from staff Thinking about staff not believing in me Trusting staff are there for you</p>

	<p>Trusting staff helps to get things out Working with people Others seeing things in me Staff trusting me</p>
Relationships with social networks/loved ones	<p>Developing friendships Getting advice from friends Getting on well with other patients Going to be an auntie Having valuable friends Having friends Having relationships Having someone who cares Making others happy Not wanting to upset people I care about Other people giving me hope Other people seeing the good in me People being there for me People believing in me Recognising others will be there for you Seeing family Seeing if I can connect with people Seeing other people move on Seeing what other people manage doing Spending time with animals Liking animals Spending time with friends Support from others Worrying about letting people down Worrying I might not meet others' expectations</p>
The future/moving forwards	<p>Feeling distressed thinking about the future Feeling happy about leaving hospital Feeling like I am moving forwards Feeling like I want to get out Feeling more normal living in a flat Feeling scared of the unknown Finding a way to keep on going Focusing on leaving hospital Freedom motivating me Getting escorted leave Going out Impact of seeing a friend leave hospital Living in the flats Moving forwards Moving on from hospital Moving wards Not wanting to spend my life in hospital Proving I am safe to live in the community Reaching a goal and moving to the flats Scared about moving forwards and the future Seeing life beyond hospital</p>

	<p>Seeing there being a life outside hospital Thinking about the future and freedom Thinking about life beyond hospital Thinking about life outside of hospital Thinking about why I want a life outside of hospital Walking around outside Thinking about the future Having more freedom</p>
Having goals	<p>Wanting a job Wanting to leave hospital Wanting 'normality' Wanting to improve Wanting to live a normal life Taking small steps forwards Having goals</p>
Achieving things	<p>Feeling good about myself Getting positive feedback Impact of getting feedback from others Impact of getting positive feedback Feeling proud Achieving things</p>
Control	<p>Feeling like I have control Feeling more in control</p>
Autonomy	<p>Getting more independence Having responsibility</p>
Routine and structure	<p>Getting into a daily routine Having structure and routine Having a weekly structure Having things to do Keeping myself occupied Learning the importance of routine Occupying myself Being able to do simple day-to-day things Maintaining a healthy lifestyle</p>
Medication	<p>Medication Medication and psychology working together Medication helps with the voices Side effects of medication Thinking about what I might be like without medication</p>
Stopping past behaviours	<p>Stopping aggressive behaviour Stopping self-harming</p>

Appendix 24: Theoretical coding: Development of relationships between categories

N.B. With the aid of memo-writing, theoretical coding and constant comparison, relationships between categories were compared and analysed. The below colour scheme shows categories that had key connections with each other.

Activities

Psychology

Understanding myself

Talking

Changes in who I am

Acceptance

Being a part of something

Relationships with staff

Relationships with social networks/loved ones

The future/moving forwards

Having goals

Achieving things

Control

Autonomy

Routine and structure

Medication

Feeling safe

The environment

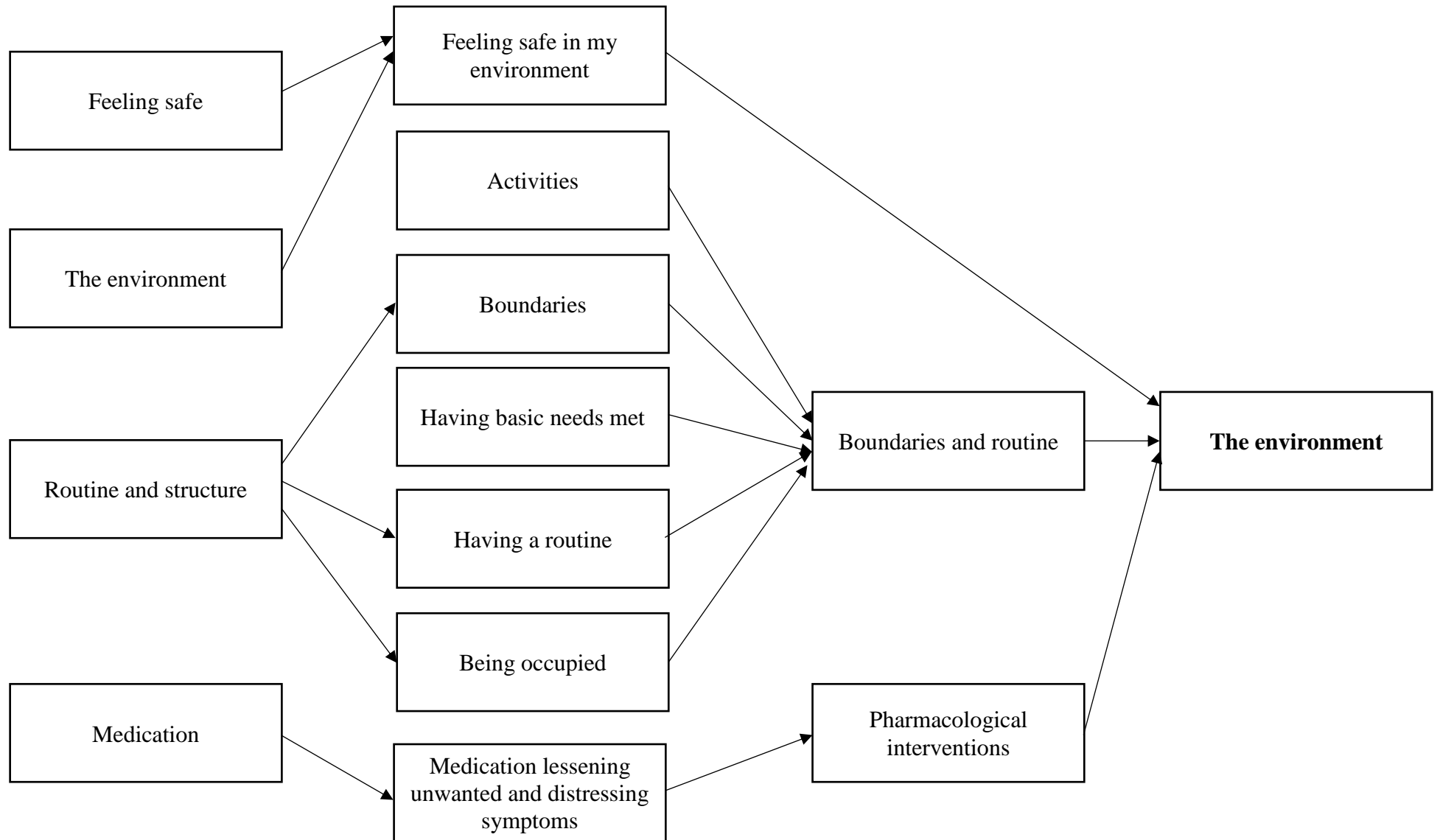
Stopping past behaviours

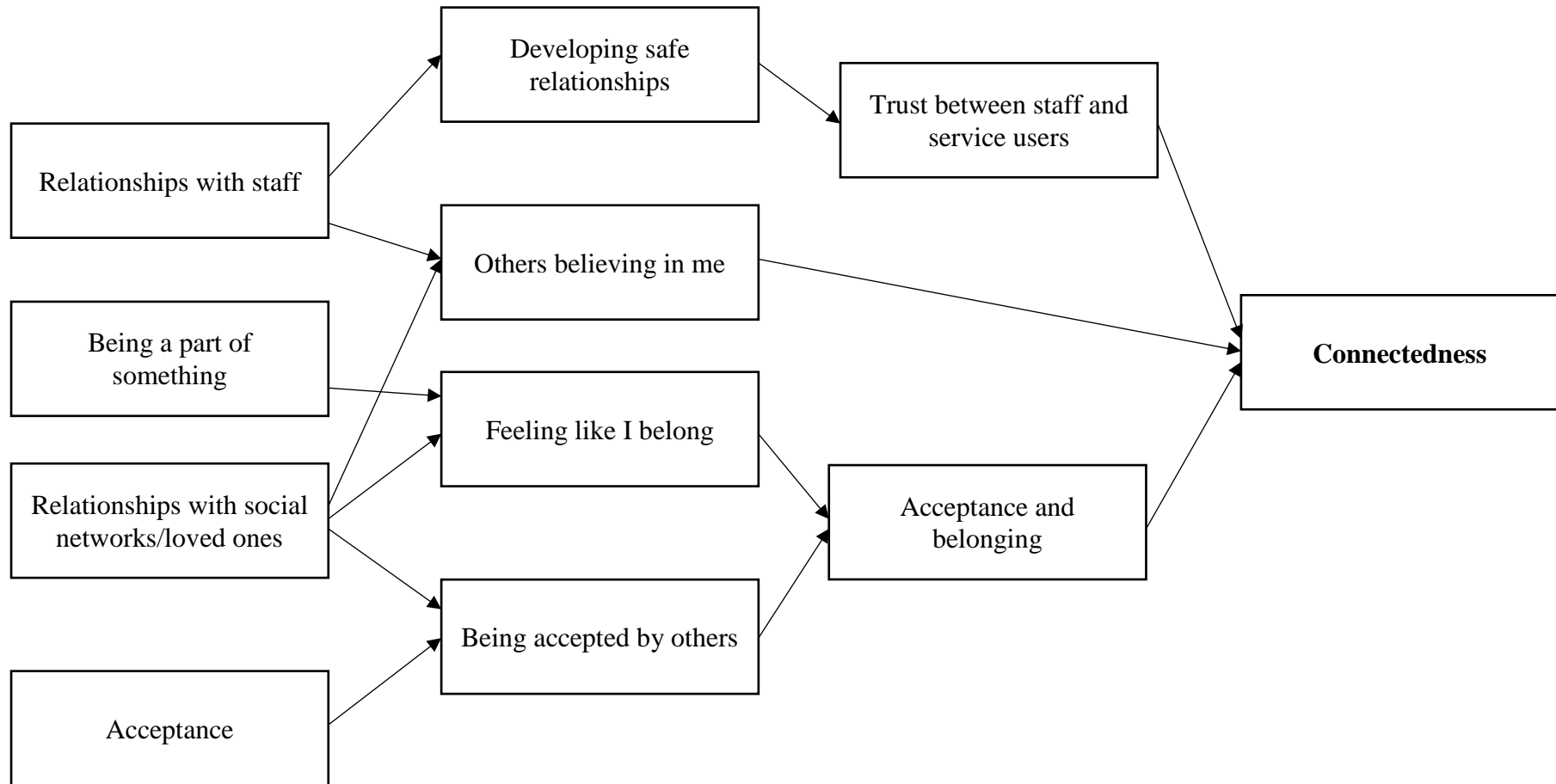
- New additional categories were found from later interviews.

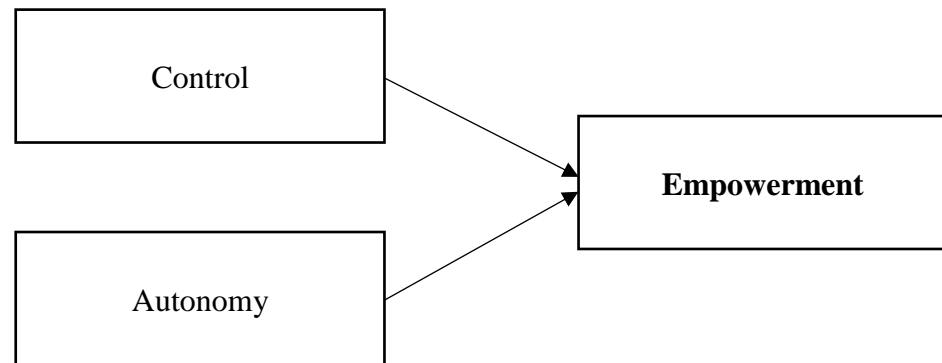
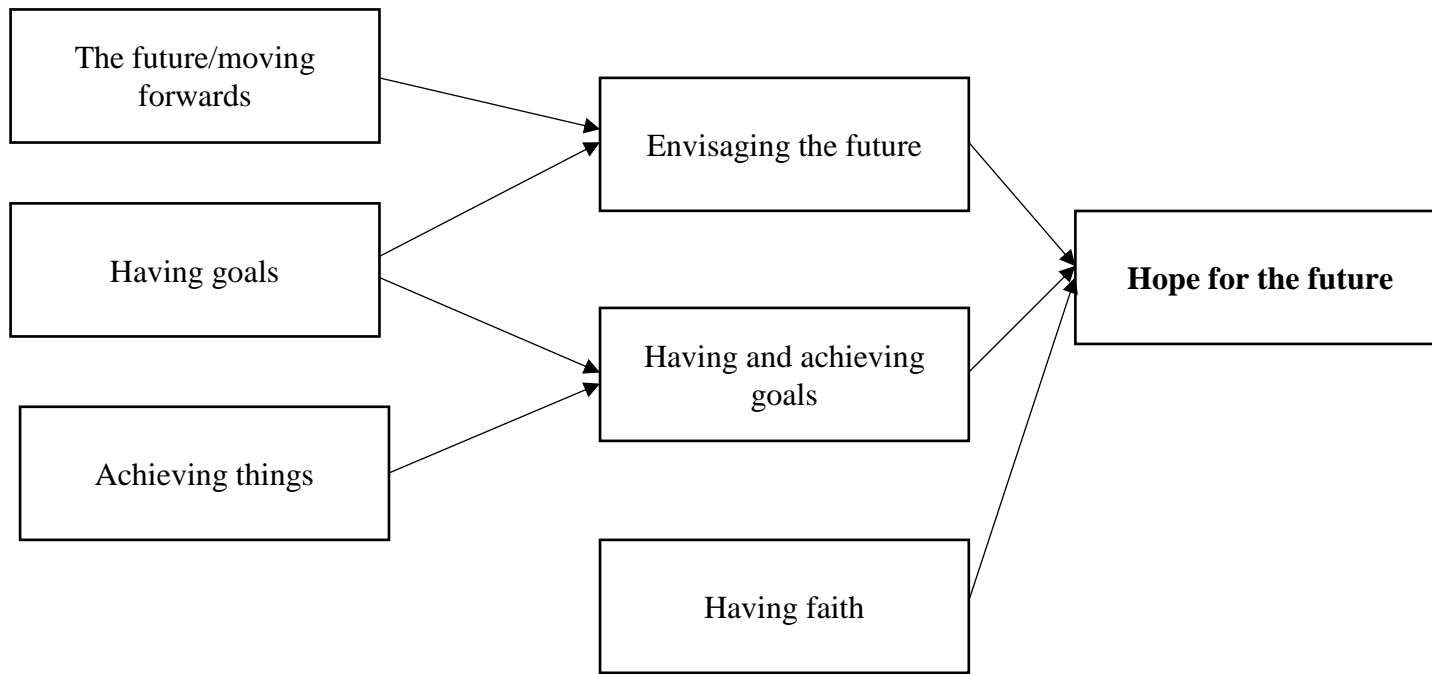
Time

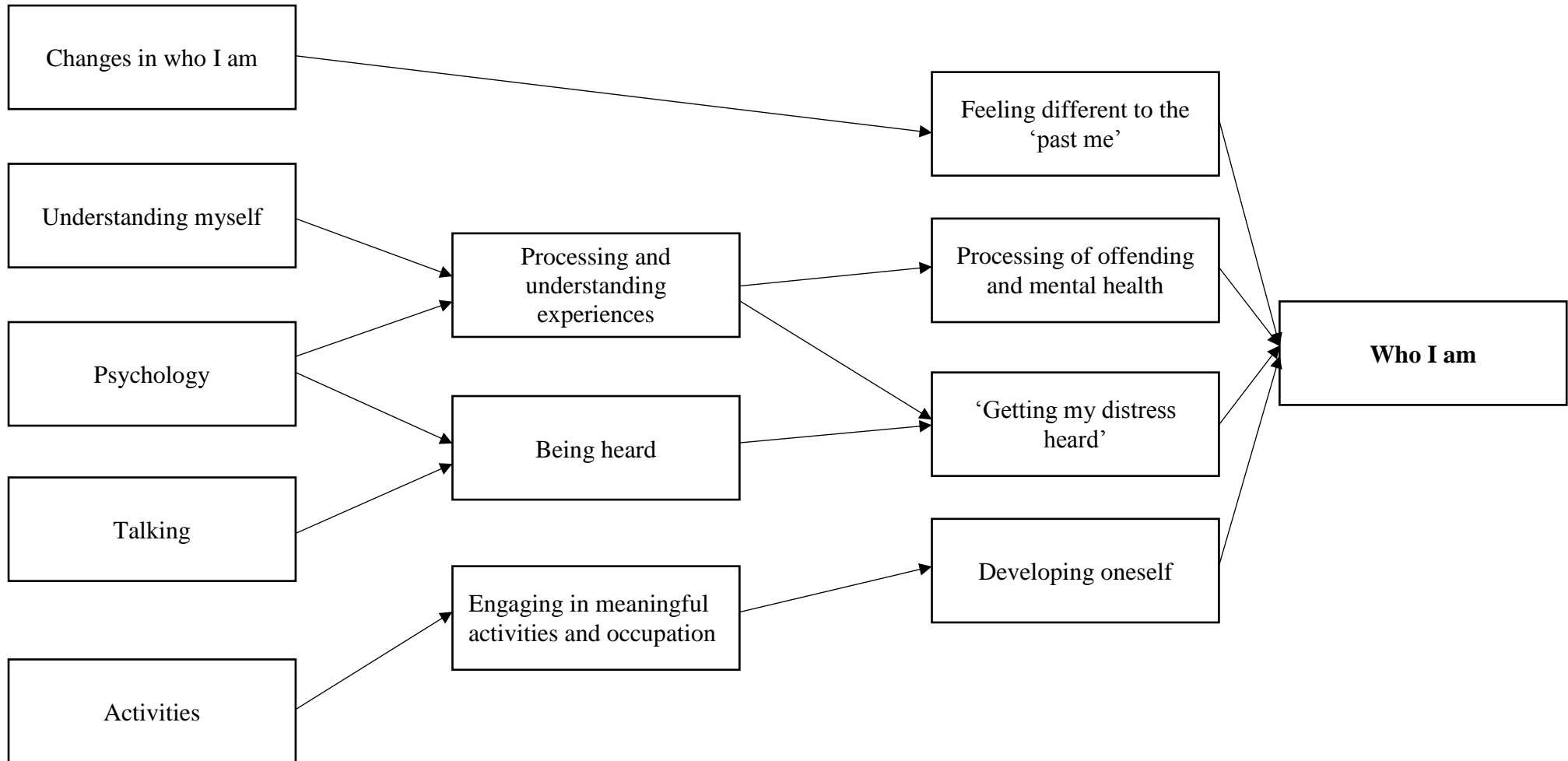
Coming to hospital

Appendix 25: Theoretical coding: Development of final core categories and sub-categories



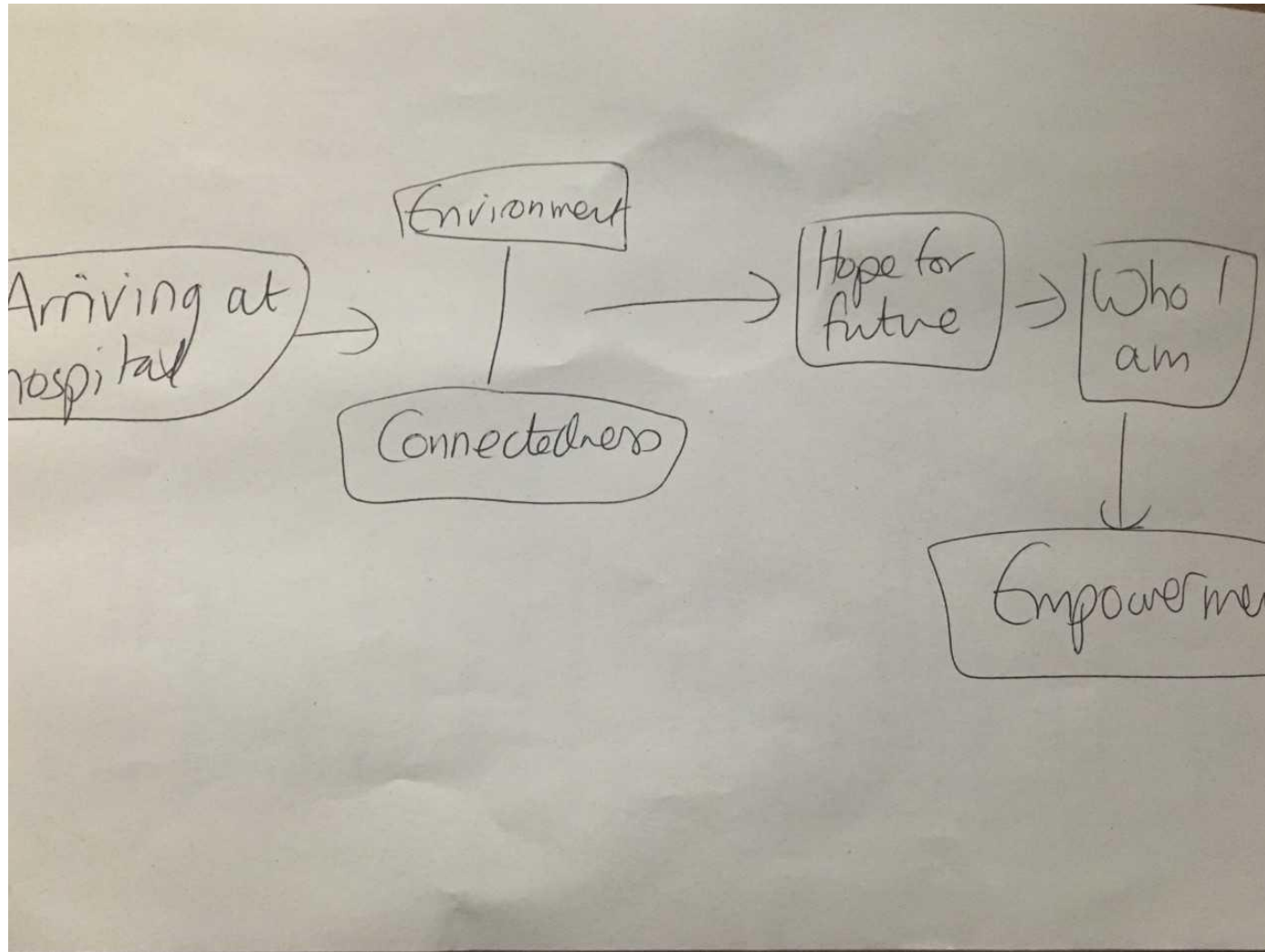


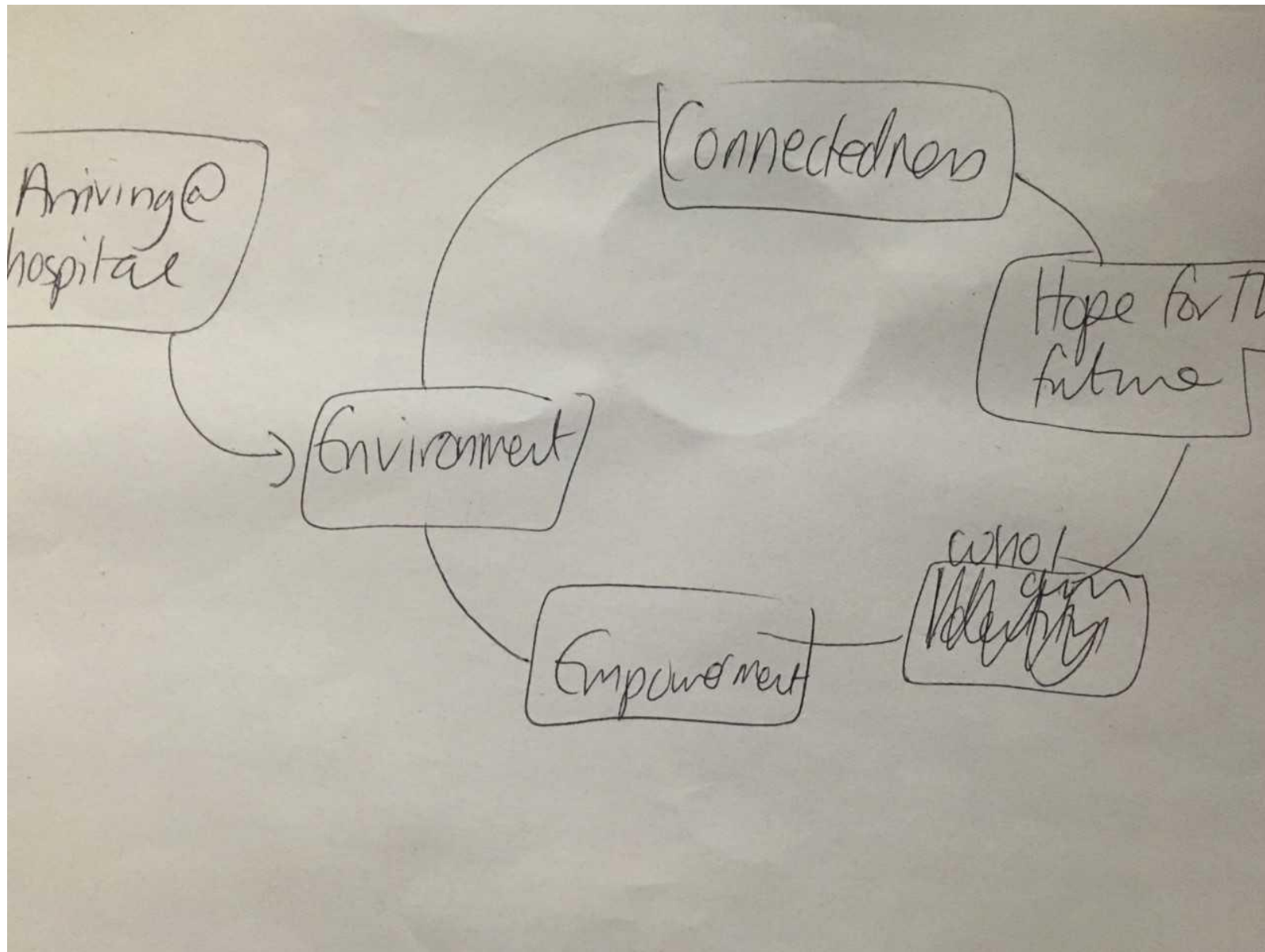


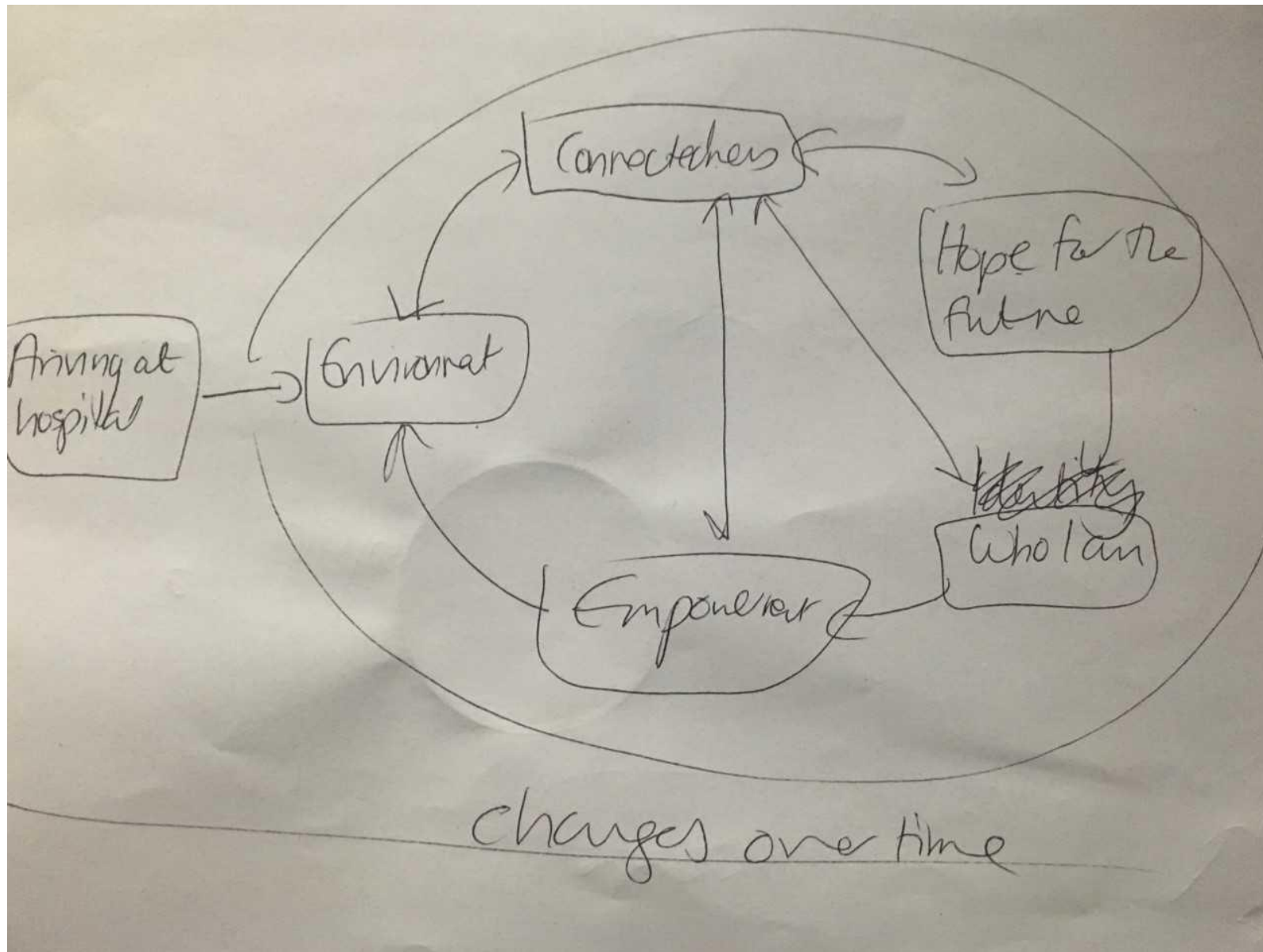


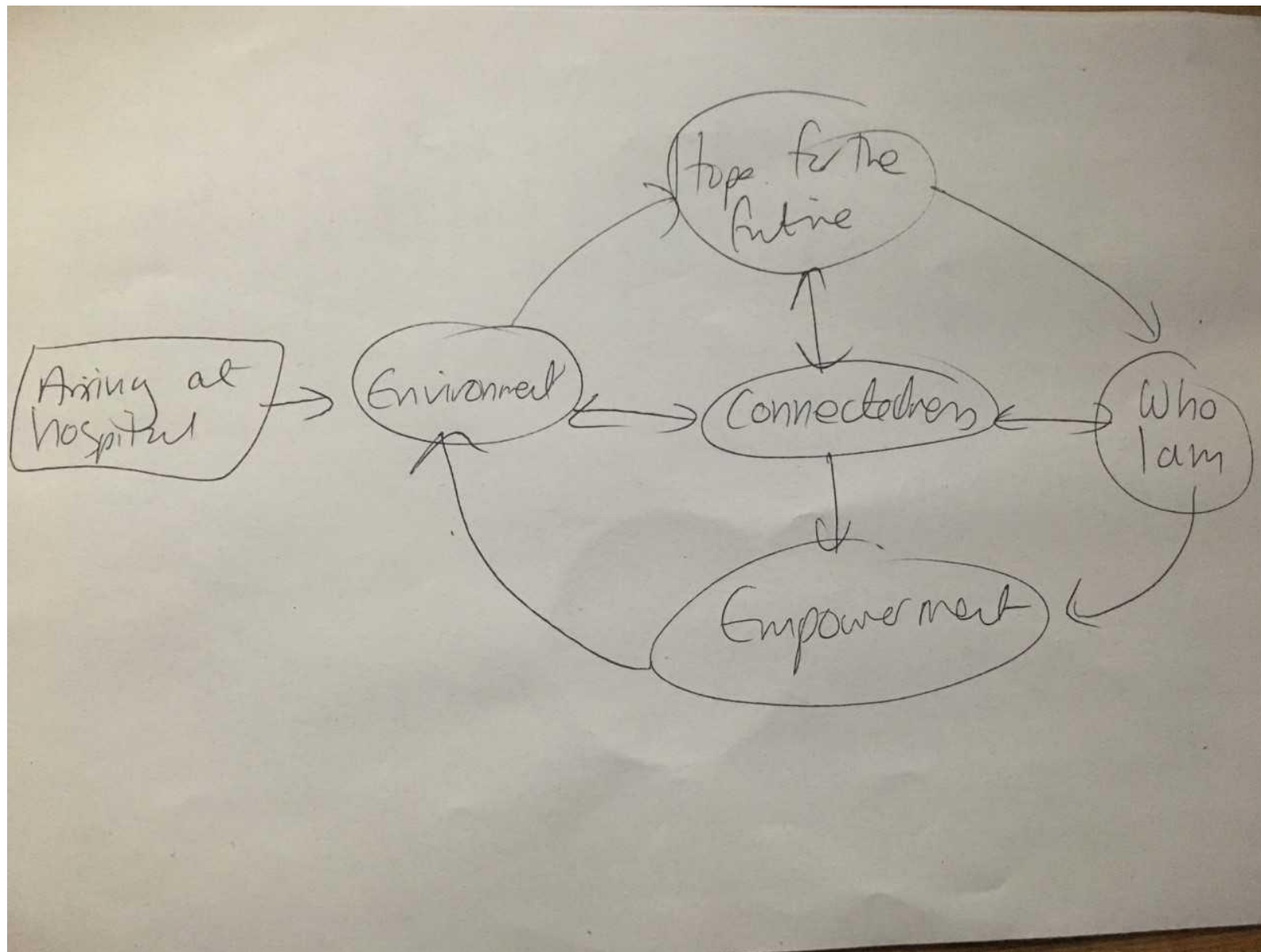
Appendix 26: Theoretical coding: Examples of using clustering (Charmaz, 2006) to develop relationships between the analytic categories

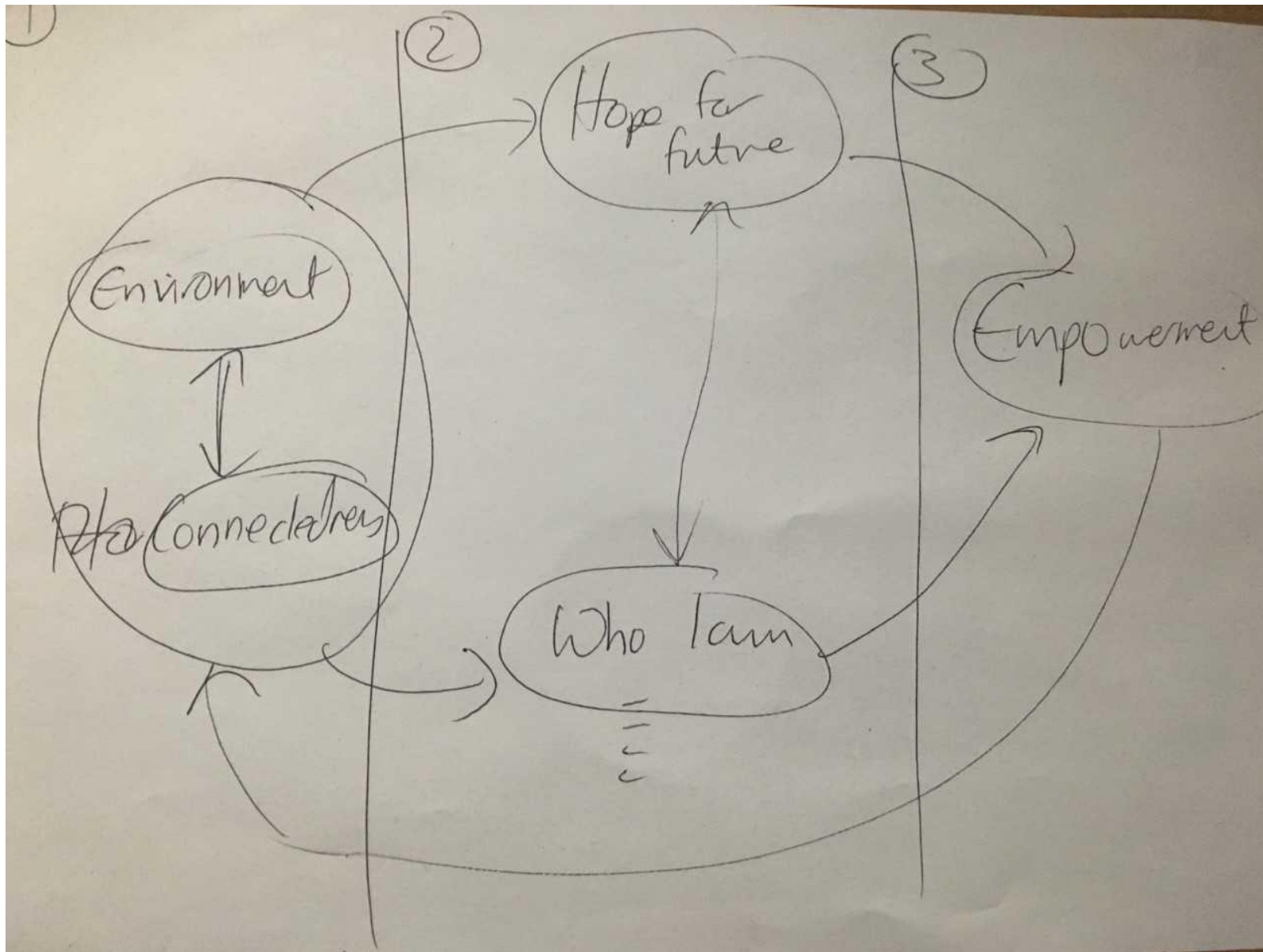
Below are some examples of the 'clusters' drawn throughout the 'theoretical coding' process to understand the relationships between the analytic categories. The inter-relationships were constantly compared to earlier codes and the raw data across all the interviews. The later 'cluster' shows how the three additional categories relate with the data.











Appendix 27: Table of examples of quotations that helped to form the core categories and sub-categories

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Appendix 28: Examples of memos

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Appendix 29: Abridged reflective diary

This has been removed from the electronic copy.

Appendix 30: Focus group response validation

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Appendix 31: End of study form for NHS ethics committee and HRA

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Appendix 32: End of study/summary letter to ethics panel/HRA/R&D Department

“My Journey through the System”: A Grounded Theory of Service User Experiences of Recovery in Forensic Mental Health Services

Objective:

Recovery-orientated practice has become the guiding principle for mental health service delivery in the UK. Forensic service face unique challenges to applying this approach. Research has highlighted themes associated with recovery in these settings but it is unclear how these themes come about and relate to each other. The purpose of this research was to develop a theoretical model of service user experiences of recovery in forensic mental health settings.

Method:

Sixteen service users who had been detained under the Mental Health Act and had a history of offending were interviewed, using a semi-structured interview, about their experience of recovery in forensic mental health settings. They resided in lower security accommodation or in the community in two NHS Trusts. Grounded Theory methodology was used to analyse the interview data. A focus group was held for respondent validation of initial findings.

Main findings:

A cyclical model was constructed representing service user experiences of recovery in forensic mental health settings (see below). The model is titled ‘My journey through the system’ and contains five superordinate categories: the environment; connectedness; hope for the future; who I am; and empowerment. These were described as occurring in three phases of 1) feeling safe and secure, 2) moving forwards and 3) empowerment. All categories strengthened and reinforced each other in a cyclical process, which suggests participants’ perceived recovery as an on-going phenomenon. No one category was sufficient to facilitate recovery, without the aid of other processes. Two additional categories were found that encompassed the process, which were ‘arriving at hospital’ and ‘changes over time’. The temporal dimension of the model was important, to enhance potential for change.

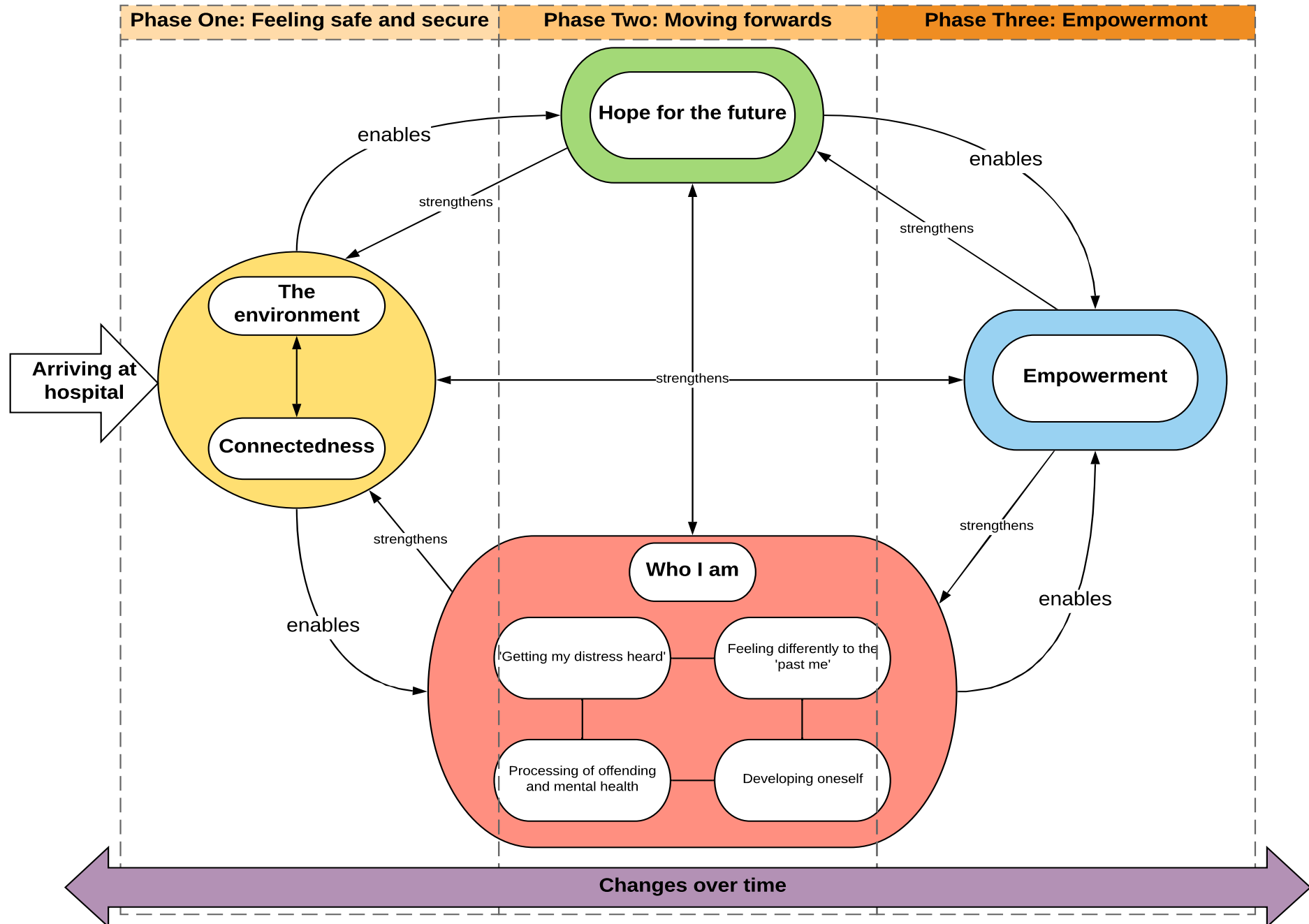
Participants portrayed what it was like arriving at hospital, providing a context for their state of mind. ‘Feeling safe and secure’, the first phase in the recovery process, was described as a reciprocal relationship between two superordinate categories, ‘the environment’ and ‘connectedness’; this provided a necessary basis for other recovery processes to occur. ‘Feeling safe and secure’ enabled participants to move onto a second recovery phase: ‘moving forwards’. Participants described building hope for the future, alongside processing and developing ‘who I am’. These two superordinate categories strengthened and worked alongside one another. Thinking about ‘who I am’ was portrayed as a complex process of “getting my distress heard”, processing of offending and mental health, feeling differently to the “past me” and developing oneself. Having hope and developing a greater sense of ‘who I am’ helped empower individuals, moving to a third recovery phase of ‘empowerment’. This reinforced people feeling safe and secure, not only in their external world but also within themselves, which they described not feeling on arrival to hospital.

Implications: The proposed model has clinical implications and can be located at the heart of service delivery. The model provides services with a frame of reference for what they are

trying to achieve in terms of recovery. From an organisational level, structures can be put in place enhancing recovery-orientated care, such as in staff training. In terms of 'on the ground' staff, the model can be implemented in a range of interactions with services from how a ward round is conducted to one-to-one informal interactions with service users. It would be important for services to consider whether their current approaches are underpinned by the principles outlined in the model.

Dissemination: The findings from this study will be presented to the two psychology departments of the services participants were recruited from, during team meetings. A written summary of the findings will be shared with all participants. The research is proposed to be published in the Journal of Forensic Psychiatry and Psychology.

For further information please contact t.r.lovell180@canterbury.ac.uk



Appendix 33: End of study report for participants

“My Journey through the System”: A Grounded Theory of Service User Experiences of
Recovery in Forensic Mental Health Services

Dear _____,

As you may remember, you kindly took part in a research study about your experiences of recovery in forensic mental health services. The study is now complete and, as discussed, here is a summary of the findings. This study would not have been possible without your participation and I would like to thank you for your time and contributions to the research. Your involvement has been invaluable in helping to understand the process of recovery in forensic services from service users' perspectives.

The findings of this study will be presented to relevant teams for the NHS Trusts that participated in the research. This will hope to help staff start to think about how they can use the proposed model in their services. The findings will also be sent to the Journal of Forensic Psychiatry and Psychology for publication.

If you have any questions, then please contact me on t.r.lovell180@canterbury.ac.uk. If you have any concerns about the study that you feel you cannot discuss with me, please contact Dr Fergal Jones, Research Director, Salomons Centre for Applied Psychology – fergal.jones@canterbury.ac.uk. (03330117070).

Thank you again for your participation, and for sharing your stories and experiences with me.

Best wishes,

Tamsin Lovell

Trainee Clinical Psychologist

Salomons Centre for Applied Psychology

Canterbury Christ Church University

“My journey through the system”

Research exploring service user experiences of recovery in forensic mental health services

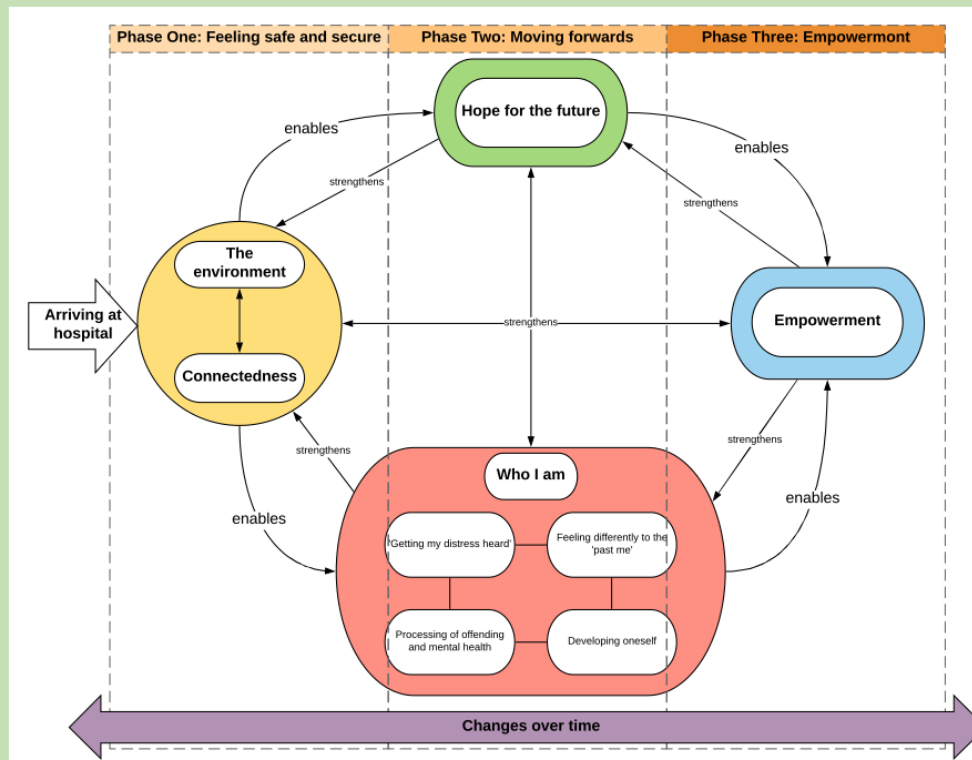
Why did we carry out the research?

- To better understand how recovery can happen for service users in forensic services
- To develop a theoretical model of service user experiences of recovery in forensic services

How was the research carried out?

- Participants were recruited who were residing in lower-security accommodation of living in the community
- 16 service users were interviewed about their experiences of recovery in forensic settings
- Interviews were typed up and compared with each other to develop an overview of what people said
- After everyone was interviewed, a diagram was put together to try and represent peoples’ described experiences
- The initial diagram was explained to some of the participants, who felt it represented their experiences

What did we find?



- ‘Feeling safe and secure’, the first phase in the recovery process, was described as a reciprocal relationship between ‘the environment’ and ‘connectedness’; this provided a necessary basis for other recovery processes to occur.
- ‘Feeling safe and secure’ enabled participants to move onto a second recovery phase: ‘moving forwards’.
- Participants described building hope for the future, alongside processing and developing ‘who I am’.
- These two superordinate categories strengthened and worked alongside one another.
- Having hope and developing a greater sense of ‘who I am’ helped empower individuals, moving to a third recovery phase of ‘empowerment’.
- This reinforced people feeling safe and secure, not only in their external world but also within themselves, which they described not feeling on arrival to hospital.
- Time was needed for change to occur.

Categories and sub-categories.

Categories	Sub-categories
The environment	Having boundaries and routine Pharmacological interventions
Connectedness	Trust between staff and service users Acceptance and belonging Others believing in me
Hope for the future	Having and achieving goals Envisaging the future Having faith
Who I am	‘Getting my distress heard’ Processing of offending and mental health Developing oneself Feeling different to the ‘past me’
Empowerment	N/A

What can we learn from this?

This model can be located at the heart of forensic service delivery. It can help staff to understand service users’ perspectives of recovery and can be used in staff training. It can also help staff working with service users every day in their interactions, making sure current approaches are underpinned by the principles outlined in the model.

Appendix 34: Author guidelines for Journal of Forensic Psychiatry and Psychology**Instructions for authors**

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