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CLARE L HOLT BSc (Hons) MSc (Hons)

THE REHABILITATION OF OFFENDERS DIAGNOSED WITH SEVERE MENTAL ILLNESS

SECTION A: The challenges of rehabilitation for offenders diagnosed with severe mental illness: A critical review of the existing evidence

(5499 words)

SECTION B: The journey through forensic mental health services toward reintegration into the community: A Grounded Theory

(7998 words)

SECTION C: Critical appraisal

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A thesis submitted in partial fulfilment of the requirements of Canterbury Christ Church University for the degree of Doctor of Clinical Psychology

JULY 2011

SALOMONS

CANTERBURY CHRIST CHURCH UNIVERSITY

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed ..... (Candidate)

Date .....

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

Signed ..... (Candidate)

Date .....

Signed ..... (Supervisor)

Date .....

STATEMENT 2

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

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Firstly I would like to offer my sincere thanks to all participants. To the men who have willingly shared their personal and, at times, difficult experiences of forensic services; I hope others will learn from the admirable progress they have made towards rebuilding satisfying and fulfilling lives. To the staff members who kindly imparted their understanding and experiences; their passion and commitment toward empowering hostel residents to live safely and happily in the community is pivotal to the rehabilitation journey.

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SUMMARY OF MRP PORTFOLIO

Section A: This paper reviews the existing theoretical and empirical literature of relevance to offenders with severe mental illness (SMI) in the UK. Due to the lack of theory accounting for progress through forensic mental health services (FMHS) as currently constituted, the adjacent areas of mental health recovery and forensic rehabilitation are the major focus. Relevant empirical literature is synthesised and critically evaluated and this paper concludes by (a) summarising research challenges that remain pertinent to this area of enquiry and (b) outlining recommendations as to how research can usefully proceed.

Section B: This empirical paper reports a qualitative investigation into the journey of offenders with SMI through FMHS towards reintegration with the community. Based upon semi-structured interviews with seven FMHS-users and three staff members, and triangulating with a booklet of published personal accounts, this grounded theory study produced a preliminary model of the journey from entry into forensic services towards reintegration with the community. The paper outlines the categories and sub-categories that comprise the model and interview quotations further illustrate the preliminary theoretical account. Findings are discussed in relation to the existing literature and to conclude this paper addresses the limitations and clinical implications of this study.

Section C: In order to reflect upon the process of conducting this project, the author considers four questions: (1) what research skills have been developed and what skills continue to require development?, (2) what would be done differently were this project to be repeated?, (3) what changes in clinical practice will occur as a consequence of this research?, and (4) what areas would future research focus on and how would this be approached?.

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CANDIDATE: Clare Holt

SECTION A

The challenges of rehabilitation for offenders diagnosed with severe mental illness: A critical review of the existing evidence

WORD COUNT (excluding abstract & references): 5499

Abstract

This paper focuses on the rehabilitation of offenders diagnosed with severe mental illness (SMI); a group who typically present with abundant treatment needs. In the absence of a theoretical account specific to this population there is a trend for theoretical and clinical approaches to two related areas of study to be applied; theories of offender rehabilitation and recovery from SMI are reviewed. There are important differences a) between the clinical needs of offenders diagnosed with SMI and general offender and psychiatric populations, and b) in service provisions for these groups, therefore it is argued that use of these theoretical and clinical approaches is somewhat problematic.

To review treatment approaches for offenders with SMI, systematic literature searches were conducted. Sixteen UK-based evaluations of treatment outcomes for offenders with SMI are reviewed; limitations to the existing evidence base are outlined. Overall, service provision for offenders with SMI continues to lack a robust theoretical basis and empirical support.

This paper concludes by summarising existing gaps and challenges in this area of research. There remains a pressing need for a theoretical account of rehabilitation that is specific to offenders diagnosed with SMI. To date the views and experiences of consumers of forensic mental health services (FMHS) have received little recognition, and qualitative investigations have the potential to provide a more nuanced understanding of this area.

Background information

The umbrella term ‘mental disorder’ (MD) refers to “any disorder or disability of the mind” (Mental Health Act [MHA], 2007). Five subtypes of MD are relevant to forensic settings: mental illness (MI), personality disorder, learning disability, substance misuse disorder, and disorders of sexual preference (McMurran, Khalifa, & Gibbon, 2009). The term ‘mentally disordered offender’ (MDO) therefore refers to a heterogeneous population crossing the entire spectrum of psychiatric diagnoses, personality disorders and criminal offences (Rice & Harris, 1997). Given the diverse characteristics of MDOs, this paper focuses on one sub-group within this population: offenders diagnosed with SMI (i.e. a psychotic and/or mood disorder) who “warrant interventions beyond those of the usual criminal justice process” (Blackburn, 2004, p.298). It is common for MDs to co-occur; offenders with a learning disability, substance misuse disorder or personality disorder without SMI are not the current focus.

Offenders with SMI typically have complex needs including: mental health (MH) management, criminogenic needs, affective and cognitive deficits, poor life and social skills, substance misuse, trauma, and personality disorder traits (Muller-Isberner & Hodgins, 2000). In general offenders experiencing SMI require a co-ordinated, long-term, multi-agency approach (McCann, 1999).

The term ‘rehabilitation’ can have different connotations in forensic contexts (Andrews & Bonta, 2010) and MH contexts (Killaspy et al., 2005). Harris and Rice (1997) claim the rehabilitation of offenders with SMI should be measured by “reductions in criminal

recidivism...in hospitalisation and service use, increases in use of other services...vocational and community adjustment, quality of life...happiness, and decreases in symptoms" (p.362). Despite consensus that the rehabilitation of offenders with SMI involves the dual task of risk reduction and MH management, professionals disagree about which is the primary concern (Blackburn, 2004).

Context

Policy context

Two circulars outline government policy for achieving treatment and care of offenders with SMI, rather than punishment through the criminal justice system (CJS; Fitzgibbon & Cameron, 2007). In brief, Provision for Mentally Disordered Offenders (Home Office, 1990) and Mentally Disordered Offenders: Inter-agency Working (Home Office, 1995) stress the importance of partnership working and information sharing between all agencies working with offenders experiencing SMI.

Reviewing services in England, the Reed Report (Department of Health [DH] & Home Office, 1992) proposed the needs of offenders with SMI can only be met by a diverse, integrated range of health and social services. The 276 recommendations advise that this population receive care from health and social services, not the CJS. Underscoring the aim of treatment services (to maximise rehabilitation and independent living) the review reiterates that patients should not be disadvantaged by their status as offenders.

The government has re-emphasised its commitment to FMHS provision. Following the Bradley Report (DH, 2009), Improving Health, Supporting Justice (DH, 2009) emphasised "the need for a systematic and joint NHS/CJS approach to offender mental health" (p.67).

Service context

Service context is a dynamic feature influencing rehabilitation and must be considered within any holistic account (Lindqvist & Skipworth, 2000). Challenging FMHS, the UK population of MDOs rose by 45% between 1996 and 2006 (Rutherford & Duggan, 2007).

Permitting the transfer of MDOs from the CJS to MH facilities, 'diversion from custody' aims to ensure appropriate service provision. Different diversion mechanisms are associated with different elements of the MHA (Prins, 1995; appendix 1). The Offender Mental Health Care Pathway states "no-one with acute SMI should be in prison" (DH, 2005b, p.2) and outlines best practice guidance for MH services serving forensic populations.

Offenders with SMI are subject to the Care Plan Approach (CPA) which adopts an individualised approach to assessment and treatment planning, involves multi-agency input, and should promote social inclusion and recovery (DH, 2008). Offenders with SMI can pose challenges to service providers; transfers between prisons, hospital and community can complicate care continuity and services' primary purpose can become confused given the "dual mandate of treating the patient and containing the offender" (Mullen, 2002, p.300).

Since 2000 the Home Office and DH have worked in partnership to provide services to offenders with SMI in high-, medium-, low-secure, and community settings (Fitzgibbon & Cameron, 2007). Parallel, integrative and hybrid models of FMHS delivery have developed. Although a nationwide survey indicated UK FMHS are typically delivered in parallel to generic psychiatric services (Judge, Harty, & Fahy,2004), current empirical evidence doesn't elucidate one optimal way of achieving high-quality FMHS (DH, 2007). Whilst individual FMHS models have been proposed (e.g.Gudjonsson & Young, 2007) service delivery currently proceeds in a piecemeal fashion; "what works for which patients" remains unclear (Humber et al.,2011, p.199). Representing the tensions inherent to providing services to this population, despite aiming for collaboration "there can be a lack of understanding on the part of MH professionals regarding the CJS and of Offender Managers regarding the MH and social care systems" (DH, 2008, p.45).

Theoretical approaches

Despite descriptive investigations of associations between SMI and offending (Mullen, 2002), searches of the current literature suggested that no psychological theory incorporates SMI and offending behaviour. Therefore two relevant areas are reviewed below: offender rehabilitation and recovery from SMI (Muller-Isberner & Hodgins, 2000).

Offender rehabilitation

A complete account of psychological theories of offender rehabilitation is beyond the scope of this review (see Andrews & Bonta, 2010;Hollin, 2001). The "two broad models of offender rehabilitation" (Ward & Stewart, 2003, p.126) are described below.

Risk-Need-Responsivity (RNR) model

Underpinned by three separate theories (see Ward, Melser, & Yates, 2007), the RNR-model proposes social-learning, psychological, biological, cultural, interpersonal, and situational factors that explicate offending behaviour. It is proposed criminal behaviour is learnt within social contexts which may include: social support for criminal behaviour and for cognitions conducive to criminal behaviour, criminal history, antisocial personality factors, family dysfunction, substance misuse, and limited social achievement (Andrews & Bonta, 2010). As a consequence of their environment offenders may develop inadequate cognitive skills, rigid and egocentric thinking patterns, and learn inappropriate, impulsive behaviours. Proponents of the RNR-model advocate cognitive-behavioural techniques to help offenders "face up to the consequences of their actions...understand their motives...and develop new ways of controlling their behaviour" (Lipton et al., 2003, p.80).

Underpinning the RNR-model the risk principle states treatment intensity should be tailored to offenders' risk level, the need principle states effective interventions focus upon criminogenic needs (dynamic risk factors functionally related to criminality), and the responsivity principle addresses how interventions are delivered. 'General responsivity' dictates that structured, cognitive-behavioural programmes are preferable. 'Specific

responsivity' incorporates individual factors including learning style and motivation (Andrews et al., 1990).

Meta-analyses support the RNR-model (Losel, 1995;McGuire, 2000); consistent with its theoretical bases, effect sizes increase with adherence to the RNR-principles (Andrews & Bonta, 2006). Cognitive-behavioural programmes adhering to RNR-principles are posited as the gold standard offender rehabilitation programme. Based on conclusions that "if any criminal justice policy will work in reducing recidivism it is a treatment-based policy rather than a punishment-based policy" (Andrews & Bonta, 2010, p.47) such programmes are routinely delivered across the UK CJS (McGuire, 2005).

Ward et al. (2007) provide a detailed critique of the RNR-model and its theoretical underpinnings. Despite providing an empirically defensible framework, the RNR-model doesn't "offer a theoretically integrated view of the rehabilitation process" or a "conceptually integrated" explanation of the relationships between criminogenic needs (Ward & Stewart, 2003, p.30). The RNR-model incorporates limited detail about the causal mechanisms responsible for criminogenic needs and therefore offending behaviour. Whilst focusing on risk, the RNR-model neglects alternative, pro-social methods for offenders to meet needs.

Enhancement models

Alternative theoretical approaches shift focus from 'what works?' to 'what do offenders need/want?'; the primacy of criminogenic need in the RNR-model is substituted with consideration of human needs (Ward & Maruna, 2007). Enhancement models claim human needs involve the "attainment of personal goods that sustain or enhance an individual's life" (Ward & Stewart, 2003, p.134). 'Categorical needs' derive their value from the need itself (e.g. autonomy and competence; Deci & Ryan, 2000); 'instrumental needs' are dependent on a contribution to a further goal (e.g. anger-management can assist attaining parole). Requiring internal and external conditions for fulfilment, basic categorical needs underpin human well-being; failure to meet basic human needs results in social maladjustment and problematic behaviours including offending (Ward & Stewart, 2003).

Enhancement models suggest human well-being should be the major construct driving rehabilitation; interventions focus upon offenders "constructing a picture of the best possible kind of life" (Ward & Stewart, 2003, p.140). By identifying internal barriers (e.g. beliefs) and external barriers (e.g. social factors) to pro-social attainment of categorical needs, the rehabilitation process accounts for offenders' capabilities, skills and support networks.

One strengths-based rehabilitation model, the Good Lives Model (GLM;Ward & Maruna, 2007) aims to enhance internal skills and external opportunities to attain categorical needs. The GLM can complement and enhance traditional risk-management approaches including skills training and relapse prevention (Ward, Mann, & Gannon, 2007), and has clinical relevance to broad offending typologies (Whitehead, Ward, & Collie, 2007). As a major

strength, enhancement models provide scope for incorporating motivational strategies into offender treatment (Gudjonsson, Young, &Yates, 2007).

Enhancement models require theoretical development to account for why some internal and external obstacles lead to particular offending behaviours (Ward & Stewart, 2003). Whilst proponents of the GLM claim the empirical adequacy of enhancement-based approaches is proven (Ward et al., 2007) outcome evaluations are notably lacking (Ferguson, Conway, Endersby, & MacLeod, 2009).

Recovery from SMI

A complete review of approaches toward recovery from SMI is beyond the scope of this review (see Spaulding, Sullivan, & Poland, 2003). Biological models of SMI focus upon symptom relief; according to some authors, long-term medication "is one essential component of treatment" (Muller-Isberner & Hodgins, 2000, p.18). However SMI is associated with multiple impairments within social, financial, and psychological domains (Wood, 1980); the era of deinstitutionalisation emphasised the broad effects of SMI and encouraged a new vision for MH services (Anthony, 1993). Furthermore, medication 'side effects' are often minimised in the literature and treatment efficacy is claimed on the basis of experimental studies funded by pharmaceutical companies (Bentall, 2003;Moncrieff, 2008).

Recovery-oriented approaches to SMI integrate medical, psychological and social approaches. The National Institute for Mental Health in England (NIMHE) adopted 'recovery' as the guiding principle for MH-services (2005). The concept of recovery has

numerous definitions; Anthony (1993) summarises that recovery is "a deeply personal, unique process of changing one's attitudes, values, feelings, goals...a way of living a satisfying, hopeful and contributing life even with limitations caused by illness" (p.527). Recovery is deemed to be the intended consequence of the skilful use of effective treatments, and to occur in the context of continuing symptoms or disabilities (Ralph & Corrigan, 2005).

Given there is no complete understanding of the causes of SMI, respect for individuals' understanding of their own experiences and acknowledgement of service users as experts is paramount to recovery approaches (British Psychological Society,2000). By in large, personal accounts of recovery from SMI constitute the basis of recovery approaches (Deegan, 1996; Ridgeway, 2000). Although relevant theories have emerged, the recovery approach has derived largely from a political movement therefore psychological theory and systematic evaluations have historically been secondary considerations (Joint Position Paper, 2008). Three concepts are central to recovery approaches: hope, opportunity and control (Green, Bateson, & Gudjonsson, 2011).

Recovery process model (RPM)

The RPM proposes that people recovering from SMI move from a state of dependency to interdependency (NIMHE, 2004). At any one time numerous factors influence functioning, therefore movement from dependency to interdependency is not linear. The RPM outlines four progressive levels of recovery. During the dependent/unaware phase individuals rely upon MH-services which function to maintain dependency. During the dependent/aware phase, individuals are increasingly aware of mental illness and available services although

may not feel empowered or interested in making recovery-oriented decisions/plans. During the independent/aware phase individuals take responsibility for managing their life and distressing experiences; services may continue to help with medication management and adherence to recovery action plans. At the interdependent/aware stage individuals experience a collaborative relationship with MH-services; their support systems become accepted partners/peers on the recovery journey.

Patients progressing through these levels develop increasingly autonomous and satisfying functioning in multiple domains: peer, family, occupational, recreational, and community. Effective services encompass broad systems in which the patient is embedded and where appropriate must address less tangible factors like power, control and stigma (NIMHE, 2004). Based on the RPM, twelve principles guide best practice in recovery-oriented MH services (NIMHE, 2004):

1. service-user direction is essential
2. service-users need to be aware of the negative impact of co-dependency
3. service-users recover more quickly when hope, life-roles, educational needs, culture, and socialisation are accounted for
4. individual differences are considered and valued across the lifespan
5. recovery from mental illness is most effective when a holistic approach is considered
6. integrated approaches to treatment should include biological, psychological, social, and values-based approaches

7. clinicians and practitioners initial emphasis on hope and the development of trusting relationships influences the recovery of service users
8. clinicians and practitioners should operate from a strengths model
9. with the support of clinicians, users of services should develop a recovery management plan
10. involvement of family, partner and friends can enhance the recovery process
11. mental health services are most effective when delivery is in the context of the service-users locality and cultural context
12. community involvement as defined by the service-user is central to the recovery process

Modified labelling theory (MLT)

Recovery and social inclusion are strongly linked (Joint Position Paper, 2008); MLT considers social rejection and stigma to be causative factors in relapse of SMI. MLT states that being diagnosed with SMI spoils ones identity and lowers self-esteem, this is associated with negative social, employment and economic outcomes (Wright, Gronfein, & Owens, 2000). Negative outcomes are not a direct consequence of experiencing SMI but a consequence of the stigmatisation which results from being placed in this role (Link et al.,1997). Different psychological mechanisms are posited as responsible for labelling effects: internalised cultural conceptions of SMI; personal relevance of beliefs regarding the low status of persons with SMI; expecting rejection and suffering self-esteem, financial and employment deficits. MLT has received extensive empirical support from cross-sectional and

prospective studies which suggest that experiences of social rejection, not expectations of social rejection, increase relapse (Wright et al., 2000).

Summary of recovery approaches

The evidence base for recovery approaches is thwarted by difficulties balancing standard objective measures of clinical and social recovery with outcomes that are subjectively meaningful for service-users (Dorrer, 2006). Recovery rates for SMI reportedly exceed treatment successes for many physical illnesses; the recovery movement has challenged the chronicity paradigm (Joint Position Paper, 2008). Empirical developments are required for recovery approaches to continue expanding, for example shared definitions, meaningful outcome measures, factors mediating recovery, and service quality indicators.

Summary of theoretical approaches

With their individual strengths and weaknesses, psychological theories have guided the development of services for offenders and for individuals experiencing SMI. Existing accounts are yet to explain the complex, dynamic interactions between SMI and offending; ultimately a theoretical explanation incorporating offending behaviour and SMI is yet to emerge. It is suggested that different factors may have hampered the development of psychological theory in this area: the heterogeneity of this population which can be ill-defined; historical debate and confusion surrounding treatment versus punishment of offenders with SMI; varied definitions of ‘rehabilitation’ and ‘recovery’ as relevant to this group; and the complexity of problem domains relevant to this group.

Generalising the aforementioned theories to offenders with SMI is problematic. The applicability of the themes and theories of recovery to this client group has not been sufficiently empirically validated (Gudjonsson, Webster, & Green, 2010). A qualitative investigation concluded "some of the central concepts around recovery, i.e. hope, self-acceptance, and self-management....may be particularly problematic for forensic psychiatric patients" (Mezey et al.,2010, p.692).

Various consequences of the confluence of offending behaviour and SMI complicate the application of existing theories to offenders with SMI. This population require a dual treatment model addressing clients' needs/wishes and risk related requirements (Green et al., 2011). Offenders with SMI are subject to the CPA, an individually oriented treatment approach which differs from the population-based risk management approaches within the CJS. Offenders with SMI are often transferred between the CJS and MH services; this increases service discontinuity and exposes service-users to varying treatment approaches. The legal and physical restrictions placed upon offenders with SMI are associated with additional complicating factors: therapy will be experienced differently in secure settings, consent and volitional treatment participation are complicated, and key elements of recovery approaches (e.g. self-determination) are negated (Green et al., 2011).

Having established the difficulties applying existing theories to offenders with SMI, the evidence-base for treatment approaches for this population will now be reviewed.

Treating offenders with SMI

Based on clinical characteristics, factor analysis and clinical judgement, Rice and Harris (1997) suggest particular domains should shape the treatment of offenders with SMI: active symptoms, aggression and behaviour management, criminal propensity, skills deficits, social withdrawal, and substance misuse. Noting that treatment outcome research with MDOs is almost non-existent Rice and Harris (1997) base pharmacological, psychotherapeutic and behavioural recommendations upon research with either offender or psychiatric populations.

Outcome Studies

To review empirical evidence for the treatment of offenders with SMI systematic literature searches were conducted; appendix 2 outlines search procedures. Given that service context is pivotal to rehabilitation (Lindqvist & Skipworth, 2000) this review is limited to UK-based research. An exhaustive review of each study's strengths and weaknesses is beyond the scope of this review; findings are described, synthesised and evaluated below.

Psychoeducation

Psychoeducation is associated with successful outcomes across MH-settings (Drake et al., 2001). Jennings et al. (2002) report a ten-week MH-education programme attended by seven male offenders in high-secure conditions. Although statistical comparisons were not conducted six participants demonstrated greater insight and improved knowledge of their illness post-intervention; changes were maintained six months later. Overall participants gained more positive attitudes towards medication and authors deem this a desirable outcome. Only a minority of participants' self-esteem increased. Authors suggest that

psychoeducation with offenders experiencing SMI achieves many of the benefits demonstrated with non-secure patients.

Vallentine et al. (2010) evaluated four, 20-session psychoeducation programmes delivered to offenders in high-secure conditions. Comparisons of pre- and post-intervention measures of psychological distress and self-esteem for 31 programme-completers were statistically non-significant. However some participants showed clinically significant change in particular facets of psychological distress, including subjective well-being and social/life function. Numbers of aggressive 'incidents' by group-completers versus non-completers were not statistically different three- and six-months post-intervention. Aggression levels within incident documentation showed a non-significant trend to be lower post-intervention; unfortunately illustrative examples of 'incidents' are not provided. Qualitative data highlighted things that participants valued (e.g. hearing others' experiences), that were clinically relevant (e.g. increasing self-help skills), and that were difficult (e.g. sharing experiences).

Cognitive-behavioural interventions

Based on the assumption that the criminogenic needs of offenders with SMI can be addressed in the same way as general offenders' needs (Gudjonsson & Young, 2007), cognitive-behavioural interventions have been adapted; nine relevant evaluations were identified.

Six studies evaluated general offending-behaviour programmes combining problem-solving, emotion-control, social, and perspective-taking skills training. Overall findings demonstrated significant improvements in: dealing with frustrating social situations (Donnelly & Scott, 1999); problem-solving skills (Tapp et al., 2009); offence-supportive cognitions (Young, Chick, & Gudjonsson, 2010); disruptive behaviours (Young et al.,2010); and adaptive coping strategies (Clarke, Cullen, Walwyn, & Fahy, 2010). Some outcomes were less desirable, for example no problem-solving improvements (Young et al., 2010), changes comparable with a control group (Donnelly & Scott, 1999), and no measurable change in social comparison, anxiety, and problem-solving (Donnelly & Guy, 1998). Of note, Fleck, Thompson and Narroway (2001) did not report post-programme psychometric results.

McMurran et al. (1999) administered a problem-solving inventory to nine participants before and after a six-session problem-solving skills group intervention. Providing a starting point for further development of social skills training for offenders with SMI, analysis revealed statistically significant improvements in overall problem-solving and reductions in negative problem orientation and impulsivity (McMurran et al., 1999).

Beck-Sander, Griffiths and Friel (1998) evaluated a 20-week cognitive-behavioural group which aimed to impact five constructs: control over illness, fear of relapse, likelihood of relapse, coping with symptoms, and depression (Mulhall, 1978). Overall, across sixteen participants, perceptions of the likelihood of relapse increased significantly. Despite a trend toward increased perceived control over illness and reduced depression, changes were non-

significant; however the small sample size will have reduced power to detect statistical differences. Patients who accepted the possibility of relapse pre-intervention felt more in control of their illness, better able to cope, and less fearful of relapse post-intervention. Patients who rated vulnerability to relapse as low pre-intervention, had a reduced sense of control and perceived ability to cope post-intervention.

Laithwaite et al. (2007) applied a structured cognitive-behavioural group-programme based on Hall and Tarrier's self-esteem intervention (2003) with 15 male offenders in high-secure conditions with a diagnosis of SMI. Psychiatric symptomatology, self-esteem and depression were assessed as outcomes. According to two of three outcome measures participants' self-esteem was significantly improved post-treatment; this was not consistently maintained three-months post-intervention. Depression scores were significantly reduced post-intervention and three months later. Results showed no significant change in 'positive' or 'negative' psychiatric symptoms. Authors suggest future studies could build upon these findings by utilising matched control groups, larger samples and outcome measures validated for offenders with SMI.

Existing studies evaluating psychoeducation and cognitive-behavioural interventions for offenders with SMI have utilised small, predominantly male convenience samples, non-comparable control groups, and non-blind treatment allocation (Young et al., 2010). Further methodological difficulties include a lack of robust randomisation, limited control of medication, and participant attrition (Duncan et al., 2006). Studies have used heterogeneous outcome measures, have been conducted in varied settings with offenders at varied stages of FMHS, and have measured statistically (not clinically) significant change. These factors complicate the synthesis of results and the drawing of clinically relevant conclusions. Whilst

eradicating all bias when assessing clinical outcomes is difficult, research into cognitive-behavioural interventions has recently expanded. Duncan et al. (2006) claim it is now time to "develop more methodologically robust research in this area" (p.237).

Well-being therapy

Testing the effectiveness of well-being therapy "in a population with such complex needs", Ferguson et al. (2009) evaluated a six-session group-based intervention with 14 offenders with SMI (p.907). Based upon various standardised questionnaires, results showed the intervention impacted favourably upon negative affect, life satisfaction, positive future thinking, depression, hopelessness, and negative symptoms of psychosis. Whilst this preliminary investigation offered support for well-being based interventions, this remains an under-researched approach to treating offenders with SMI. The study encompassed a small sample, didn't include a control group, and followed-up participants for just two months. The influence of diagnosis type, admission length and offending history upon treatment outcomes was not examined. Despite proponents of well-being approaches suggesting such programmes can "improve overall outcomes in recovery and well-being for those detained in secure settings" (Ferguson et al.,2009, p.917), the application of enhancement models to offenders experiencing SMI requires further evaluation.

Substance use interventions

Substance misuse is commonplace rather than exceptional amongst offenders with SMI (Morris & Moore, 2009). Four UK-based evaluations of substance-use interventions were

identified. Ritchie, Billcliff, McMahon, and Thomson (2004) report an eight-week drug and alcohol education programme attended by 51 male offenders detained in high-secure conditions. Intended to be the first stage in drug/alcohol treatment, the programme aimed to increase knowledge, motivation and internal control. Two locally developed and two self-administered questionnaires with established validity and reliability were completed pre- and post-intervention. Overall results indicated that participants' drug and alcohol knowledge significantly increased however changes in locus of control and stage of change were non-significant. Authors discuss potential explanations: knowledge change is not associated with behavioural/cognitive change; outcome measures lack precision; or the restricted hospital environment limits change potential.

Miles et al., (2007) report a one-year pilot study of a three staged integrated substance-use intervention in medium-secure conditions. 18 participants completed stage one (12 motivational sessions) and/or stage two (12 sessions focused upon action, maintenance and relapse), and were invited to attend a social support group for up to six-months. The percentage of inpatients completing at least stage one who were substance-free post-treatment was 74%; this rose to 79% six months later. Although the small sample prevented statistical analysis of all findings, participants increasingly believed they had substance-related problems, reported increased confidence in their ability to reduce their substance-use, and indicated more adaptive beliefs post-treatment. Authors conclude the study provides initial evidence for integrated substance-use interventions with MDOs.

Morris and Moore (2009) evaluated a group-CBT programme with 22 offenders with SMI and a history of substance use. Pre- and post-intervention scores on validated measures of

stage of change and drugs-based thinking styles indicated significant reductions in ambivalence scores and significant positive changes on four of eight thinking styles; there was no significant change in recognition and action steps. Semi-structured interviews with four participants and staff recorded incidents are reported and contribute to the conclusion that "cognitive-behavioural intervention can help offender patients with dual diagnosis" (Morris & Moore, 2009, p.573).

Oddie and Davies (2009) implemented the first module of Thomas and O'Rourke's (2002) program for substance-using offenders with SMI in secure conditions. Aiming to enhance readiness to change and to explore links between substance-use, mental-illness and offending, the 17-week module comprised weekly group sessions and five individual sessions. Multiple evaluation methods were used: semi-structured patient interviews, quantitative self-report measures, and concordance between self/facilitator-rated change. Overall results suggest the program was acceptable to participants "with some evidence of effectiveness in some areas" (Oddie & Davies, 2009, p.138).

Despite preliminary evidence supporting substance-use interventions with MDOs, research in this area is yet to overcome methodological shortcomings: small samples, no control group and limited follow-ups (Miles et al., 2007).

Community treatment

Driven by the Reed Report (DH & Home Office, 1992), there were 37 UK community forensic mental health teams (CFMHT) by 2006 (McMurran et al., 2009). Estimates suggest that half of CFMHT offer therapeutic interventions and that 20% offer psychodynamic and

family therapy (Judge et al., 2004). In comparison to generic services, CFMHT have shown favourable outcomes in terms of reconviction (Sahota, Davies, Duggan, & Clarke, 2009). However Coid, Hickey and Yang (2007) found comparable hospital readmissions and re-convictions for CFMHT and generic MH-services. Current evidence does not enable definitive conclusions about the effectiveness of community-based interventions for offenders with SMI (McMurran et al., 2009). The rising numbers of offenders recognised as experiencing SMI will increase demand for CFMHTs (Mullen, 2002), however there are no guidelines for such services and no framework for their development (Judge et al., 2004). Whilst aiming for seamless service provision from secure to community settings, significant gaps in these services remain (Blackburn, 2004); further evaluation appears pivotal to increasing the quality and effectiveness of service delivery.

Service-user perspectives

In order to better determine health needs, improve quality of life and patient satisfaction, health services increasingly emphasise service-user perspectives (Sullivan, 2003). Perhaps because of increased discrimination, social exclusion and ethical difficulties encountered in secure settings (Coffey, 2006), forensic research based on service-user views is limited.

The Mental Health Commission (2000) interviewed three FMHS-users and their family members to gather experiences of what hindered and aided recovery. Interview dialogues are presented in full without systematic data analysis although certain themes emerged: difficulties accessing services, relations with professionals, cultural insensitivity, and the institutional tension between sanctuary and confinement. Family members spoke about:

feeling helpless, blamed and dismissed by professionals; their desire to do everything possible for their relative; and difficulties obtaining support and service information. Service-users and family members agreed that particular factors contributed to recovery: respectful professionals who instil hope, appropriate timing of interventions, talking openly, and finding spiritual/personal support. This study was conducted in New Zealand; generalisations to the UK are not yet empirically supported.

As a rare example of collaboration with consumers of UK FMHS, Laithwaite and Gumley (2007) aimed to develop an experiential perspective of recovery in psychosis and interviewed MDOs in high-secure conditions. Participants spoke about their relationships and a changing sense of self in terms of two broad categories: past experiences of adversity and recovery in the context of being in hospital, further sub-categories are presented in detail. Authors acknowledge the preliminary nature of findings in this area.

Based upon literature reviews, Coffey (2006) concluded "we still know relatively little of the experience and perspectives of people who use forensic mental health services, and may judge available findings as unreliable" (p.73). The current review upholds this assertion; there seems to be much greater need to hear from service-users themselves than has so far been the case.

Summary

Seven criteria can measure outcome study quality: clearly defined target symptoms, reliable and valid measures, use of 'blind' evaluators, assessor training, manualised and replicable

treatments, unbiased treatment assignment, and treatment adherence (Foa & Meadows, 1997). According to this framework the studies reviewed are generally of low quality.

Evidence-based practice has been slower to develop in FMHS than in the CJS and MH-services. This review confirms that the efficacy of interventions for offenders with SMI remains unclear; interventions remain "more pragmatic than theory-driven" (Blackburn, 2004, p.306). Outcome evaluations have proceeded in a piece-meal fashion measuring specific elements of recovery and rehabilitation, a paucity of evaluation studies focus upon multi-component treatments. Morgan et al. (2007) found less than 1% of 12,000 FMHS outcome studies included MH and criminogenic outcomes. Likewise this review suggests outcome studies fail to combine the problem domains characteristic of offenders with SMI (Rice & Harris, 1997).

General offender and psychiatric interventions have been adapted for MDOs however issues of co-existing disorders (Cree & Hodgins, 2007), motivation to change (Hodge & Renwick, 2002), and trauma (Crisford, Dare, & Evangeli, 2007) distinguish MDOs from offender and psychiatric populations. For offenders experiencing SMI, the need for "better theories to guide service development and evaluation" remains (Blackburn, 2004, p.307); hearing more from service-users themselves may be an important step in enabling such theories to develop.

Despite the above difficulties, in practice, UK FMHS have established ways to combine the available evidence from the offender rehabilitation and SMI literature in order to provide services aimed at meeting the needs of offenders with SMI. The CPA provides a clear

framework in which professionals must consider the mental health, social and risk management needs of all service users (McMurran et al., 2009). Rice and Harris (1997) outline principles of effective service for offenders with SMI based upon "what is known about effective services for persons with serious mental disorders and services aimed at reducing the criminal recidivism of offenders in general" (p. 383). They recommend FMHS should: use actuarial risk assessments to identify criminogenic needs as treatment targets; use psychotropic medications conservatively; incorporate behavioural and cognitive-behavioural therapies; include broader treatment targets including fostering pro-social peer groups; be community based where possible; and be able to measure their own integrity. The service model proposed by Gudjonsson and Young (2007) delineates how five different 'layers' of treatment in combination can meet the needs of offenders with SMI: mental health, pro-social competencies, offending focus, indirect focus for example trauma work or anxiety, and specific environment focus. Literature regarding offender rehabilitation and recovery from SMI can differentially guide and shape the interventions offered at these different 'layers'.

Research challenges

Research into the rehabilitation of offenders with SMI is complicated by the heterogeneous nature of this population and their treatment needs. FMHS are complex and face several challenges including the competing trends of punishment versus treatment, and criminal rehabilitation versus MH-recovery (Lindqvist & Skipworth, 2000). Balancing services' responsibilities to clients, the legal system, and the community is demanding. Although the literature alludes to the complexity of factors inherent to FMHS, it is challenging for research to encompass and reflect the extensive range of associated variables. A lack of theoretical

integration is ever present in this area; research continues to focus on separate elements of forensic rehabilitation.

The heterogeneous population of MDOs has been defined differently across studies (Harris & Rice, 1997) and studies have failed to control or report characteristics known to influence treatment outcome, for example stage of service contact, motivation to change, and degree of insight and recovery style (Fitzgerald, 2010). Posing a challenge, research regarding offenders with SMI must take into account a whole host of influential, dynamic variables.

Difficulties defining and capturing concepts key to recovery/rehabilitation and low base rate outcomes also hamper research. A review of over 300 forensic MH studies concluded that many domains other than recidivism and MH are important, yet under-represented outcomes for example quality of life and psychosocial adjustment (Fitzpatrick et al., 2010). Whilst measures relevant to public safety, clinical, rehabilitation, and humanitarian outcomes are meaningful and necessary, the heterogeneity and limited validity of outcome measures in this field remain problematic.

Ward and Willis (2010) review ethical challenges relevant to forensic research: professionals' dual role of therapist and researcher; unintentional coercion of vulnerable, restricted participants; and assumptions about SMI and offender's 'treatability'. Emphasising the abundant ethical issues relevant to forensic settings authors concede that professional ethical codes can leave pertinent ethical issues undetected.

Making large-scale, controlled studies which are the mainstay of offender rehabilitation virtually impossible, the treatment needs of offenders with SMI are individual and multi-faceted (Davies, Howells, & Jones, 2007). Whilst some advocate large-scale, longitudinal outcome studies within the context of everyday practice (van Marle & van der Kraft, 2007) others concede that randomised-controlled studies are difficult to achieve in the absence of valid theoretical bases (Farrington & Joliffe, 2002). Offenders with SMI may experience population-based interventions in the CJS and the health service culture which is less supportive of formal treatment programmes and routine evaluation (Davies et al., 2007). In the context of such difficulties, research is yet to delineate effective services for offenders with SMI.

Future directions

This review implies the rehabilitation of offenders with SMI warrants further exploration; research could usefully proceed in several ways. Given the fissures that are evident in the existing literature, a theoretical account encompassing the journey from secure conditions to reintegration into community settings could provide insights relevant to service provisions for offenders with SMI. A theoretical account incorporating offending behaviour and SMI could also promote increased integration of research and clinical practice, that is, a psychological theory linking and making sense of varied empirical observations could enable empirically-based interventions to develop further. A theory incorporating the dual facets of offending and SMI could further promote the values-based attitudes promoted by the policies which underpin FMHS in the UK: this population should receive a holistic approach which acknowledges and addresses all problem domains that are of relevance to their presenting needs (DH, 2009).

This review highlights the limited inclusion of service-user perspectives in the forensic MH literature. The National Service Framework for long-term conditions (DH, 2005a) "reflects the value placed on the opinions of people who use services" (p.87). Tensions exist between objective measures of clinical/social recovery and what is subjectively meaningful to individuals; service-users views and experiences can help bridge these disparities (Joint Position Paper, 2008). Given that FMHS-users are on the receiving end of the numerous issues and tensions outlined in this paper, gathering personal experiences of forensic rehabilitation as an adjunct to additional objective measures could help to synthesise this field of literature.

Given the difficulties outlined, novel research approaches are required to study the rehabilitation of offenders experiencing SMI (Lindqvist & Skipworth, 2000). Rather than suggest an implicit hierarchy among research designs it is argued that qualitative and quantitative studies can have equal validity when used in the appropriate context (DH, 2005a). Quantitative approaches can assume universality amongst participants; this assumption is largely inaccurate for offenders with SMI whose presenting difficulties have long and complex causal pathways (Victoria, Habicht, & Bryce, 2004). It is proposed qualitative methods hold the potential to provide individualised, nuanced insights into this population's rehabilitation.

Conclusions

In the UK the number of offenders recognised to experience SMI is increasing. This review highlights the continued shortage of high quality empirical and theoretical study in this area.

Given the potential consequences of inadequate FMHS-provision both for service-users and society as a whole, there is a pressing need to develop the existing accounts of the rehabilitation journeys experienced by offenders with SMI. As an adjunct to larger-scale quantitative outcome studies, it is recommended that future studies develop a holistic theoretical understanding of the rehabilitation of offenders with SMI, utilise service-user perspectives, and apply qualitative methodologies in order to gain further insight into the processes of forensic rehabilitation.

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SECTION B

The journey through forensic mental health services toward reintegration into the community: A Grounded Theory

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Abstract

The UK's increasing recognition of offenders with severe mental illness (SMI) and the lack of a theoretical account specific to this group provided the rationale for this study. The aim was to develop a preliminary model of the ways offenders with SMI progress through forensic mental health services (FMHS) towards reintegration with the community. Semi-structured interviews were conducted with seven FMHS-users and three FMHS staff members. Grounded theory was used to build a preliminary model, which contained six main categories: learning about and managing mental health, establishing facilitative relationships with staff, moving on from prison and early experiences of FMHS, developing self-direction, doing work in therapy, and managing wider support networks. Findings extend existing literature by providing a preliminary theoretical account of the multiple domains that influence progression of offenders with SMI towards reintegration with the community. Results are discussed with regard to the existing literature and clinical implications are outlined. Recommendations for future research are made.

The journey through forensic mental health services toward reintegration into the community: A Grounded Theory

Falling within the broader category of 'mentally disordered offenders' (MDOs), offenders with SMI (here defined as a psychotic and/or mood disorder) typically have complex treatment needs including mental health (MH) management, criminogenic risks, substance misuse, personality disorder traits, impaired cognitive abilities, and poor social skills (Blackburn, 2004). These heterogeneous clinical needs complicate treatment planning and service provisions; additional difficulties are presented by the increasing number of offenders recognised as requiring MH services (Rutherford & Duggan, 2007). Offenders with SMI commonly experience MH and criminal justice services (CJS); government documents emphasise the importance of partnership working and inter-agency communication (Department of Health [DH], 2009).

Theoretical accounts

Searches of the theoretical literature indicated that no extant theory encapsulates the confluence of offending behaviour and SMI. Indeed Blackburn (2004) commented on the limited theoretical understanding of this population. Whilst some preliminary accounts focus upon specific issues relevant to this population, for example post-traumatic stress (Gray et al.,2003) and motivational factors (Gudjonsson,Young, & Yates, 2007), existing evidence does not provide a holistic theoretical explanation of the rehabilitation of offenders with SMI within UK FMHS. Therefore in this introduction the author focuses on two areas: MH recovery and offender rehabilitation.

Recovery approaches.

The 'recovery approach' is increasingly promoted as the guiding principle for UK MH services (DH, 2001). Whereas the traditional medical model assumes a biological disease process, the recovery approach is consistent with social models of MH which posit that the capacities of people with perceived impairments (e.g. SMI) are constrained and prejudiced by physical and attitudinal barriers created and perpetuated by the non-disabled majority (Beresford, 2004). Since recovery journeys are individual in nature varying definitions of 'recovery' exist (Anthony, 1993); however there is consensus regarding the centrality of three concepts: hope, opportunity and control (Green, Batson, & Gudjonsson, 2011). Recovery approaches aim to empower and foster optimism, promote collaboration, and value individuals' strengths, potential and life goals (Shepherd, Boardman, & Slade, 2008).

Recovery approaches are underpinned by personal accounts of those experiencing MH difficulties (Ridgeway, 2000). Based on 50 experiential accounts Andresen, Oades and Caputi (2003) posit four component processes of recovery (hope, self-identity, life meaning, and responsibility) and five stages of recovery (moratorium, awareness, preparation, rebuilding, and growth). Andresen et al. (2003) describe that hope can come from within a person or be triggered by another, and argue that hope not only triggers recovery but also maintains the recovery process. Self-identity can be lost by some experiencing SMI, and Andresen et al. (2003) posit that "the process of self-redefinition is central to recovery" (p.589). Finding meaning in life is documented as central to the recovery process however the source of that meaning can vary greatly between individuals and over time. Andresen et al. (2003) suggest responsibility includes self-management of wellness and medication, autonomy in one's life choices, and accountability for one's actions. In brief the moratorium stage of recovery is characterised by denial, hopelessness, identity confusion, and

withdrawal. The awareness stage may involve "a first glimmer of hope of a better life, and that recovery is possible" (Andresen et al., 2003, p.591). During the preparation stage the person resolves to start working on recovering and it is during the rebuilding stage that the hard work of recovery takes place, i.e. the individual sets and begins to work toward personally meaningful goals. During the final stage of recovery, growth, the person has learnt how to manage their illness and is resilient in the face of setbacks. Despite preliminary development of tools measuring stages of psychological recovery (Wolstencroft et al., 2010), Davidson, Roe, Andres-Hyman, and Ridgway (2010) suggest stage models cannot capture the non-linear nature of recovery, the person-disorder-environment interactions, and the influence of discrimination, resources and support. A richer set of concepts may be required to capture these complex, dynamic processes.

Recovery approaches acknowledge the ways social factors including labelling, stigma and social-exclusion contribute to and exacerbate SMI. Receiving extensive empirical support the modified labelling theory (Scheff, 1966) posits that labelling and stigma have a causative role in relapse of SMI; social psychological mechanisms account for this process (see Wright, Gronfein, & Owens, 2000). Given the stigma and fear surrounding perpetrators of serious offences, social-exclusion and attitudinal barriers are likely heightened for this population.

A review of UK-based recovery research identified six theoretical papers (Stickley & Wright, 2011) however conceptual, philosophical and values-based considerations predominate these accounts. Arguably a lack of psychological theory continues to hamper recovery approaches. Whilst evidence indicates favourable outcomes of recovery-based services (Warner, 2010), critics argue that subjectively meaningful outcomes are often neglected due to these approaches being applied in a top-down manner; this can defeat the object of devolving more power to service-users to define their own recovery (Dorrer, 2006).

Whilst some advocate the application of recovery principles to MDOs (Gudjonsson, Webster, & Green, 2010) a recent qualitative investigation concluded that for forensic populations "some of the central concepts around recovery, i.e. hope, self-acceptance...self-management and having one's achievements recognised, may be particularly problematic" (Mezey et al., 2010, p.692). Illustrating how the confluence of SMI and offending behaviour creates complications, most participants viewed offending behaviour as a greater barrier to recovery than their mental illness. Findings suggest this population has specific needs unaccounted for by recovery approaches as currently conceived. For example, whilst trying to move towards reintegration with society offenders with SMI are, by necessity, segregated from it. Gudjonsson et al. (2010) note limited published data on the recovery approach within forensic services.

Laithwaite and Gumley (2007) present a qualitative, experiential account of recovery from psychosis amongst offenders within high-security settings. Two overarching themes were common across participants and confirmed the significance of this population's confinement in secure conditions: past experiences of adversity and recovery in the context of being in hospital. In explicating these themes and their sub-categories authors depict tasks characterising the sample's recovery: building relationships, developing trust, coping, and working towards achievements and a satisfying life. Authors acknowledge this study was preliminary and further research is required; participants were yet to experience less restrictive conditions and little attention was paid to offence-related rehabilitation processes. Noiseux et al. (2010) argue care-provider perspectives are "important because they often witness significant outcomes" of MH-services (p.162); unfortunately Laithwaite and Gumley (2007) did not incorporate staff perspectives.

Theories of offender rehabilitation.

The Risk-Need-Responsivity model is deemed the most influential model of offender rehabilitation (RNR; Andrews & Bonta, 2006). Supported by numerous meta-analyses the RNR-model claims interventions should: target high-risk offenders, focus upon criminogenic needs, use cognitive-behavioural techniques, and be responsive to offenders' individual characteristics. The RNR-model outlines social-learning, psychological, cultural, interpersonal, biological, and situational factors that explicate criminogenic needs that are the primary rehabilitation target. The RNR-model is underpinned by three theoretical accounts (see Ward et al., 2007, for a detailed description). The Psychology of Criminal Conduct (PCC; Andrews & Bonta, 2003) posits that individual differences in propensity to commit crimes can be accounted for by distinct patterns of social and psychological factors that increase the chances of an individual breaking the law. The assumptions of the PCC approach guided the development of a broad theoretical framework that aims to account for crime in a scientifically defensible manner, the General Personality and Social Psychological Perspective on Criminal Conduct (GPSPP; Andrews & Bonta, 2003). Based upon a number of cognitive, behavioural, biological, and situational facets, the GPSPP outlines three clusters of causal factors that can independently result in a high-risk situation for the commission of crime: immediate situational factors, delinquent associates, and crime supportive attitudes. Whilst the GPSPP identifies causal factors associated with crime, it does not specify the mechanisms in sufficient detail (Ward et al., 2007). The third account underpinning the RNR-model is the Personal Interpersonal Community-Reinforcement Perspective (PIC-R; Andrews & Bonta, 2003). Providing a more detailed account of the mechanisms that initiate and maintain criminal behaviour, the PIC-R proposes that criminal behaviour is acquired and sustained through a combination of operant and classical conditioning, and observational learning. Whilst the PIC-R provides a more explanatory account of criminal behaviour, the

relationship between different risk factors remains vague and the mechanisms associated with different risk factors are not substantially delineated. Ward et al. (2007) posit that individually, the three theories underpinning the RNR-model do not provide the necessary theoretical components to ground the model.

Although the RNR-model is commonly criticised for being translated into 'one-size-fits-all' interventions, recent investigations have concluded RNR-based interventions are far from being so. Whilst increasing theoretical sophistication has shifted focus from 'what works' to 'what works for whom, and when', much about 'what works for whom' is yet to be investigated (Polaschek, 2011).

Ward et al. (2007) cite various criticisms of the RNR-model's theoretical basis including: a primary focus on risk-reduction; the narrow notion of human nature that ignores human requirements for certain goods to achieve satisfying lives; personal identity, agency and the therapeutic alliance are neglected; and the Risk, Need and Responsivity principles are insufficiently theoretically grounded.

Given the RNR-model's limitations, alternative accounts focusing upon enhancing offenders' capabilities and quality of life have emerged (e.g. Good Lives Model, Ward & Stewart, 2003). Underpinned by psychological theories of need (Deci & Ryan, 2000) enhancement-based approaches posit that rehabilitation efforts should focus on building internal and external conditions that enhance human well-being. Whilst historically the RNR-model and enhancement-based approaches have been viewed as opposing accounts, more recently "an integration of the two approaches or...utilisation of both to different facets of the rehabilitation process" (Ward et al., 2007, p.225) has been proposed. However Serin and Lloyd (2009) claim that all existing accounts neglect the transition from crime to desistance and that detailed study of these processes has important clinical and theoretical implications.

Treating offenders with SMI

The paucity of outcome research relevant to offenders with SMI has long been acknowledged (Blackburn, 2004). A systematic review of group interventions with MDOs concluded research remained small-scale and methodologically limited (Duncan et al. 2006). Searches of the current literature uncovered recent outcome evaluations (e.g. Clarke et al., 2010) however studies continue to have significant limitations, perhaps because of difficulties inherent to conducting research in forensic settings (Coffey, 2006). Empirical evaluations continue to focus on individual elements of service provision (e.g. single, time-limited interventions), thereby neglecting to provide a holistic account of offenders' journeys through FMHS.

Summary

It is suggested that no existing theoretical account adequately explains the processes of recovery and rehabilitation of offenders with SMI. Whilst theoretical and empirical literature in MH and offender rehabilitation offers some relevant insights, offenders with SMI appear to warrant their own theoretical investigation. In the context of the theoretical, empirical and clinical difficulties outlined, a preliminary theoretical account based on an in-depth analysis of the personal experiences of a small sample of offenders with SMI and the insights of clinicians working with them could begin to explicate some of the complex processes involved in moving towards reintegration into the community.

Study aims

This study aimed to increase theoretical understanding of the ways offenders with SMI progress through FMHS toward reintegration with the community. By incorporating the first-hand experiences of (a) a sample of offenders with SMI judged to be close to reintegration

into the community after time in secure-FMHS and (b) staff working in FMHS, this in-depth qualitative investigation aimed to build a preliminary theory that addressed the following research questions:

- What individual and psychological changes are experienced by offenders with SMI during their journey through FMHS toward reintegration into the community?
- In what ways do FMHS appear to influence the journey of offenders with SMI toward reintegration into the community?
- What factors external to FMHS seem to influence the journey of offenders with SMI toward reintegration into the community?

Method

Participants

Since the "confirmation of findings through convergence of different perspectives" increases the quality of qualitative research (Willig, 2001, p.148) the sample of ten participants consisted of FMHS-users and staff members. Seven participants were male FMHS-users living in a community forensic hostel or a low-secure rehabilitation unit of a local medium-secure unit (MSU) awaiting a placement in a community forensic hostel or supported housing. All participants had progressed from the same MSU and participants' time in forensic services included prison, high-, medium-, and low-secure FMHS. Table 1 presents further demographic details.

Table 1

Service-User Participant Demographic Information

Participant	**Age range in years**	**Ethnicity / cultural background**	**DSM-IV diagnoses**	**Index offence(s)**	**Time in forensic services**	**Current place of residence**
Geoff [1]	55-60	White British	Psychosis	Murder	20yrs	Community hostel
Luke	< 30	White British	Psychosis	Murder	4yrs	Community hostel
Tom	< 30	Mixed native-American	Delusional disorder	Rape	4yrs	Community hostel
Tony	55-60	White British	Psychosis	Manslaughter Armed robbery	20yrs	Community hostel
Barry	30-35	White British	Psychosis Borderline PD	Arson	7yrs	Low-secure rehabilitation unit
Harvey	30-35	African	Psychosis Learning disability	GBH	5yrs	Low-secure rehabilitation unit
Aaron	45-50	Pakistani	Major depression	GBH	5yrs	Low-secure rehabilitation unit

[1] - names have been changed to protect anonymity

LEGEND: PD = personality disorder GBH = Grievous Bodily Harm

The three staff-member participants worked at a community forensic hostel and provided individualised, day-to-day support for hostel residents, conducted one-to-one ‘key-work’

sessions, and contributed to ongoing care plans. Table 2 presents further demographic details. Sampling issues are discussed further in the Procedure section.

Table 2

Staff Member Participant Demographic Information

Participant	**Age range in years**	**Ethnicity / cultural background**	**Time working in forensic services**	**Job title**
Sarah [1]	55-60	White British	4.5yrs	FMH-support worker
Louise	40-45	Black British	5yrs	FMH-support worker
Andy	45-50	Black British	2yrs	FMH-support worker

[1] – names have been changed to protect anonymity

LEGEND: FMH = forensic mental health

Design

Given the research aims a non-experimental, qualitative design was used. Grounded theory (GT), a method designed to facilitate the process of theory generation (Willig, 2001) and to elucidate social and internal psychological processes (Strauss & Corbin, 1998), was applied to analyse data from semi-structured interviews.

Measures

Semi-structured interviews are a flexible data collection method which generate rich, full data and enhance the development of rapport with participants (Coolican, 1999). Grounded

theorists use interviews as directed conversations, not as closely controlled structured endeavours (Pidgeon & Henwood, 2000). The author generated provisional interview questions based upon the research questions; these were refined during consultation with an ex-user of FMHS, with a member of FMHS-staff, and with the research supervisors, to form the first stage interview schedule (Appendix 3). To avoid "becoming constrained by pre-formulated questioning" (Pidgeon & Henwood, 2000, p.91) initial interviews comprised broad, open questions of relevance to the research questions: individual changes, factors within services, and factors external to services.

Procedure

Recruitment.

The study was introduced verbally to staff and residents at a community forensic hostel by the service-based consultant psychologist during a regular resident/staff meeting. All potential participants were given a Participant Information Sheet to consider (Appendix 4). The author visited the hostel one week later to gather details of residents and staff-members initially willing to participate. Consistent with the GT-approach, the participation of individuals residing on the rehabilitation unit of a MSU who met criteria indicated by theoretical sampling (detailed below) was requested as the study progressed.

Participants provided written consent prior to participation (Appendix 5).

Data collection and analysis.

In order to generate theory in a transparent, systematic way, Strauss and Corbin's (1998) GT techniques and procedures were followed. A critical realist stance was adopted: whilst aiming for the discovery of theory which emerges from the data (Strauss & Corbin, 1998), the

influence of the author, her supervisors' input, and the context in which explanations evolved were acknowledged.

Within GT, data collection and analysis inform and guide each other iteratively. In accordance with Strauss and Corbin (1998), 'constant comparisons' and 'theoretical sampling' were important considerations during data collection and analysis. Helping to stimulate thinking about properties and dimensions, the constant comparison method entails the seeking of similarities and divergences that reflect the multiple facets of emerging concepts (Strauss & Corbin, 1998); this included negative case analysis (Willig,2001). Theoretical sampling involves sampling on the basis of emerging concepts and aims to explore the dimensions and conditions along which concepts' vary (Strauss & Corbin, 1998).

Data were collected via audio-recorded, face-to-face semi-structured interviews which lasted 50 to 90 minutes. The interview schedule became increasingly focused during the study in accordance with the themes and hypotheses emerging from the data (Appendix 6).

All interviews were transcribed in an anonymous form by the author (Appendix 7). Transcripts were analysed in accordance with the progressive stages outlined by Strauss and Corbin (1998). During coding the author kept memos of reflections on the data (Appendix 8); these guided further data collection and category development.

- The first four transcripts were coded line-by-line using open coding. The numerous 'in vivo' codes generated remained close to the meaning directly expressed in the data.
- Later transcripts were analysed using focused coding which helped synthesise the open codes according to shared properties and dimensions.
- Enabling more precise and complete explanations, axial coding related categories to subcategories according to properties and dimensions.

- Selective coding integrates and refines categories. During selective coding transcripts were reviewed for relevant information with emerging categories in mind.

Appendix 9 contains examples of coded data.

Theoretical saturation is a "matter of degree" (Strauss & Corbin, 1998, p.136). Consistent with Strauss and Corbin's (1998) guideline that "within the limits of available time...the researcher finds...no new data are being unearthed...new data would only add, in a minor way" to the emerging theory (p.292), theoretical saturation was marked by the attainment of well developed categories that provided a sufficient explanatory framework for the data.

For quality assurance, triangulation and respondent validation (detailed below) were carried out subsequent to initial analyses.

Quality assurance

In addition to constant comparisons, theoretical sampling and memo keeping, different procedures aimed to enhance research quality. The author kept a research diary which helped shape category development and guided conversations with research supervisors (Appendix 10); personal reactions to the material were noted and discussed in supervision, to aid reflexivity and stay alert to alternative interpretations of the data. An audit trail was maintained throughout the analysis process (Pidgeon & Henwood, 2000).

Three transcripts were analysed by the lead research supervisor at different stages of analysis. In instances of disagreement, discussions were held until a consensus was reached and then necessary alterations were made.

Providing a forum to discuss methodological and analytic issues, the author attended a peer support group with others conducting GT investigations; one support group member cross-checked samples of data coding.

Respondent validation aimed to determine whether participants felt the theoretical categories and preliminary model accurately represented their experiences.

Additionally increasing the validity of findings, a booklet containing FMHS-users' experiential accounts was used for triangulation (South West London and St.George's NHS Trust, 2010; Appendix 11). Increasing data credibility, extensive interview quotations and exemplars of triangulation are presented throughout the results section.

The above assurance measures satisfy recommendations made by Yardley (2007).

Ethical considerations

This study received ethical approval from the: university ethics panel (Appendix 12), local Research Ethics Committee (Appendix 13), and local NHS Research and Development team (Appendix 14).

Results

Initial open coding generated 262 codes from which 67 focused codes were generated. Focused codes were subsequently collapsed to form 23 sub-categories and six main categories (Table 3). Appendix 15 illustrates the category development process.

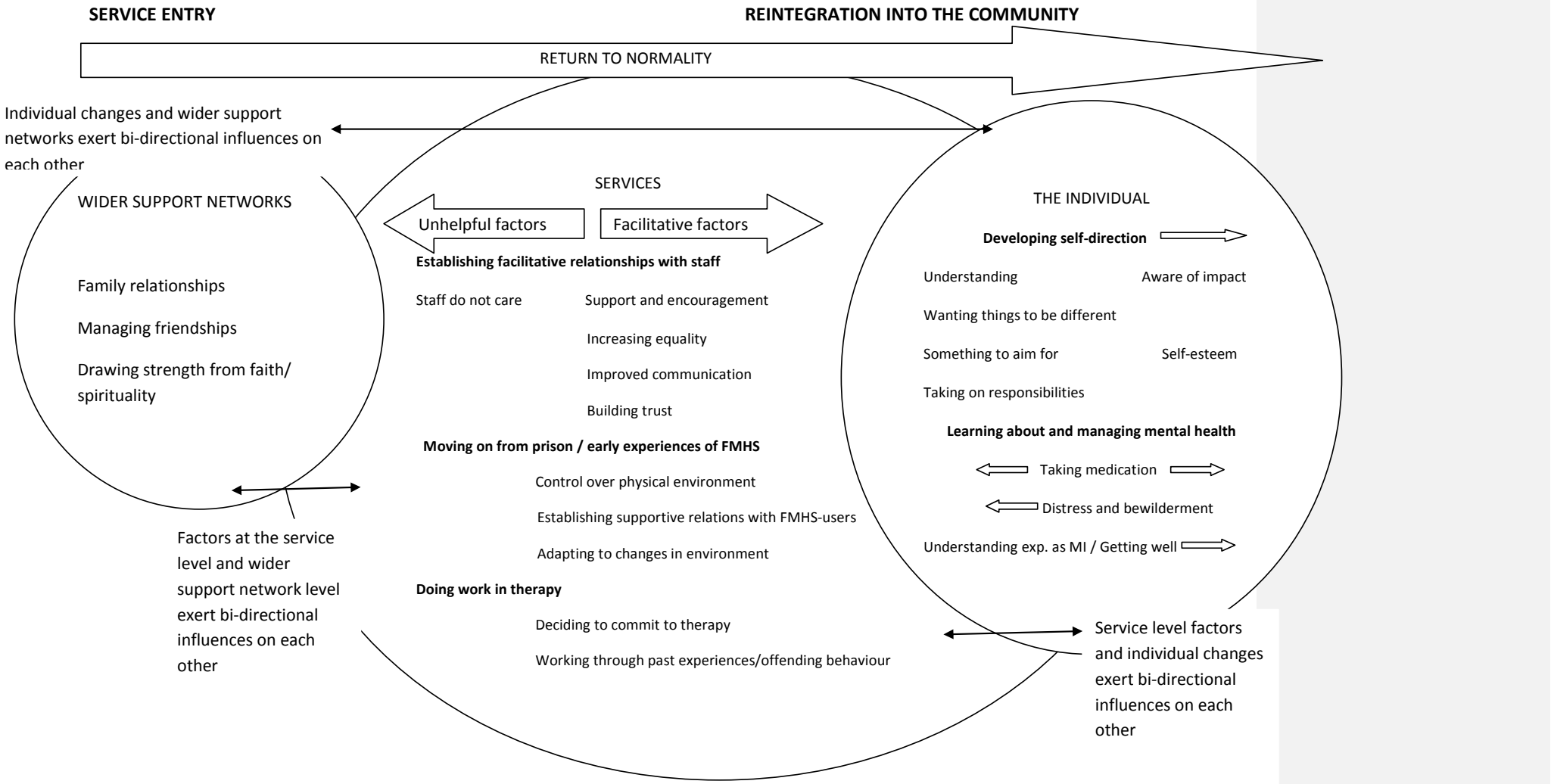
Table 3

Table of categories and sub-categories within the GT-model

Category	**Sub-category**
Learning about and managing mental health	Distress and bewilderment
	Taking medication
	Coming to understand experiences as mental illness
	Getting well
Establishing facilitative relationships with staff	Staff don't care
	Being supported and encouraged
	Increasing equality
	Improving communication
	Building trust
Moving on from prison and early experiences of FMHS	Control over physical environment
	Establishing supportive relations with fellow FMHS-users
	Adapting to environmental changes
Developing self-direction	Developing self-understanding
	Becoming aware of the impact of past offences/behaviours
	Wanting things to be different
	Building self-esteem
	Something to aim for
	Taking on responsibilities
Doing work in therapy	Deciding to commit to therapy
	Working through previous experiences and offending behaviour
Managing wider support networks	Managing friendships
	Family relationships
	Drawing strength from faith / spirituality

Analysis produced a preliminary model of patients' journey through FMHS, from entry toward reintegration into the community. Participants who had been transferred to FMHS from prison described how their prison experiences influenced subsequent progress; therefore these experiences are incorporated in the model where relevant. The emergent model illustrates the combination of factors at three levels which facilitate and impede patients' progress: the individual, services, and wider support networks. Figure 1 provides a visual representation of the emergent model; overlapping circles depict how factors at the individual, service, and wider support network level are inherently inter-linked and exert bi-directional influences upon each other. A combination of fluid factors at these different levels influence patients at any one time, therefore the journey towards reintegration with the community depicted by this model follows a non-linear, non-sequential trajectory. The relationships between different categories and sub-categories are detailed further within the written description of the model. Categories are described and illustrated by quotations; triangulation data is labelled 'OUR STORIES'. Pseudonyms are used to ensure confidentiality. Appendix 16 further explicates sub-categories.

Figure 1. Visual representation of the preliminary model including categories and sub-categories



Category One: Learning about and managing MH

Distress and bewilderment.

Participants described the early stages of being within forensic services as chaotic and confusing; some patients had been unaware of their MH difficulties.

> I don't think anybody knew what was going on.(Geoff)

> On the ward...often patients are quite chaotic...disturbed...confused.(Louise)

Participants spoke about distressing symptoms previously endured. For some, symptoms had interfered with receiving treatments and therefore impeded progress.

> I was imagining stabbing people, shooting people...was getting hallucinations with them as well.(Geoff)

> I wouldn't take it [medication]...I thought they was poisoning my food...thought the prison officers were going to kill me.(Barry)

Participants felt that upon entry to prison or FMHS their illness-related distress was managed ineffectively. Participants reported not getting the help that they required; some were introduced to unhelpful management techniques.

> [In prison] I was getting...psychotic intrusive thoughts telling me to kill people...he said...get an elastic band on your wrist and just flick it...that's all he said, that was it.(Geoff)

Taking medication.

Ranging from general comments that medication had been helpful to descriptions of medication reducing particular symptoms and therefore assisting progress, participants reported that medication 'works'.

> The medications helped me a lot.(Barry)

> The voices it's taken them away...I'm not distracted I'm not...pre-occupied...it's helped me get where I am.(Tom)

> After about two months on the same medication, the voices reduced...then they disappeared...I'd been struggling with them for two years...screaming for them to go...this 'wonder drug' as I see it, done the job.(OUR STORIES)

Participants reported various medication side-effects ranging from transitory experiences to long-lasting/permanent effects; some had felt unprepared for dealing with these.

> Some of them do lack motivation...because of their medication.(Sarah)

Staff expectations regarding medication compliance were described to influence participants' opinions and behaviours.

> Doctors say I need to take it so I feel I need to take it.(Tony)

> If I refuse it [medication] then they're [staff] going to...get upset...I accepted it, there is nothing I can do about it.(Harvey)

> It would be nice to come off the medication but my doctor says different. (OUR STORIES)

Coming to understand experiences as mental illness (MI).

For some participants, once they perceived medication as reducing symptoms, their belief that they had a MI increased. As participants' understanding developed, they realised that some previous and current experiences could be attributed to and explained by their MI. For some, making sense of these experiences and understanding them as part of MI impacted their self-concept.

> Once they got me on the right medication...and it helped me...I thought to myself you know...it was just an illness.(Tom)

> I used to think I was evil...these hallucinations it must be somebody who is evil...once I started getting medication...I thought...the devil wouldn't let this medication work...I thought I'm not bad I'm just ill.(Geoff)

> I have a greater understanding of my diagnosis...I see sense in it.(OUR STORIES)

Getting well.

Participants described various effects of being symptom free over time: being able to think clearly and concentrate, feeling 'normal', and being able to judge right from wrong. One feature of 'getting well' was progress toward medication self—management; this represented decreased reliance on staff and services.

> Now that I am well...I can think about things clearly.(Tom)

> When I'm completely free from my voices...I can judge...I understand everything...everything I can judge for myself.(Aaron)

> The biggest goal I have achieved is taking my own medication, which is needed for independent living.(OUR STORIES)

Category Two: Establishing facilitative relationships with staff

Overall patient-staff relationships had been pivotal to patient progress; these fluctuated in nature, sometimes in accordance with variations in patients' MH.

> People say I got myself out...I say I got myself out but I couldn't have done it without the right staff.(Geoff)

> It was my mental illness that affected my relationship with staff [during early stages of FMHS-contact].(Tom)

Staff don't care.

An accumulation of experiences left some service-users feeling like staff didn't care. Participants described staff exercising power in unhelpful ways and being "nasty", for example threatening patients and speaking disrespectfully. At times, patient-staff relations provoked anger and aggression. This sub-category was more prominent at earlier stages of participants' journey, for some this was in prison.

> It's like boarding school for a lot of them [high-security hospital staff] ...power goes to their head.(Geoff)

> They [prison officers] were just cold heartless people...their objective for the day was to upset you...be cruel to you.(Barry)

> A new staff member might come on...they might be in a bad mood and say...you can't go out and shut the door...really winds you up...many times I've felt like going mad.(Luke)

Participants described not getting what they needed from staff; this encompassed emotional support, a 'listening ear', and practical help and assistance.

> I was really upset...crying in front of him...he [high-security hospital staff member] said hang on a minute I'm watching this programme.(Geoff)

> They often say they've been let down...[staff] make them promises, say that...this is going to happen that's going to happen and it doesn't...sometimes they get the support...but it's not consistent.(Sarah)

Participants portrayed an unhelpful distance between staff and patients during the earlier stages of their journey; this was associated with mistrust and a non-believing stance from staff. One participant described a "them and us" style of relating to characterise patient-staff relations.

> You see the client's...in the social area...the [MSU] staff stay in the office...they're not out and about getting involved...it's that kind of them and us. (Sarah)

> I think they [prison staff] might have thought I was trying things on or something.(Geoff)

Being supported and encouraged.

Supportive dimensions of patient-staff relationships are encompassed within the focused codes 'being cared for' and 'being listened to'. Staff participants described feedback that being cared for and listened to left residents feeling understood and more willing to talk to staff about things on their mind.

> They said...our experience here [at the hostel] is different [from at the MSU] you actually sit down and talk with us...ask us questions about ourselves...we talk about anything and everything...that makes me feel good that you actually listen to what I've got to say.(Andy)

> If the staff are closer to me and are kinder to me...I find in myself that I am...stronger.(Aaron)

Participants' depicted how staff encouragement and empowerment had impacted some of the individual changes encompassed within this model: 'building self-esteem', 'having something to aim for', and 'taking on responsibilities'.

> They [MSU staff] sort of helped me...believe that I could do stuff.(Luke)

> Coming here [the hostel] they realise that things can change...we are always focusing on the positive, how well they've done...if you can just give them that lift. (Sarah)

> Not doing everything for them...giving them that bit of power...control over their own life.(Sarah)

At later points during their journey participants had felt certain of staff availability; this encouraged them to be open and to share with staff and for some it provided strength and confidence to try new tasks and challenges.

> Staff are there...if I start feeling unwell...or things are going wrong I can just talk to them...even though they're not always there in your face and being intense, they're there...that's helpful.(Tom)

> People don't think that they're being pushed away...we have time for them...there are times when it's very busy...but they'll know that you're always going to meet with them later.(Sarah)

Increasing equality.

Participants described that patient-staff relationships evolved in terms of equality during progress through FMHS; patients began to adopt an active (rather than passive) stance and for some, a mutual respect emerged. As patients began to take assertive action and exercise their power of choice in regard to their treatment for example, this appeared to influence the development of self-direction.

> The residents have a lot of respect for staff...we have a lot of respect for residents...we don't act as if we're above them.(Sarah)

> If you haven't got a good primary nurse ask for a change and it gets changed. (Geoff)

> I have more control over my life now...the two pints rule was agreed together rather than the team telling me what to do.(OUR STORIES)

Improving communication.

Participants described barriers to patient-staff communication (staff not sharing information, patients' reluctance to share with staff); these were experienced as unhelpful and exacerbated "them and us" patient-staff relations. Over time participants had experienced improved patient-staff communication and spoke about the benefits of this: knowing where you stand and increased trust.

> It was hard to tell some staff if you had problems...worried with how the team would react... I don't think there was enough information about what the team were thinking...why they were doing certain things.(OUR STORIES)

> One of the other things is to let you know what's going on...not to keep you in the dark, that helps a lot.(Luke)

Building trust.

Trust (or lack of trust) was a feature defining patient-staff relationships. Over time consistency and familiarity promoted trusting relationships; once trust was formed service-users felt more able to be open and to share with staff.

> If you've got the same person doing the group for so long...your confidence and your trust in those people is so big.(Geoff)

> You have to build strong trusting relationships with these guys for them to...succeed...to come to you and say actually I'm not feeling so great.(Louise)

Participants depicted how building trusting patient-staff relationships can be challenging, it takes time and effort. Comments suggested that feeling unable to trust staff can influence one's future outlook.

> It's hard...trusting someone you don't know...you just think well where's all this going to lead.(Tom)

> If they don't have any trust...it makes them feel like they're constantly being let down...instead of...looking ahead and planning for the future...it...makes them...not so positive about the future.(Sarah)

Category Three: Moving on from prison and early experiences of FMHS

Control over physical environment.

Participants described unpleasant, restrictive physical environments at earlier stages of their service contact. At these times, participants had limited autonomy over material possessions and daily routines/activities; this was challenging and experienced as infantilising.

> It's so stifling in that place [MSU]...I felt claustrophobic ...frustrated...haven't really got walking space...fed up of being in your room...keep pacing around...thoughts are just running around in your head.(OUR STORIES)

> You're constantly relying on people [in secure conditions]...you feel so powerless.(Barry)

> They [prison officers] did tell us we was going gym and then they cancelled it...sometimes we didn't get to go out on Fridays.(Luke)

As participants progressed through FMHS they experienced 'increasing freedom' and 'peaceful, relaxed environments'. Experiencing more control over day-to-day routines was described to increase patient autonomy and well-being and facilitated further progress forward.

> I think that it [environment change] aids their recovery...gives them more time to focus on what they want to do in the future...if there are lots of things going on its very hard to look at your needs and what you're going to do.(Sarah)

> The first thing I felt [upon moving to the rehabilitation unit] was the freedom**...**I could go and cook...I could cook before but only between certain times. (Geoff)

Establishing supportive relations with fellow FMHS-users.

Participants described relations with other service-users to be a barrier to progression and a facilitative influence. Descriptions depicted 'difficulties living amongst others in distress'; although these difficulties were more influential at early stages, they re-appeared throughout participants' journey through FMHS. Additional challenges were 'bullying' and 'norms and expectations' which patients felt compelled to comply but which prevented some from expressing themselves, making changes, and moving forward.

> Very difficult being around other patients when they're unwell...especially if you're well.(Barry)

> I'm a different person but when I was back in there [prison]...there's no way I would've let another prisoner see me cry...wouldn't want them to think I was weak...fear of being bullied.(Luke)

Participants described receiving support from peers: companionship, sharing experiences and learning from others. Hearing others' experiences reduced participants' feelings of isolation and learning through others assisted progress through FMHS.

> There's a lot more...patient interaction [at the MSU than in prison] which is helpful...you can talk...you hear that they're getting through the situation...they say to ya oh come on sort yourself out...we're all going through the same thing.(Luke)

> I had a couple of friends in there [MSU]...other patients who had the same ideals...helped to have people around you who had the same motivations.(OUR STORIES)

Adapting to environmental changes.

Whilst progressing through services patients had adapted to changing environmental restrictions and degrees of freedom; for some participants, uncertainties and anxieties surrounded these changes. Adapting to environmental changes was a continual process occurring over time; at points it encompassed unmet expectations and/or a continuing need for staff support.

> No matter what people say...you're still going to be nervous...all those things around moving from one place to another...meeting people...seeing your old friends you don't know what's going to happen.(Tom)

> Their expectations are wide...[residents] don't understand what it means to come here [hostel] under restriction.(Louise)

> He does want his freeness in the total capacity...but then I don't think he could live independently...without some kind of support somewhere along the line.(Andy)

Category Four: Developing self-direction

Developing self-understanding.

Over time patients developed their understanding of past behaviours/offences and of emotions and management strategies. This understanding was facilitated by having time to think and reflect, formal therapeutic input, and being symptom-free. Participants' increasing self-understanding appeared to encourage greater self-direction.

> [Therapy] helped me identify patterns in my behaviour...what triggers things...I understood...things I'd thought why did I ever do this why did I ever do that.(Luke)

> I used to take it out on like maybe start punching things...getting violent...going to the gym, working out really hard...that was a coping strategy. (Tom)

Becoming aware of the impact of past offences/behaviours.

Over time patients' awareness of how their offence/previous behaviours impacted upon others and themselves increased. The associated guilt and remorse appeared to contribute to patients reaching a place where they 'wanted things to be different' and to progress further.

> Sometimes you do think...the reality of the whole picture, it's not just I've done this to so and so it's the whole thing...people you've affected for the rest of their lives.(Luke)

> I really should've just had patience [pre-admission]...I wouldn't have even been in this position...I would've moved into a nicer flat...I would've just lived there quietly.(Harvey)

Wanting things to be different.

Participants' descriptions of reaching a place where they 'wanted things to be different' suggested various contributory factors: being symptom free, staff and peer encouragement, understanding past behaviours, recognising the impact of previous behaviours/lifestyle, and having something to aim for. For some, 'building self-esteem' and 'managing friendships' differently than in the past helped to facilitate shifts in their identity.

> I don't think now about getting out and doing crimes...I think about getting out and settling down...I'm not like that no more.(Tony)

> There's a lot of changes**...**the way I think about my life and the way I behave. (Tom)

> I knew that I couldn't carry on like that...took a long hard look at the situation I was in...decided to take responsibility for myself.(OUR STORIES)

Building self-esteem.

Although some participants anticipated stigma and rejection, over time participants developed a confidence that resulted from achieving qualifications or engaging in new activities; participants indicated they were proud of their progress and achievements whilst in FMHS. Heightened confidence and receiving positive regard from staff within the context of

supportive, caring relationships are two factors that seemed to increase participants' self-worth.

> Some people think if you're in a mental health hostel...you're dangerous...not easy to...have that in the back of my mind.(Tom)

> When I passed my GCSE...only a C grade but it was...really significant...I never got nothing at school...I thought hold on a minute I can actually do things...up until that point I was like no can't do learning.(Luke)

> I hated myself...that's one huge shift that you recognise...now you actually like the person that you are.(Barry)

Something to aim for.

As patients progressed there was a transition from 'feeling hopeless' towards 'looking forward' and 'developing a focus'. Various elements contributed to this altered outlook: overcoming the shock of being in forensic services and accepting the situation, staff and peer encouragement, experiencing increased freedom and responsibilities, and working towards/focusing upon something.

> When I first went in, I felt hopeless...lost...wasn't much hope to start off with at all...thought it was the end of my world.(OUR STORIES)

> They've got that light at the end of the tunnel...if they stay well...they can have the opportunity to...integrate back into the community.(Louise)

> I found that [training course] really helpful...given me something to aim for something to achieve.(Tom)

> I tried lots of different things...pottery, woodwork...it was helpful, gives you an incentive...try and find a focus.(OUR STORIES)

Taking on responsibilities.

Whilst adopting increasing responsibilities was described as a necessary component of progress, participants described some difficulties during this process. It was acknowledged that increased responsibilities can function as a risk factor for backward steps.

> They're used to everything being done for them...Here [hostel] they have to take on more responsibility...there may be little hiccups when they first leave...it could be very easy for them to abuse that money [benefits].(Sarah)

Category Five: Doing work in therapy

All participants described that therapeutic work impacted their progress; this was generally viewed as a valuable part of the journey.

Deciding to commit to therapy.

Prior to engaging fully with therapeutic work some participants worked through attitudinal barriers, for example some participants viewed psychology as a 'box to tick' at earlier stages of their service contact. Others spoke of 'bottling up their emotions' and this was associated with the perceived 'norms and expectations' existent in forensic services.

To be honest...I really used to look at it...psychology is just one of the boxes that you have to tick.(Luke)

I was a bit reluctant to sort of open up.(Tom)

Over time participants became motivated to receive help and consequently were prepared to commit to therapy.

I made the decision to be honest**...**to tell everything...thought it's going to be my only opportunity to get well....made the decision I wasn't going to leave...until I felt safe, not just safe to myself but safe to others...seeing Becky [psychologist] gave me the opportunity to be really honest...was the start of my release.(Geoff)

Working through previous experiences and offending behaviour.

Participants described the process of expressing within therapy; whilst most participants spoke about the benefits of talking therapies some described benefits of art and dramatherapy. Descriptions explicated how 'going over' past experiences was cathartic. Despite the benefits of sharing within therapy, participants also recognised that reliving particular memories was painful and effortful.

The biggest help to me has just been talking about it, going over and over it.(Barry)

[Therapy] was hard...brings back a lot of memories...have to live through past experiences which you'd rather not do.(Tom)

Descriptions of the therapeutic process highlighted factors that facilitated participants' 'working through' of past experiences: being permitted time to reach a place where they were able to 'use' therapy, having consistent contact with the same professional, and being afforded autonomy to come to one's own conclusions within therapy.

> She [psychologist] said well I thought you'd bring it out when you're ready to tell us.(Geoff)

> They would never tell you why you had done these things...they would sort of suggest...do you think it could have been this, do you think it could have been that...my opinion meant something.(Geoff)

Category Six: Managing wider support networks

Managing friendships.

Participants spoke about 'building new friendships' during their journey through FMHS; they garnered support from others who had been in situations similar to themselves. Some participants had established friendships outside of forensic services; this helped them experience others' acceptance. Some participants had found it important to 'deliberately change their friendship networks'; this was explained by patients' increased self-understanding, their awareness of the impact of their old behaviours/lifestyle, and a motivation for 'things to be different' and for further offending to be avoided.

> They care for me [new friends]...they know where I come from...know my mental illness...know I'm a murderer...none of them hold it against me.(Geoff)

I don't bother with them [old friends] anymore...it'd just end up with me back in there [prison] again.(Luke)

Family relationships.

Family relationships influenced patients' progress in different ways. Some participants had been rejected by their family; this was associated with guilt, remorse and lowered self-esteem. Participants whose family had remained supportive described how their family's emotional and practical support had assisted their progress. Progression required constant adaptation on the part of the patient and their families; negotiating changing circumstances could be difficult and family relationships could destabilise patients.

I still think what my family must think of me...my family have disowned me. (Geoff)

They're there for me in times of need. If I need help they're there...showed me a lot of love...in meetings...my family will tell them about the medication from what I've told them.(Harvey)

Sometimes family dynamics...can rock the stability.(Louise)

I'm luckier than others...have my family who come to visit me and love me. That's where my hope comes from.(OUR STORIES)

Drawing strength from faith/spirituality.

Although not relevant to all participants, religion had shaped some participants' outlook on life and helped them focus on following a 'straight path'. Some participants had received acceptance and love from their religious communities; one participant likened this to gaining a new family.

> I'm just not interested in that now...my desire to live for God is much stronger than to go and do that stupid stuff.(Luke)

> I've got a new family with my church...they're more of a family than my family will ever be.(Geoff)

Respondent validation

Feedback from one staff member and one service-user participant confirmed that the model accurately summarised their experiences and did not omit any significant factors (Appendix 17).

Discussion

Results from this study offer preliminary indications of influential factors at the individual, service, and wider support network levels for the progress of offenders with SMI toward reintegration with the community. GT analysis generated six main influences on progress; results will now be considered in relation to relevant literature.

Consistent with existing conceptualisations of MH-recovery that are based upon patient and staff perspectives (Noiseux et al.,2010), results imply that progress towards reintegration with the community follows a non-linear trajectory and can take many years. Intra-individual, inter-individual and contextual dynamics in combination influence this journey which

includes obstacles and advances. Supporting assertions that recovery is "influenced by person-disorder-environment interactions" (Davidson et al., 2010, p.213), findings contradict stage models which depict linear processes and neglect the complex, dynamic interactions influencing offenders recovering from SMI.

Consistent with Laithwaite and Gumley (2007) results highlight the importance of patients' environmental context, relationships with staff and peers, and efforts towards valued goals. By considering the experiences of participants closer to reintegration with the community and by incorporating staff perspectives, results extend the findings of Laithwaite and Gumley (2007). Current findings incorporate additional facets including: progress toward medication self-management; adapting to environmental changes and increasing freedom; increased self-esteem; and adopting greater responsibilities.

Findings encompass four documented component processes of recovery; hope, self-identity, life meaning, and responsibility (Andresen et al., 2003). In line with claims that "hope is the catalyst" of recovery processes (Andresen et al., 2003, p.589), results depict patients' transition from feeling hopeless towards feeling hopeful. Having 'something to aim for' appeared central to this transition; this is consistent with suggestions that hope comprises three elements: a goal, envisaging pathways to the goal and belief in one's ability to pursue the goal (Snyder, Michael, & Cheavens, 1999). In terms of self-identity, participants described wanting to move on from 'old me' and for some, coming to understand current/previous experiences as part of their MI influenced their identity. Andresen et al. (2003) propose that various sources evident in the current results can facilitate finding meaning in life: employment, family, creative pursuits, and spirituality. In Andresen's account 'responsibility' refers to taking responsibility for one's own recovery including medication self-management and autonomous life choices; empowerment and self-direction are important contributors encompassed within the emergent model. Results additionally

suggest that adopting increasing practical responsibilities (e.g.finances) contributed to participants' progress through FMHS. Despite the current focus upon offenders, documented recovery processes were highly relevant to participants' experiences.

This appears to contrast with suggestions that "hope, self-acceptance, and management...may be particularly problematic" for offenders with SMI (Mezey et al., 2010, p.692). Despite facing considerable challenges during the process of integrating back into the community, participants appeared to feel largely hopeful about the future and to manage large levels of responsibility for their own MI. Whilst it is important not to minimise the difficulties and barriers overcome during the (at times very lengthy) journey through FMHS, the current findings gauged from patients and staff at a later stage in service delivery provide an optimistic account of the experiences and potential of offenders with SMI.

In relation to extant offender rehabilitation literature, current findings support the underlying ethos of enhancement-based approaches: human well-being should drive rehabilitation efforts which aim to enable offenders to meet needs via pro-social methods, and account for individuals' skills, temperament, social supports, and goals (Ward & Stewart, 2003). Results emphasise the individuality of patients' journeys and particular sub-categories emphasise the relevance of enhancement-based approaches: 'something to aim for', 'taking on responsibilities', 'self-esteem', and 'support and encouragement'. Whilst some facets relevant to the RNR-model emerged (e.g. emotion management skills), these represented one small factor amongst complex pathways towards reintegration with the community. As suggested by Ward et al. (2007) both approaches to offender rehabilitation can contribute to different facets of the rehabilitation process; combining aspects of each may prove fruitful.

Serin and Lloyd (2009) suggest that external contingencies and internal motivations in combination trigger offenders' transition to desistance. The emergent model depicts that participants wanting to change (internal motivation) continued to be supported by

professionals whilst aware of the potential for return to secure services (external contingencies). Offenders' personal identity and how they visualise themselves in the future impacts their cognitions and behaviours (Serin & Lloyd, 2009). Indeed participants described a shift in their future-outlook whilst progressing toward reintegration with the community; for some, understanding their experiences in the context of MI and increased self-esteem altered their self-concept.

Whilst the extant recovery and offender rehabilitation literature can assist interpretation of current findings, the current study builds upon previous accounts by simultaneously considering the multiple facets relevant to offenders with SMI reintegration into the community. Findings support the recent proposal of Roberts (2011): when viewed as "'values in action' that need reinterpretation in context", recovery approaches have utility within FMHS (p.188).

Limitations

Noiseux et al.(2010) discuss tensions between theoretical models "general enough to orient the practitioners' gaze, and specific enough to take into account the singularity of the persons and their condition of health" (p.162). The broad focus upon diverse elements of the journey towards reintegration is a major strength of the current GT which is more suited to orienting the practitioners gaze and illuminating the array of influential factors. Findings are less able to draw in-depth conclusions about each of the facets identified as they operated for each individual participant. However a general strength of qualitative methods over quantitative is that they can enable much more detail about individuals to be explored and hypotheses to be made about interactions between the complex array of factors influencing them. These can then lead to suggestions for quantitative hypothesis-testing studies.

Given the importance of qualitative research avoiding "overgeneralisations that spill out from the conclusions" (Thorne & Darbyshire, 2005, p.1107), the concept of 'analytic generalisability' (sometimes referred to as transferability) is a useful consideration. In 'analytic generalisation' (Firestone, 1993) researchers generalise from particulars to broader constructs or theories. Whilst the current findings are not generalisable in the statistical sense of population representativeness, the rich, in-depth analysis informed by constant comparisons does enable theoretical and analytical generalisations about the processes illuminated within the emergent model. The incorporation of triangulation and negative-case analysis further increases the trustworthiness of findings. The sample and service settings described within this paper enable judgements about other individuals and services to which the current findings can be transferred more or less easily in relation to the degree to which those individuals or services share characteristics of the current sample and setting. The findings, in the current context, provide the facility to derive hypotheses about processes operating in other contexts on the basis of their similarities or differences along specific dimensions explicated here, for example offender characteristics.

Empirical studies commonly neglect factors that hinder recovery (Noiseux et al., 2010). Although this study has identified some factors that impede the progress of offenders with SMI, the focus was upon individuals who have successfully progressed toward reintegration. Therefore the experiences of patients who are 'stuck' at earlier points in FMHS require further exploration.

Interviews are unavoidably hampered by social-desirability bias; it is possible that staff participants were keen to convey positive accounts to a trainee professional, and service-user participants were reluctant to share some difficult experiences and risk-related information due to fears of repercussions. However the extent of social-desirability bias was perhaps reduced by the researcher's independence and by clear explication of the boundaries of

confidentiality. In addition data was collected retrospectively for the purposes of this study. It is recognised that this could bias the amount, types and accuracy of experiences recalled by participants. The limitations of retrospective data collection have been debated in the literature (Berney & Blane, 1997); in the current instance it is possible that retrospective data collection contributed to participants omitting important experiences and processes in ways that reduces the scope of the emergent model.

Whilst it is considered a strength of the current study that independent accounts of FMHS-users experiences were used for the purposes of triangulation, this data also comprised of unstructured accounts which were gathered retrospectively by professionals working within one FMHS. Given that the triangulation data presents the same limitations as the primary data within this study, the incorporation of triangulation data collected prospectively from a variety of different FMHS could have further enhanced confidence in the emergent theory.

Finally, the sample was necessarily small and came from one FMHS. Although participants did draw on experiences prior to entering that service, it remains possible that some categories might have been extended or further tested had there been participants from other services. However, as discussed already, the findings have a fair degree of coherence with existing recovery and forensic models and empirical work, which lends them credence.

Clinical implications

Each of the barriers and facilitative factors elucidated within the current findings has potential clinical implications for offenders with SMI. For example the importance of family relationships indicates that family-inclusive service-delivery might be fruitful at all stages of FMHS-delivery. Participants described the value of increasingly equal patient-staff relationships and adopting autonomy and responsibilities; these elements provide support for applying positive risk management principles within FMHS (DH, 2007).

Participants who had experienced prison described more positive experiences subsequent to their transfer to FMHS. In general relationships with staff were more trusting and compassionate, peer interactions were more supportive, and patients' understanding and management of MH difficulties increased. Supporting recommendations that "no-one with acute SMI should be in prison" (DH, 2005, p.2), current findings indicate specific ways in which the needs of offenders with SMI can be better met within FMHS than within the CJS.

Gudjonsson and Young (2007) suggest "as patients progress through rehabilitation and recovery, they have to go through a number of layers as they move towards a community discharge" (p.548): mental illness/compliance, pro-social competencies, direct offending focus, environment focus, and community focus. Current findings provide empirical support for Gudjonsson and Young's (2007) service-delivery model. By elucidating the multiple domains of relevance to the recovery of offenders with SMI, results indicate that broad-based service-delivery approaches that move beyond specific treatment interventions (e.g. cognitive-behavioural therapy) are required to meet this population's needs.

Future research

Future research could usefully replicate this study with diverse participants in other FMHS, and could also further explore each category within the emergent theory. In particular the individual psychological changes experienced by offenders with SMI during their journey toward reintegration are of central importance to our understanding of forensic rehabilitation; these warrant further exploration. Additionally, further studies could valuably investigate the experiences of sub-groups of offenders with SMI, for example those who are 'stuck', female offenders, and those who have committed particular offence types (e.g. more versus less stigmatised offences).

Given the relevance of recovery principles to the current findings, future research could investigate whether recovery-based interventions from the wider MH field (e.g. the Wellness Recovery Action Plan, Cook et al., 2010) have clinical utility within FMHS, perhaps at later stages in particular. MH services increasingly incorporate peer support networks and input from ex-patients within service-delivery; research could explore whether such elements have applicability within FMHS.

Conclusion

This study provides a preliminary model of the factors that impede and facilitate the progress of offenders with SMI towards reintegration with the community at the individual, service and wider support network level. Given that this study has encompassed factors at these three levels, findings extend the extant literature. Whilst there remain several ways in which research in this area can usefully progress, current results appear to have clinical utility in terms of contributing to the education/training of staff in FMHS and service-delivery for offenders with SMI.

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CANDIDATE: Clare Holt

PART C

Critical Appraisal

WORD COUNT (excluding references): 1994

1. *What research skills have you learned and what research abilities have you developed from undertaking this project, and what do you think you need to learn further?*

During this project I have developed skills in qualitative data collection and analysis. Whilst collecting data via the ten semi-structured interviews, I feel I refined and developed my interviewing technique. During the first interviews my anxieties about collecting the 'right' information in ways interfered with the grounded theory (GT) approach of using interviews as directed conversations; I feel I adhered to the schedule somewhat rigidly. As the project progressed and my confidence within the interview scenario increased, I relaxed and my generic clinical skills of active listening, reflection, empathy, and warmth became more apparent. I infer that this more informal interviewing style encouraged participants to feel comfortable and therefore to share more of their relevant experiences. I feel I have also become more skilful in directing participants between different topics of enquiry; although the first interview lasted longer than anticipated, subsequent interviews did not. Whilst conducting this project I have also experienced the distinction between clinical interviews (seek therapeutic benefit) and research interviews (seek information gathering while keeping in mind participant safety) first-hand.

Whilst analysing data I have become familiar with the various techniques comprising the GT method. Specifically, by applying open coding, focused coding and axial coding I have been able to synthesise large amounts of data in a systematic and I hope transparent way. I have experienced the ways theoretical sampling and constant comparisons during data analysis help to ensure a comprehensive account that appropriately reflects the data (Strauss & Corbin, 1998). As an additional facet relatively unique to GT I have experienced the benefits of conducting data collection and analysis iteratively and allowing one to inform the

other in a fluid, dynamic process. Despite the development of various skills this is my sole experience of applying GT; I recognise my skill-set could further benefit from conducting subsequent research of this kind. In addition this project has not provided the opportunity to further develop my quantitative research skills. Although I achieved a respectable level of quantitative research skill whilst completing my MSc (Hons), continuous application and expansion of my qualitative and quantitative research skills will be important in enabling me to tailor future research endeavours to individual research questions arising.

Whilst designing and conducting this research I have become more educated about different epistemological approaches to GT, for example realist (Strauss & Corbin, 1998) and constructivist approaches (Charmaz, 1995), and to research in general. Moving away from qualitative approaches specifically, I feel my awareness of the inextricable links between epistemology and methodology has increased. By considering the epistemological spectrum of realist to constructionist and the methodological spectrum of quantitative to qualitative, I feel my understanding has moved beyond these dichotomous distinctions towards more sophisticated considerations of which approaches may be most suited to answering specific research questions.

2. If you were able to do this project again, what would you do differently and why?

GT endeavours to "extract an innovative, integrated, realistic scheme from masses of unorganised raw data" (Strauss & Corbin, 1998, p.13); I certainly found this process to be challenging at times. At different points I felt overwhelmed by the number and diversity of themes emerging from the data. Patton (1990) states the importance of "not taking shortcuts but rather putting energy and effort into the work" (p.435); it was necessary to avoid the imposition of structure on the data before it was indicated by the data itself. Maintaining an unknowing stance was difficult at times; supervision and keeping memos were valuable in this process. My experiences suggest that conducting a GT project within the Major Research Project (MRP) time constraints is taxing. Whilst I analysed data within short but regular time slots (e.g. two hours one evening, and one hour the next) *some* of the analysis demands may have been lessened if I had dedicated concentrated blocks of time (e.g. two weeks solid) to analysis. This feels more consistent with the GT approach of immersing oneself in the data and is something I would ensure if repeating this project.

Whilst the current findings are greatly strengthened by the incorporation of staff *and* service-user perspectives, given that the results indicate the importance of family relationships in the journey through forensic services, if I were to repeat this study I would aim to include family-member experiences.

With the benefit of hindsight, if repeating this project I would utilise an approved company to transcribe all interviews. Whilst interview transcription increased my familiarity with the data being gathered, I had not anticipated how time consuming this would be. Given the time pressures surrounding the MRP and other demands presented by clinical training I feel this could have proved worthwhile.

3. Clinically, as a consequence of doing this study, would you do anything differently and why?

My pre-clinical training experience of working in HM Prison Service suggested a heavy focus upon offending behaviour in prison settings can leave issues relating to offenders' mental health (MH) somewhat neglected. Therefore the implications of the confluence of offending and severe mental illness (SMI) were of great interest to me; findings will influence my clinical practice in different ways.

Extending my previous appreciation of the importance of patient-staff relations, findings elucidate the specific elements of these relationships that are helpful, and should be strived for, when working in forensic mental health services (FMHS): empowerment, equality, transparency, and trust. Findings also highlight the importance of clinicians being responsive to particular individual factors; in my future clinical practice a client's current understanding about their MH and degree of self-direction will usefully guide my judgements about which clinical approaches may be of benefit to them at that time.

Findings highlight the process of "Learning about and managing mental health"; for some, understanding their MH and applying this understanding to previous and current experiences facilitates progress and represents an important adjunct to offence-focused work. The bulk of my clinical experience within forensic settings to date has focused upon ameliorating specific cognitions and behaviour; such approaches are distinct from recovery approaches which aim to facilitate service-users in defining their own MH-recovery pathways and accept the possibility of living fulfilling, satisfying lives despite ongoing MH-difficulties. Whilst conducting this research I have become increasingly familiar with recovery approaches and appreciate their clinical utility within FMHS.

Whilst findings illustrate the individuality of FMHS-users' recovery experiences, the emergent model provides an all-encompassing framework of factors that warrant consideration within any psychological formulation. The model emphasises how multiple systems might simultaneously influence FMHS-users; therefore it seems important that clinicians hold in mind a multi-layered conceptualisation. Whilst the current findings highlight the dangers of reverting to individualistic formulations, my clinical experience has demonstrated how easily this can happen. To enable a more thorough understanding of clients' presenting difficulties, in future I intend to consider a broader range of factors within multiple domains throughout assessment and intervention.

Current findings indicate ways that family relationships can facilitate and impede FMHS-users' progress. Extensive literature from mainstream MH-services explores the consequences of 'carer-burden' for carers and service-users themselves (Askey, Holmshaw, Gamble, & Gray, 2009). Whilst best practice guidance for FMHS-professionals and information for carers emphasises the importance of family-inclusive practice (Royal College of Psychiatrists, 2010) the extent to which UK FMHS currently provide family-inclusive services is unclear. Canning et al. (2009) report difficulties incorporating carer support within FMHS-delivery however literature searches did not further elucidate this element of FMHS-provision. Warranting attention during my own clinical practice, current findings suggest that incorporating family members at different stages of FMHS-provision may assist favourable service-user and carer-outcomes.

4. If you were to undertake further research in this area what would that research project seek to answer and how would you go about doing it?

Research in this area could usefully proceed in multiple ways. The current findings provide a substantive theory based upon the experiences of service-users and staff recruited from one FMHS in England. Before findings can be reliably applied to offenders with SMI in general, it will be important for future studies posing the same research questions to be conducted in different service settings and with diverse samples. Given the heterogeneity of offenders with SMI, investigations focusing on sub-groups within this population also seem warranted. Qualitative investigations aiming to explicate the similarities and divergences amongst different sub-groups' journeys through FMHS toward reintegration with the community could focus upon female offenders, offenders with co-occurring 'mental disorders', and offenders suffering from post-traumatic stress. As a starting point, GT methodology could build a substantive theoretical account relevant to such sub-groups. Perpetrators of particular offence types (e.g. sexual offences) may be subject to increased stigma and exclusion in ways that influences their experiences of FMHS and their journey towards reintegration; this requires further exploration.

To extend the current findings future research could explore the longitudinal progress of offenders with SMI living in the community; relevant qualitative and quantitative investigations exploring MH, offence-related and quality of life outcomes over extended time periods can be envisaged depending on the research question being posed. To assess this population's long-term clinical needs, research could investigate the quantity and nature of service contact via longitudinal, large-scale clinical surveys. The occupational/employment experiences of offenders with SMI could be monitored to offer insights into this population's

future prospects in these domains. In order to examine the long-term influence of discrimination/stigma upon offenders with SMI living in the community, qualitative research could provide in-depth, longitudinal explorations of perceived stigma, exclusion and rejection, perhaps in a study similar to that of Wright, Gronfein and Owens (2000) who focused on a non-offending sample.

Interpretative Phenomenological Analysis (IPA; Smith, Flowers, & Larkin, 2009) explores participants' experiences of the subject of interest and could be utilised in research with offenders with SMI. For example IPA could investigate how offenders with SMI experience familial relationships, environmental factors, symptoms, and 'being well' (a) at different stages of their journey through FMHS and (b) once living in the community. IPA can examine single cases (Smith et al., 2009) and in this way could build upon the current findings which posit hypotheses, but do not enable precise conclusions about the ways influential factors operate for specific individuals.

Existing quantitative research in this field is generally limited and of low quality. To extend the extant therapeutic outcome literature, future controlled studies incorporating large, randomised samples, and valid, reliable outcome measures could further elucidate how different therapeutic interventions impact on offenders with SMI. Measures could usefully attempt to capture self-management capabilities, self-esteem and self-concept, and social networks and inclusion as well as more conventional MH and offence-related outcomes. In addition to exploring therapeutic modalities, future research could ask how and why interventions are associated with particular outcomes and thereby explore the mechanisms of change.

Given the current study highlights influences in multiple domains, it appears important that future quantitative studies broaden their focus beyond therapeutic endeavours. Recent

quantitative investigations have confirmed the needs of FMHS-users' family members (Absalom-Hornby, Gooding, & Tarrier, 2011). Empirical evaluation of family-inclusive interventions or service-delivery models for FMHS-users is one avenue for future research which could incorporate family-member perspectives and experiences.

The process of 'Developing self-direction' appears to warrant further empirical attention. Results indicate that recovery approaches have potential to bolster the individual changes experienced by offenders with SMI as they progress toward reintegration with the community: hope, control and increasing responsibilities, and self-esteem. Quantitative studies could focus on developing valid, reliable measures of recovery-based indicators of progress. Green, Batson and Gudjonsson (2011) report preliminary attempts to develop such a measure within FMHS although concede that further validation of the measure is required in relation to quality of life, clinically relevant factors including treatment engagement, and forensically relevant factors including violence and recidivism. This may be an area to which some patients at an advanced stage in their progress could make a valuable contribution in a consultancy or research partnership role, given their direct experience of this journey.

Research relevant to offenders with SMI has three levels: epidemiology/prevalence, therapeutic intervention and service delivery/organisation (Brooker, Repper, Sirdifield, & Gojkovic, 2009). Brooker et al. (2009) emphasise the 'parallel universes' of MH and criminal justice services and claim that extant service delivery and organisational research is limited. Future research measuring the outcomes of different service-delivery models currently employed within FMHS could elucidate which are associated with favourable subjective outcomes (service-user experience and quality of life) and objective measures of MH, social inclusion and offending behaviour.

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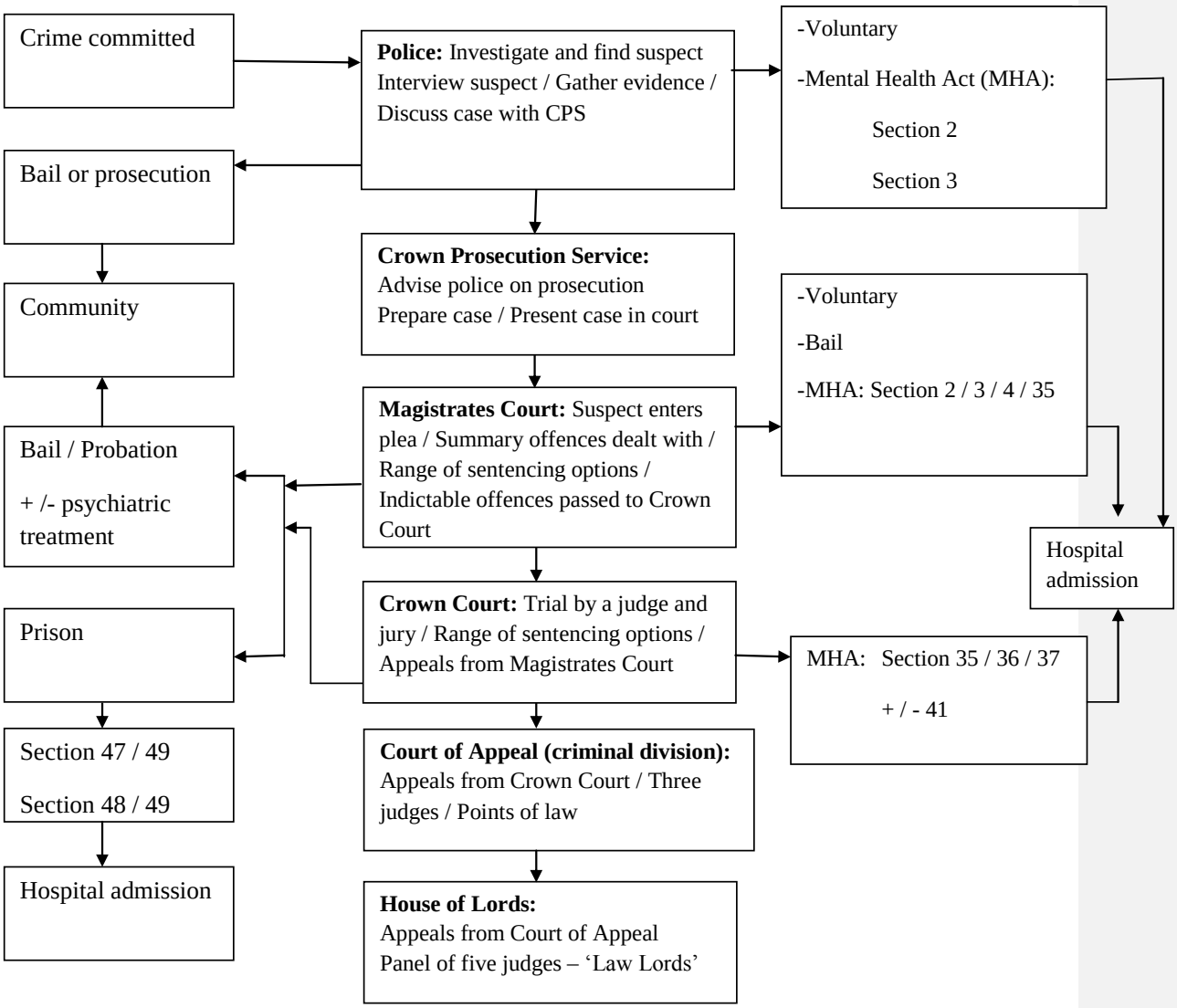
CANDIDATE: Clare Holt

SECTION D

Appendices

Appendix 1: The criminal justice process and diversion mechanisms (McMurran et al., 2009)



Appendix 2: Literature search strategy and results

During March 2011 the following search terms were used to search the PsychINFO, MEDLINE, ISI Web of Science, Science Direct, and Cochrane Library electronic databases: (mentally disordered offender$ OR offender$) and (treatment OR therapy OR intervention) and (forensic OR forensic mental health). Where possible, searches were limited to articles published in peer reviewed journals and written in the English language. Earlier reviews allude to a paucity of relevant literature (Blackburn, 2004) and therefore in order to be inclusive searches were not restricted by year of publication. PsychINFO returned 413 articles, Ovid MEDLINE returned 342 articles, Web of Science returned 300 articles, Science Direct returned 5 articles, and the Cochrane Library electronic database returned zero articles.

Abstracts were hand-searched. To ensure inclusivity relevant articles were placed in the Web of Science cited search tool and references of relevant articles were hand searched for appropriate articles. References cited in a systematic review of structured group interventions (Duncan, Nicol, Ager, & Dalgleish, 2006) were also searched for relevant studies.

Outcome evaluation studies of any non-pharmacological intervention with offenders diagnosed with a SMI were reviewed. Literature reviews, articles describing interventions, studies conducted outside of the UK, and studies incorporating offenders without a diagnosis of SMI were excluded. A total of 16 relevant articles were identified and are reviewed.

Appendix 3: First-stage interview schedule

SERVICE-USER PARTICIPANTS

Can you tell me about how you came to be here in the forensic hostel?

What have been your experiences of forensic rehabilitation?

How would you describe the role your mental health difficulties have played in your rehabilitation?

What difficulties have you had to overcome in getting to this point?

What role have any individual changes that you have made, played in your rehabilitation?

How would you describe the role that different interventions have had during your forensic rehabilitation?

PROMPT for medication, group therapy, individual therapy

Is there anything else that has happened in your life that has played a part in your forensic rehabilitation?

STAFF MEMBER PARTICIPANTS

What have been your experiences of working with patients that have progressed from the acute ward to forensic hostel?

Can you describe some of the changes you have noticed in patients who are at different stages of their service contact (i.e. acute ward, rehabilitation ward, forensic hostel)

From your experience, what things can help patients progress through forensic services?

From your experience, what things can hinder patients' progress through forensic services?

What factors stand out for you as being particularly important during a patients' rehabilitation?

Appendix 4: Participant information sheets

Salomons Campus at Tunbridge Wells

Participant Information Sheet (for service-user participants)

Study Title: Rehabilitation in forensic services

Hello, my name is Clare Holt and I am a trainee clinical psychologist.

I would like to invite you to take part in a research study that I am doing as part of my training. Brian McKenzie and Sue Holttum are advising me with my research. Before you decide whether to take part, I would like you to understand why the research is being done and what it would involve for you. I will attend your next resident meeting to talk about the research study and to answer any questions you may have. After this meeting, myself or Brian will go through this information sheet with you and answer any questions you may have. We suggest this will take about 10 minutes. Ask us if there is anything that is not clear. You may also find it helpful to talk to others about the study.

What is the purpose of the study?

The research study will look at people's experiences of forensic services. We are interested in how people progress from the acute ward to the forensic hostel. Our findings will show what patients find helpful and unhelpful about forensic services.

Please note this study is focused on non-drug users. Therefore, people currently taking illegal substances are not able to participate in this study.

Do I have to take part?

No, it is up to you to decide to join the study. Brian and I will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form to say you have had your questions answered and agree to take part. But you will be free to withdraw at any time, without giving a reason. This would not affect the care you receive.

Canterbury Christ Church University

Salomons Campus at Tunbridge Wells

What will happen to me if I take part?

If you decide to take part you will be invited to a 60 minute interview with me. The interview would take place at the hostel. In the interview I will ask you to talk about your experiences of forensic services.

Before the interview, you will be asked if there are any areas you don't want to discuss. You will only be asked to talk about the areas you feel comfortable to.

Will my taking part in the study remain confidential?

It is likely that others at the [hostel name] / [clinic name] will be aware that you are taking part in the study. But I will store all information securely. I will type up the interview without including your name or any personal information. Only I and my two research supervisors will have access to the original recordings. Personal information will be kept out of reports of study findings. Direct quotations from your interview may be written anonymously in some articles written about the study.

There are a few circumstances in which confidentiality would have to be broken. If the researchers were worried about your safety or the safety of someone else, information would be passed to professionals outside of the research team. If you disclosed specific information about criminal activity for which you have not been convicted, this would be passed to professionals outside of the research team. If a serious reportable issue is disclosed during an interview, e.g. malpractice, information would be passed to professionals outside of the research team. As I am only interviewing 10 to 15 people, this makes it possible that individuals would be identifiable if information had to be passed outside of the research team of myself and my two supervisors (e.g. to hostel managers).

What will happen to the study results?

At a later date you will be invited to attend a session at which I will give a brief summary of the main findings. I will be interested to hear people's views on whether the results seem accurate. But you will not have to come to this session if you do not want to.

Salomons Campus at Tunbridge Wells

I will write up results for my research at Canterbury Christ Church University. The research team shall also write-up and submit the study findings to a national psychology journal. No participant will be identified in any part of the write-up or article. I hope that the research findings might help bring about improvements in forensic rehabilitation services in the future.

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

You can leave the study at any time you want to. If you leave the study, any information you have provided will be destroyed.

Who has reviewed the study?

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

What if there is a problem?

Some of the issues you will be asked to talk about may be upsetting or sensitive. Within one month of taking part in the study, you will be able to contact the psychology team at the [clinic name] in order to gain support if you wish. Dr Brian McKenzie, Consultant Clinical Psychologist, works at the hostel. You will be able to tell Brian if you would like to see a psychologist.

If you have a concern about any part of the study, you can speak to me by leaving a message on the answer phone number 01892 507673, stating that your message is for Clare Holt. If you are not satisfied you may take your complaint to Dr Sue Holttum (leave message for her on the same number) or Dr Brian McKenzie.

If you remain unhappy and wish to complain formally, the National Health Service complaints mechanisms are available to you. The Independent Complaints Advocacy Service can give advice about using the NHS complaints system (0845 337 3061). You may also wish to seek advice from the Patient Advice and Liaison Service (0800 917 7159).

Further information:

If you would like further information about this study, you can contact me by leaving a message on the 24-hour answer phone number, (01892 507 673) and stating that your question is for Clare Holt. I will get back to you as soon as possible. Alternatively you can speak to Dr Brian McKenzie, Consultant Clinical Psychologist, who works at the hostel.

If you decide to take part in the research study, you shall be given a copy of this information and a signed consent form to keep.

Salomons Campus at Tunbridge Wells

Participant Information Sheet (for staff member participants)

Study Title: Rehabilitation in forensic services

Hello, my name is Clare Holt and I am a trainee clinical psychologist.

I would like to invite you to take part in a research study that I am doing as part of my training. Brian McKenzie and Sue Holttum are advising me with my research. Before you decide whether to take part, I would like you to understand why the research is being done and what it would involve for you. I will attend your next staff meeting to talk about the research study and to answer any questions you may have. After this meeting, myself or Brian will go through this information sheet with you and answer any questions you may have. We suggest this will take about 10 minutes. Ask us if there is anything that is not clear. You may also find it helpful to talk to others about the study.

What is the purpose of the study?

The research study will look at patient and staff experiences of forensic services. We are interested in how people progress from the acute ward to the forensic hostel. Our findings will show what patients find helpful and unhelpful about forensic services.

Do I have to take part?

No, it is up to you to decide to join the study. Brian and I will describe the study and go through this information sheet. If you agree to take part, we will then ask you to sign a consent form to say you have had your questions answered and agree to take part. But you will be free to withdraw at any time, without giving a reason.

Canterbury Christ Church University

Salomons Campus at Tunbridge Wells

What will happen to me if I take part?

If you decide to take part you will be asked to take part in a 45 minute interview with me. The interview would take place at the hostel. In the interview you will be asked to talk about your experiences of working in forensic services. Before the interview, you will be asked if there are any areas you don't want to discuss with the researcher. You will only be asked to talk about the areas you feel comfortable to.

Will my taking part in the study remain confidential?

It is likely that others at the [hostel name] / [clinic name] will be aware that you are taking part in the study. But I will store all information securely. I will type up the interview without including your name or any personal information. Only I and my two research supervisors will have access to the original recordings. Personal information will be kept out of reports of study findings. Direct quotations from your interview may be written anonymously in some articles written about the study.

There are a few circumstances in which confidentiality would have to be broken. If the researchers were worried about your safety or the safety of someone else, information would be passed to professionals outside of the research team. If you disclosed specific information about criminal activity for which you have not been convicted, this would be passed to professionals outside of the research team. If a serious reportable issue is disclosed during an interview, e.g. malpractice, information would be passed to professionals outside of the research team. As I am only interviewing 10 to 15 people, this makes it possible that individuals would be identifiable if information had to be passed outside of the research team of myself and my two supervisors (e.g. to hostel managers).

Salomons Campus at Tunbridge Wells

What will happen to the study results?

At a later date you will be invited to attend a session at which I will give a brief summary of the main findings. I will be interested to hear people's views on whether the results seem accurate. But you will not have to come to this session if you do not want to.

I will write up results for my research at Canterbury Christ Church University. The research team shall also write-up and submit the study findings to a national psychology journal. No participant will be identified in any part of the write-up or article. I hope that the research findings might help bring about improvements in forensic rehabilitation services in the future.

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

You can leave the study at any time you want to. If you leave the study, any information you have provided will be destroyed.

Who has reviewed the study?

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

What if there is a problem?

If you have a concern about any part of the study, you can speak to me by leaving a message on the answer phone number 01892 507673, stating that your message is for Clare Holt. If you are not satisfied you may take your complaint to Dr Sue Holttum (leave message for her on the same number) or Dr Brian McKenzie.

Canterbury Christ Church University

Salomons Campus at Tunbridge Wells

If you remain unhappy and wish to complain formally, the National Health Service complaints mechanisms are available to you. The Independent Complaints Advocacy Service can give advice about using the NHS complaints system (0845 337 3061). You may also wish to seek advice from the Patient Advice and Liaison Service (0800 917 7159).

Further information:

If you would like further information about this study, you can contact me by leaving a message on the 24-hour answer phone number, (01892 507 673) and stating that your question is for Clare Holt. I will get back to you as soon as possible. Alternatively you can speak to Dr Brian McKenzie, Consultant Clinical Psychologist, who works at the hostel.

If you decide to take part in the research study, you shall be given a copy of this information and a signed consent form to keep.

Appendix 5: Participant consent form

Canterbury Christ Church University

Salomons Campus at Tunbridge Wells

Title of Project: Rehabilitation in forensic services

Name of researcher: Clare Holt

Participant identification number for this trial:

1 I confirm that I have read and understand the information sheet dated 29th April 2010 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2 I understand that my participation is voluntary and that I am free to withhold personal information or to withdraw at any time. I do not have to give any reason for withdrawing, and my medical care or legal rights will not be affected. ☐

3 I understand that the individual interview will be tape recorded. I retain the right to ask for the tape to be destroyed if I so wish. ☐

4 I agree to quotations from my interview being anonymously written into the coursework of Clare Holt and articles that may be written for publication about the study. ☐

5 I understand that I will be invited to a feedback session of results. It will not be compulsory for me to attend this session. ☐

6 I agree to participate in the study. ☐

.....	.....	....
Name of participant	Date	Signature
.....	.....	....
Name of person collecting consent	Date	Signature

Appendix 6: Final-stage interview schedule

MENTAL HEALTH

Can you tell me about your experiences of taking medication?

Can you tell me about your attitudes toward taking medication both now and in the past?

What are the main things that have assisted your **recovery** from mental health difficulties?

Once you began to understand some experiences as mental illness, did that have an effect on how you thought about yourself or did you still think about yourself in the same way as before? **How** has that influenced your journey to where you are now?

RELATIONSHIPS WITH STAFF

Have there been times when you've not got what you needed from staff? Can you say more about that?

Have your relationships with staff changed over time? in what ways?

Some people have spoken about the importance of communication between staff and patients, how have you experienced that?

What factors have influenced whether you have felt able to trust staff members or not?

ENVIRONMENTAL FACTORS

Can you explain how environmental factors have influenced your journey through services?

People have spoken about the increased freedom and responsibilities that are experienced over time; how have you experienced this?

Some people have described a "return to normality" – if this is something you have experienced what has this been like for you?

INDIVIDUAL CHANGES

What individual changes have you noticed in yourself as you've progressed along your journey?

How has your view of yourself changed over time?

Would you say your understanding of yourself, past actions, and things that affect you, have changed over time?

To what extent does this understanding affect you now in how you live your life, e.g. choosing friends and leisure activities differently? How easy or difficult is it to make those choices? – What can get in the way? What helps?

THERAPEUTIC WORK

What, if any, barriers have you experienced to interfere with your engagement with therapeutic work?

How would you describe that the psychological work you have engaged in has affected you?

What have you found helpful during the therapeutic work?

What characteristics of therapists / psychologists have you found helpful / unhelpful?

FACTORS EXTERNAL TO FMHS

Can you describe what role your family have played in your journey?

Have you noticed a difference in your friendships / how you choose friends?

Appendix 8: Example memos

Open coding: Geoff

- Line 61: *"getting these psychotic intrusive thoughts telling me to kill people and* everything and he said well when you get an elastic band on your wrist just flick it *and that's all he said, that was it full stop"*

Geoff is describing some severe, distressing experiences and a response from staff members that was experienced as unhelpful and insufficient. I wonder if this left him feeling misunderstood, possibly unsupported, and perhaps wondering whether effective help/management would ever be received.

Open code: Staff offering unhelpful suggestions

- Line 102: *"I don't think anybody knew what was going on"*

At this stage not only did Geoff not understand his own symptoms but he felt as though no-one around him did either. I am wondering how this felt and at what stage he felt as though people did "know" more; when he did feel like he (and others) were more aware, what were the things that contributed to this and how did this impact on him and possibly enable him to progress forward?

Open code: Confusion around symptoms of mental illness

- Line 277: *"You can't tell anybody because you end up with a scar on your face* and *named a grass you know"*

This statement implies an unwritten rule that telling others about bullying is unacceptable amongst fellow patients; I am struck by the inevitability and implied severity of potential consequences. I begin to wonder whether Geoff experienced this position to be isolating and whether these consequences were feared or an actuality that he had experienced. Was this

fear there throughout time in secure-services, and if not at what point did this cease and what contributed to that?

Open code: Being fearful of grassing

- Line 333: *"you know because you don't expect the public to react the way they do to like fifteen lifers"*

It appears that Geoff had anticipated stigma and perhaps rejection from members of the public; he was surprised by their actual response. I note that he refers specifically to 'lifers' and wonder if this implies a significance of the severity of the offence that Geoff committed in terms of his anticipation of rejection. I am considering issues related to identity in relation to this comment; what does this anticipation of rejection do to one's identity and self-esteem? I wonder what impact the public's acceptance and kindness had upon Geoff's overall journey and whether this influenced his self-concept (which he described at one time to be evil) and his confidence to interact with others external to FMHS.

Open code: Surprise at acceptance by members of the public

- Line 589: *"I mean they just made me relaxed, made me comfortable you know, sort of they didn't dive straight in there trying to find out what's wrong with me they sort of* they wanted more to help me relax and be comfortable with them **...** you know what I *mean, it's like when you are assessed on the admissions or in prison they say to you* why this and why that *and you're like I don't know, that's why I'm here"*

Here Geoff describes the importance of feeling relaxed and comfortable within the therapeutic relationship. It seems that Geoff was given time to acclimatise to the therapeutic situation and this was facilitative. He explains that this was different to how he felt when he first entered prison. At this earlier stage it seemed as though no-one (patient or professionals) had the answers and I am reminded of his earlier description of not getting effective help with his symptoms from staff. Geoff felt as though people were looking at him for answers he was unable to give and I suspect that this was not very containing, frightening perhaps.

Open codes: Being given time to relax and feel comfortable in therapeutic relationships

Confusion around symptoms of mental illness

- Line 626: *"if you've got the same person doing the group for so long you know your confidence and your trust in those people is so big you know"*

Geoff describes the benefits of having consistent staff in the therapeutic group; he mentions the way it enables trust to be built and maintained, it seems that this also instils a confidence in that staff member; is confidence synonymous with trust? I am wondering if there are other benefits to this consistency of staff.

Open code: consistency enabling trust

- Line 791: *"it was fantastic when I was able to open up, you know I would leave the* sessions and I would be really down you know the things I had talked about and *(couldn't be heard) but after a couple of hours you know (couldn't be heard) you've* done really well there Geoff*, you know pat yourself on the back mate"*

Geoff expresses the mixture of emotions involved in expressing within therapy; whilst it was very difficult and painful to revisit past experiences and memories, he experienced a sense of satisfaction afterward and was able to recognise that he had achieved something. I am wondering about what motivated him to attend therapy in the first place given it was a challenging task for him to engage in.

Open codes: expressing previous life experiences

being proud of own efforts

- Line 1273: *"they* [staff at the clinic] would say what can we do about it**...**and not sort of sticking an injection up your backside**...**things like how can we help you know, how do you think we can help you**...***I had a lot of input into my treatment"*

Geoff describes a large change in the way he experienced his treatment by the time he was at the low-secure unit. He felt as though he was consulted in the treatment process, as though his thoughts and suggestions mattered and did have an influence. This is in contrast to his description of previously been subjected to certain treatments regardless of his preference. At earlier stages there was a distinct lack of control conveyed within Geoff's descriptions and later he appeared to experience some control over his treatment options.

Open code: Having input to treatment

- Line 1399: *"God will help you if you ask him and I asked you know and then you* know it was a big thing a turn*ing point in my life"*

Here Geoff describes finding god as a turning point; it seems to have been a momentous step in his journey. I am curious about what prompted him to 'ask' god and what his pre-existing religious beliefs may have been if any were present. There are multiple functions which religion could potentially serve (social contact, sense of forgiveness, 'rules' to follow) and this may warrant further exploration where relevant in future interviews.

Theoretical sampling: I am wondering about people for whom faith has not played a part in their journey and about people who were perhaps practising a religion before their entry into forensic services.

Open code: finding god as a turning point in life

Open coding: Louise

- Line 17: *"their expectations are wide...they don't understand what it means to come* here under restriction**...***even though it's been told to them and they you know they do you know someone sits them down and says well you can't do this you can't do this"*

Louise describes how expectations about life at the hostel are sometimes not met by reality. I wonder how patients feel when they have worked hard to get to the forensic hostel only to

find out there are more restrictions than they are anticipating – I consider the possibility of a sense of deflation and am reminded how even at these later stages of service contact, residents are at the mercy of various rules, restrictions and sometimes decisions that are outside of their control.

Theoretical sampling: it may be useful to explore this with future participants who explain they were surprised at the extent of freedom afforded at the hospital (i.e. was expecting more structure and more rules) and how this was experienced. Can also ask staff about this.

Open code: expecting unlimited freedom at the hostel

- Line 88: *"*we often talk about expectations for those who are looking to come out of hospital and become a resident here and those who are already a resident here and *the shift even in the short period of time when they look at they've done wo*rk in hospital and they feel quite confident these are the guys that are still there**...**and they *feel really confident and they're really looking forward to coming out of hospital and they've got it all sorted in their head and they're quite adamant and the*n you listen to *the other side the guys that are out and they say well actually it's not what you thought it was"*

Here Louise emphasises the continuous nature of the adaptation process for patients in FMHS. Louise has noticed a large 'shift' in patients in a relatively short space of time between discharge from secure conditions and living at the hostel; again I get a sense of deflation that things aren't going to be as expected for those still at the medium-secure unit. I am reminded of the challenges that may present themselves at this crucial time (alcohol, peers etc).

I note that Louise describes peers preparing each other for what is to come during the next stage of the journey; it would seem the sharing of personal experiences can help to build more realistic expectations for patients awaiting discharge. This is a shift from participants' descriptions of earlier on in their service contact when peers generally did not share due to fears of being seen as weak.

Open code: attempts to set realistic expectations

fast changing realisation that release into the community is not as expected and brings with it difficulties

supporting each other by sharing experiences

- Line 107: *"some will come will move into the community and become quite humble,* um and almo*st realise they're quite vulnerable...and I think sometimes when they are in hospital they don't realise how vulnerable they are"*

Louise recognises some residents may feel vulnerable on moving to the hostel; I wonder if they are open about this sense of vulnerability or whether it is more a sense that Louise has. I am reminded of some of the elements that may be experienced by participants at earlier stages of their service contact, e.g. vulnerability, uncertainty, having to adapt their expectations. Do patients also get this sense of going backwards when they move to the hostel given the challenges that can re-emerge? The non-linear nature of progression is evident when considering these aspects.

Open code: realise personal vulnerability and the need for others' help

- Line 140: *"I think those who have insight into their into how their life has sort of evolved and those who don't have insight"*

Louise suggests those who do have insight are more able to progress through FMHS and present less risks.

Open code: developing an understanding of oneself and past behaviours

Negative case: Line 150 - *"I was going to say that those who've got insight are more likely* to do a lot better but then I have thought of a good couple that that is not the case and I just had one *that returned and he constantly said that I'm um I haven't got a mental a mental health problem"*

However if a sufficient care plan is in place insight is not necessarily required in order to enable progress. This raises the issue of internal change versus external support structures

provided by services and other avenues. This reminds me that the emerging categories and sub-categories are not going to apply across the board for all participants.

Open code: invalid assumption that patient insight is associated with better progress

Comprehensive care plan compensating for lack of insight

- Line 238: *"when I was on the ward and often then the patients are quite* chaotic**...**disturbed, er confused, angry, and I suppose when they get to this point they are l*ooking to put all their life back together"*

Here Louise describes the progression from chaos, confusion and anger (on the medium-secure unit) to a sense of hope and looking forward; by the time they reach the hostel Louise feels that residents can see a way forward. As I consider the things that may contribute to this shift I recall other open codes: 'gaining knowledge and understanding about MI', 'hope from hearing others' progress' and 'developing a future-oriented perspective'. It would also seem that relationships with staff influence residents getting to a place where they see a way forward; this requires further exploration.

Open codes: confusion around symptoms of mental illness

putting life back together again

Focused coding: Andy

- Line 107: *"beca*use by the time they get here there is still a lot of institutionalised *behaviour that needs to be eradicated"*

This has been mentioned by other staff member participants; some residents continue to require support when they arrive at the hostel. Given the change in environment and large adaption processes that this demands, perhaps this need for support soon diminishes after time at the hostel and time to adapt. I am suspecting that this is one area that is particularly individual, as evidenced by Louise's descriptions of residents who a) expect unlimited

freedom and b) those who expect consistently high levels of support. I am wondering about the individual factors that perhaps shape the ways patients manage/adapt to environmental changes (or not).

Open code: institutionalisation and expectation of continued support structure

Focused code: continued need for support

- Line 198: *"they've actually been off alcohol for more than 10years***...**so for that determination to me... that shows a lot of light about that pe*rson"*

This resident has taken purposeful steps to change their behaviour and to assist their progress; this requires individual determination. I am wondering if there are other elements of support that assisted with this behavioural change. Whilst the current focused code is behavioural change, I am aware I need to be deciphering more the function of this behavioural change and residents' motivations for doing so; this could reflect residents' desire for things to be different in their life or it could reflect a fear of breaching conditions and therefore returning to secure conditions for example. What contributes to this behavioural change and how does it impact further on their progress through FMHS?

Open code: abstaining from previous behaviours

Focused code: behavioural change

- Line 383: *"whatever kind of difficulties he may find, he might come back here and talk to somebody about it, he will find somebody that he trusts"*

Andy feels confident that this resident would turn to staff when facing difficulties; this represents a contrast to participants' descriptions of earlier stages of their service contact where there was a sense of feeling as though staff did not care, did not listen, and could not provide the necessary help. It is clear trust contributes to this shift in relationships; I wonder what other things may contribute to this. It currently seems as though trust is one pivotal element of patient-staff relationships that entails various dimensions; I am considering that this may be a sub-category.

Open code: opening up to a familiar member of staff

Focused code: consistency and familiarity promote trust

- Line 457: *"allowing them to feel all the different things that they're feeling but explain to them that yes it's frightening but look at the journey that we've both travelled or that you (emphasised) have travelled in order to get to the end of it"*

This seems to depict a very important supportive function of patient-staff relationships; resident's emotional experiences are accepted and heard yet Andy also adopts a positive focus and emphasises the extent of progress that has been achieved by that individual. Based on coding so far it would seem that staff empowerment is an important dimension of staff encouragement; I am considering how staff empowering residents enables achievements/progress forward to be sustainable. In addition, empowerment likely bolsters residents' self-esteem and self-belief, an individual change that currently comprises one sub-category. I am thinking that trust may be a necessary precursor to patients allowing staff to provide encouragement and empowerment.

Open code: staff encouraging patients to be hopeful, i.e. focus on the progress they have made

Focused code: being encouraged and empowered

- Line 549: *"they said well our ex*perience here is different you actually sit down and talk with us you know you sit down and ask us questions about ourselves we talk about anything and everything and that makes me feel good that you actually listen to *what I've got to say, there's a sense that nobody listens to me back there but there's a lot of sense of you lot listening to me when I'm here"*

Andy depicts a change in patients' experiences of staff as they progress to the hostel: staff listen to you. It is clear that patients have described this makes them feel 'good', I am wondering about other potential consequences of being listened to and am reminded of other participants descriptions of an increasing sense of self-worth (i.e. I am worth being listened

to), a sense that others are available to support one's needs when required, and an emerging equality between staff and patients. I am considering how being listened to may fall into a sub-category of feeling as though staff are there to support and encourage

Open code: it really makes a difference when staff listen

Focused code: being listened to

Coding of final stage interview: Harvey

- Line 51: "every morning I woke up and I kept on noticing that I was dribbling... or that I had dribbled shall we say and erm (pause) you know it like was not when I was *talking (pause) yeah it was like actually when I was talking to people"*

Harvey describes side effects of medication; this was a large focus of this interview and he bought conversations back to this topic a few times. I consider how Harvey's particular experiences encompassed within this subcategory could have impacted on his self-esteem (currently a sub-category).

Focused code: medication causes problems

Sub-category: taking medication

Category: learning about and managing mental health

- Line 177: "*I know that I'll never go back to taking drugs again**...**you know I've had my days my past where I was using, trying a lot you know but now since (couldn't be* heard) settled right down now, never go back to doing that*"*

Harvey conveys a confidence that his behaviour changes will continue to be maintained in the future. He now wants different things from life and his identity has shifted over time. Some of the elements Harvey describes as contributing to him wanting to move on are present amongst various participants accounts; having time to think / reflect, having something to aim

for, and reflecting upon and understanding past behaviours. I am reminded of the sub-category that was previously labelled 'behaviour change'; it seems that at times people's behaviour changes can be attributed to them wanting their future to be different to their pasts. Participants' comments have highlighted how this can entail shifts in identity and a desire to move forward and to actively affect their progress through FMHS.

Focused code: time to move on from the 'old me'

Sub-category: wanting things to be different

Category: developing self-direction

- Line 336: *"you say to yourself you know what now I'm trying to do something to* qualify as an engineer to get something at least some goals set some goals and then if *you don't you know you've got behind everything you've still got the NHS services like"*

Harvey further illustrates one of the functions of the sub-category 'staff support and encouragement'; knowing staff are there gives him the confidence to try things and to set goals. I consider the ways that these seems associated with some individual changes emerging from participants' descriptions, in particular having something to aim for and adopting increasing responsibilities.

Focused code: knowing staff are there

Sub-category: support and encouragement

Category: establishing facilitative relationships with staff

- Line 404: *"I really* should have just had patience more *patience ... I've thought that if* I did have more p*atience like I wouldn't have even been in this position"*

Harvey describes a retrospective appreciation of how his life could have been if he had not entered FMHS; there is an associated sense of regret which seems to contribute to his desire to move forward and to avoid similar mistakes in the future. I consider how other participants

have also described regret as well as shame; this has provided some motivation and determination to make changes and to engage in interventions where relevant, e.g. therapy.

Focused code: aware of the impact on one's own life

Sub-category: becoming aware of the impact of past behaviours / lifestyle

Category: developing self-direction

Appendix 9: Examples of coded data

Luke: Open coding

Int: are there other things you can think of that you thought were helpful?

Participant: yeah they used to help us to pass cigarettes around like (couldn't be heard) but in there I don't know, it's so lonely in there the most someone would probably give you an ear to talk to

Int: yeah, ok

Participant: but that's enough, that's enough

Comment [C1]: It really makes a difference if staff listen

Int: and when you say it was lonely can you say a bit about what that was like?

Participant: um, yeah when I say it like this I'm not saying oh look poor me because I deserved to be in there like, you know like I'm not saying , I'm just saying how it felt in there

Comment [C2]: Believing one deserves to be punished

Int: yeah yeah and that is what we are interested in

Participant: like um, (pause) I don't know it just kind of felt um (pause) why did I do what I did, why, I don't know you've just got like a million things going through your head like

Comment [C3]: Confusion about one's own reasons for offending

Int: yep, and can you say more about what might have been going through your head and what that was like?

Participant: eeer, yeah just like, got to, I was trying to get on and keep my head down as much as possible but I was also thinking oh I can't let anyone disrespect me because then other people walk all over you, so I was trying to put on this bravado

Comment [C4]: Putting on a front due to fears of others' perceptions and responses

Int: mmm, ok

Participant: all this, you know

Int: and what was it like when you were doing that?

Participant: I'd done that, I'd done that for a lot of my teen years anyway like

Int: ok

Participant: it's not nice, it's not nice, you just pretend that you are all big and all that but really inside you're not

Comment [C5]: Putting on a front due to fears of others' perceptions and responses

Int: mmm ok, and you have said a bit about what the staff did that was helpful, can you think of anything else about that time that was helpful for you?

Participant: that was helpful?

Int: mmm

Participant: (laughs)

Int: (laughs) and then we will come on to the other side of things as well

Participant: the meals yeah, cor the meals were massive (i.e. significant). Err yeah, when they did like groups, when they did groups and stuff like that

Int: ok

Participant: like art class, that was really relaxing, they let you go out on the art block and let you just draw, like on the erm camp and let you draw and that and that was really good

Comment [C6]: Art as relaxing

Int: ok

Participant: just to be relaxed, to get out of your cell as much as possible, all the stuff

Comment [C7]: Time out of cell

Int: yeah

Participant: like church and that, that was really helpful, um and as well one of the other things they do a thing called er Listeners, I don't know if you've heard of that?

Comment [C8]: Church as helpful

Int: I have yeah

Participant: yeah they are really good they are

Int: that's something you used?

Participant: yeah you get to talk to people who are in your own situation like

Int: yeah

Participant: that was good that was

Comment [C9]: Supporting each other

Int: can you say a bit about what it was like when you used the listeners and why it was helpful?

Participant: just again, its someone that you can talk to a bit and be a bit more relaxed around 'cos obviously you can't, really I got the listeners out because I was asking them a lot of questions about oh what do you think will happen with my case blah blah blah

Int: ok

Participant: and it's just a bit like, just to talk to someone like who was in the same boat sort of thing

Comment [C10]: Supporting each other by sharing experiences

Int: yep, yeah ok

Participant: but then you don't want to, when you was speaking to the prison guards at that time I wouldn't want to give away too much and all stuff that was a bit more

Comment [C11]: Not giving away too much to staff

Int: yeah, and the listeners felt like people you could speak to

Participant: yeah

Int: ok, you mentioned art, did you do any other groups in the prison?

Participant: yeah English class yeah and er that was it I think

Int: and how was English or the education?

Participant: um yeah it was good, good, it was alright, I don't really remember much of it because they had just changed my medication and I was really tired

Comment [C12]: Negative effects of medication

Int: oh I see, can you remember much about that healthcare in the prison service?

Participant: the healthcare, yeah, I was on that, that was the wing I was on the healthcare wing

Int: ok

Participant: what do you mean by the healthcare?

Int: so any, I suppose any, so you said your medication had been changed

Participant: yeah

Int: and I am just wondering about any help you might have got at the time, or (interrupted)

Participant: yeah yeah, you saw the psychiatrist once a week

Int: ok

Participant: yeah they'd also come down and see you, um (pause), I think do you know the most, one of the other things is to let you know like what is going on and not to keep you in the dark that helps a lot

Int: yep

Participant: so you knew where you stood

Comment [C13]: Knowing where you stand

Int: ok, yep, have you got an example of when you did know where you stood and it was helpful?

Participant: when one day they told me I was going to hospital and then, like, a lot of the staff would always say look I don't know I don't know, and this one, I remember this one particular officer he would say look I'm, every day I'm on I'm going to phone the hospital and find out when you're going to go there

Int: ok

Participant: and he would come back, and he would come in my cell and talk to me, he was really nice

Comment [C14]: Officer going out of his way

Int: ok ok

Participant: really nice

Int: and it might sound like a sort of obvious question but why was that so important at the time?

Participant: it's nice like when someone's got a genuine care for you like especially in a situation, like a lot of prisoners probably feel like, when they've done things wrong and that are like 'oh no like' and feel rejected and whatever, and when someone gives an ear like that it's nice when someone (tails off)

Comment [C15]: Anticipating rejection from others

Comment [C16]: Feeling cared for by staff

Int: yeah yeah, ok and then it is probably important for me to ask the things in prison that weren't so helpful for you looking back?

Participant: errr (pause), I don't know, I don't know, I can't really say like um

Int: anything you can think of at all

Participant: well obviously I'd like to say I'd want to be out my cell more and all of that but you can't it's prison isn't it (pause) I don't know

Comment [C17]: Resignation to not having control

Int: it is prison, yes

Participant: yeah

Int: but there are also things that you might looking back think if I'd of been out of my cell more it would have been important, you know helpful for this reason or for that reason, but it is all valid points and it is just whatever you think

Participant: on healthcare they wouldn't let us go to the gym but I think that is because a lot of people there are like mentally disturbed

Comment [C18]: Opportunities to be active / out of cell dictated by others (staff and other prisoner groups)

Int: yeah

Participant: so smash up the gym and whatever and there's a lot of heavy weights in there so

Int: I see yeah

Participant: but that would have helped if they'd have done probably more of a deeper assessment and watched over us because they did tell us we was going gym and then they cancelled it

Int: oh ok, yeah

Participant: (laughs) and that was um, and then sometimes we didn't get to go out on Fridays because of the Islamic service and stuff

Int: ok

Participant: that didn't help at all like, I think you know they're doing their thing we shouldn't have to ...

Int: have an alternative

Participant: yeah yeah, but I'm only saying that, the majority of the time they let us out but

Int: ok, ok. Are there other things you think could have been different and it might have been helpful for you?

Participant: er yeah, probably, the phones, the phone time that's shit, you hardly get any time on the phone whatsoever

Int: ok

Participant: and it's just, you're on it, you call someone and usually like it's a two minute thing like you know 'how are you' like and someone's behind you like 'oh come on come on' so it's like

Int: and what impact do you think that had on you at the time when you didn't have much time on the phone

Participant: oh you've just got to, in there I just had to sort of block it out my head and just write to them like I wasn't thinking about it too much

Int: yeah

Participant: I mean I had money for the phone but I didn't really put it all on because I thought you don't really get to speak for long enough anyway

Int: yeah, ok. Are there other things you think you just sort of 'blocked out' in there?

Participant: eeer (pause) I can't think really

Int: no?

Participant: no

Int: ok, so you were there for 2 months (interrupted)

Participant: oh well yeah, I suppose emotions yeah

Int: ok

Participant: I blocked out emotions

Comment [C19]: Opportunities to be active / out of cell dictated by others (staff and other prisoner groups)

Comment [C20]: Time out of cell

Comment [C21]: Difficulties maintaining familial contact in restricted conditions

Comment [C22]: Avoidance of thinking about family

Comment [C23]: Difficulties maintaining familial contact in restricted conditions

Comment [C24]: Blocking out emotions

Int: ok, can you say more about that?

Participant: yeah it was, (couldn't be heard) anger I'm a different person but when I was back in there I would have thought there is no way I would have let another prisoner see me cry like I wouldn't want them to think I was weak

Int: (verbal encouragers) and why is that do you think, why did you feel you couldn't?

Participant: fear of being bullied, stuff like that

Comment [C25]: Putting on a front due to fears of others' perceptions and responses

Int: ok, and it sounds like things have changed now and we can talk about that as we move forward to where you are now

Participant: yeah

Int: um ok yeah so you were in [prison name] for (interrupted)

Participant: [prison name]

Int: [repeats prison name], sorry, there is a [prison name] isn't there? (laughs)

Participant: yeah there is yeah

Int: um, ok so you were in [prison name] for two months and then can you tell me how you came to be transferred to [clinic name]?

Participant: yeah, they done like er an assessment and all that and the Drs and that they said they wanted me to go to the [clinic name] for er, er what do they call it, an assessment period for six months

Int: ok, yep. Can you remember what that was like so the assessment in the prison and then being transferred?

Participant: cor yeah, I know it doesn't sound all great but to get from prison to the hospital, like, when they told me I was going I wouldn't have cared where I'd have gone I just wanted to get off there

Comment [C26]: Eager to move on from prison

Int: right ok

Participant: so from the day they told me I was going I thought wow like, I thought, I didn't have a, I didn't know really what to expect

Comment [C27]: Unclear expectations of hospital

Int: ok

Participant: because a lot of people were saying to me like oh in the mental health institution you wont be able to talk to no-one, they'll be rocking backwards and forwards in their chairs and all that

Comment [C28]: Stereotypes about hospital

Int: ok

Participant: so I was thinking it was like that (laughs)

Int: yeah so, you said you would have done anything to get out, so was there a part of you that was a bit relieved?

Participant: yeah I was relieved to get out of prison, of course

Int: but then at the same time you were hearing stories about what it was going to be like

Participant: yeah, I didn't know, yeah I didn't have a clue

Comment [C29]: Unclear expectations of hospital

Int: ok, it sounds quite scary?

Participant: yeah it was yeah, it was

Int: and then you did go to the [clinic name]

Participant: yeah

Int: and what was it like initially if you think back to the beginning?

Participant: the first time I got there I see a load of like blokes with their bandanas on and all that and I thought, I walked past to my room and I thought oh here we go, it's bound to kick off here like

Comment [C30]: Expecting conflict and confrontation from peers

Int: mmm

Participant: but they're like, one of the guys there like has ended up being one of my best mates like

Comment [C31]: Ongoing friendships with service-users met during the recovery journey

Int: ok

Participant: and so I, it's a totally different atmosphere like in prison everyone is out for what they can get and I think that is because they haven't got a lot in there

Comment [C32]: Peers being out for what they can get

Int: ok

Participant: like the cigarettes and stuff like that they only get them once a week on canteen, that's a thing that could be improved in jail like more canteen

Int: ok

Participant: you only get your burn once a week and that

Comment [C33]: Restrictions on material goods

Int: ok

Participant: but yeah in the [clinic name], like the people that I was stereotyping looking at thinking ooo they are going to be trouble, they knocked on my door and I thought oh already like and he said oh I just want to introduce myself and I was like (laughs)

Comment [C34]: Expecting conflict and confrontation from peers

Comment [C35R34]: Touched by friendliness of peers

Int: ok so not what you expected at all

Participant: nah not at all, no

Int: ok

Participant: and everyone comes up to me and says oh do you want a cigarette do you want this that, and I'm like (laughs)

Comment [C36]: Touched by friendliness of peers

Int: (laughs) sounds like a lot to take in

Participant: yeah 'cos usually it's like give us a burn give us a burn

Comment [C37]: Peers being out for what they can get

Int: yeah yeah yeah ok, and you say you were stereotyping but it sounds like you were stereotyping for a reason, you know it was based on what you had come to know I suppose

Participant: yeah

Int: so you say it was a completely different atmosphere and you gave us examples of how it was different, can you say any more about how it was different to where you had been before?

Participant: yeah cos in the [clinic name] you're not locked up you know you're free to go into the communal area so there is a lot more interaction with like not only patient interaction which is helpful 'cos you can like talk to them and when you hear that they're getting through the situation it gives you a bit more

Comment [C38]: Fewer physical restrictions / time out of cell

Int: ok

Participant: sort of like, yeah, like, and they say to ya oh come on sort yourself out like we're all going through the same thing here like

Comment [C39]: Supporting each othe by sharing experiences

Int: ok

Participant: and then the staff as well you can just go up to them knock on the door, you can speak to them all night if you want

Comment [C40]: Staff being approachable and available

Louise: Open coding

Participant: we've got one particular client whose very much looking for high levels of support which is ok because that's what we're here for but it's not (couldn't be heard due to interference) integrating into the community

Int: ok

Participant: it's well lets do activities in here, you should be doing this for me, erm, and we try to encourage the guys to think about, simple things like so you've got appointments put it in the diary and try or in your phone and try and remember those things and that's what we're here to support

Int: mmmm

Participant: to start thinking about what they need to do independently

Int: m huh

Participant: and they can find that quite difficult at times, um, and almost be angry with us if we say well actually you should be should be thinking about doing that for yourself

Int: yeah

Participant: um obviously over a period of time um they do start to take that on

Int: yeah

Participant: but that's the initial response

Int: so from what you've said you are trying to accommodate quite a broad range of needs I suppose, there are people who come with expectations that there aren't any restrictions and that they can do as they please but also people who want a lot of input and who are institutionalised

Participant: yeah

Int: ok so that's really interesting. Are there other things that generally speaking have stood out from your work with people that have come from the acute ward to [hostel name]?

Participant: um (pause), I think um to be honest with you I've found the experience, I know that some people can be very difficult I've kind of found that once they've got their heads, the the guys that come here I know that they do feel like they can do as they please um he definitely definitely had this, the ones that are restricted are definitely contained by that restriction

Int: ok

Participant: on many of the occasions

Comment [C41]: Institutionalisation and expectation of continued support structure

Comment [C42]: Staff encouragement
Increased responsibilities for day to day tasks

Comment [C43]: Feeling angry about having to take on responsibilities

Comment [C44]: Increasing responsibilities for day to day tasks

Comment [C45]: Restrictions as containing and providing a focus

Int: mmm

Participant: um (pause) and I've found that, you know it's nothing big, it makes our lives a lot easier but

Int: can you say a bit more about how?

Participant: well (sighs) I think they have this fear that if they step out of line they are going to go back into hospital

Int: yeah ok

Participant: um so they tread very careful, they are very careful, most of them are very careful about um crossing those restrictions

Comment [C46]: Fear of taking backward steps

Int: m huh

Participant: so, and I think because I have worked on acute wards in, previously, that stood out quite a lot for me

Int: ok

Participant: yeah

Int: ok, um, I mean it sounds like there's a distinction between residents who are on a restriction order and those who aren't

Participant: yeah definitely and also what I've noticed because I run an active recovery group

Int: ok

Participant: and er drugs and alcohol, and we often talk about expectations for those who are looking to come out of hospital and become a resident here and those who are already a resident here and the shift even in the short period of time when they look at they've done work in hospital and they feel quite confident these are the guys that are still there

Int: mmm

Participant: and they feel really confident and they're really looking forward to coming out of hospital and they've got it all sorted in their head and they're quite adamant and then you listen to the other side the guys that are out and they say well actually it's not what you thought it was

Comment [C47]: Fast changing realisation that release into the community is not as expected and brings with it difficulties

Int: mmm, ok

Participant: and that you know when it comes to drugs and alcohol we have I have relapsed and felt really bad and that thought that I was being carted back to hospital but realised I actually just needed support and they are trying to tell the the the [clinic name] patients

actually it's not what you think it is it's not going to be like what you think it's going to be like

Int: ok, yeah, there's a realisation that yeah things are different. It's interesting that they're all in the same group as well, can you say more about the changes that you perhaps see in the people who have already left the ward and the people that are on there, what other distinctions there might be?

Participant: um (pause) ooo I don't know if that's the right word I'm thinking of, they they you'll get several different types of people and some will come will move into the community and become quite humble, um and almost realise they're quite vulnerable

Int: mmm ok

Participant: and I think sometimes when they are in hospital they don't realise how vulnerable they are um, and with, especially being male here being quite macho attitudes to um you know I'm coming out I'm going to get back into the community I'm going to get my flat and then men that are really well actually I need help I need help to even pay you know my service charge

Int: mmm

Participant: or to make a phone call

Int: yeah

Participant: you know just simple things

Int: yeah yeah

Participant: um or I'm actually scared to talk to somebody

Int: (verbal encouragers)

Participant: which makes them quite vulnerable

Int: mmm

Participant: and they look you know you have to build strong trusting relationships with these guys for them to be able for them to succeed

Int: yeah ok

Participant: for them to be able to come to you and say actually I'm not feeling so great and it's one of the most simple things

Int: ok, so there is a vulnerability that emerges sometimes

Participant: yeah

Comment [C48]: Fast changing realisation that release into the community is not as expected and brings with it difficulties

Comment [C49]: Supporting peers by sharing experiences

Comment [C50]: Realise personal vulnerability and a need for others' help

Comment [C51]: Fears of interacting with others

Comment [C52]: Trust enabling the sharing of feelings and experiences

Int: when people are out in the community, and are there other differences between the two groups that you can see?

Participant: (pause)

Int: and I'm sure there's a lot

Participant: there's a lot (laughs) oh gosh I should have thought about this more (couldn't be heard)

Int: don't worry just take your time and think and you know

Participant: eerm

Int: whatever comes to mind

Participant: god, I can't even think, too many of them, um differences, um, (stuttering) I think those who have insight into their into how their life has sort of evolved and those who don't have insight

Comment [C53]: Developing an understanding of oneself and past behaviours

Int: m huh

Participant: um (pause) I mean it's obvious that those who've got insight are more um, well no that's not always the case I mean if I'm honest there's some people don't have insight but have still done very well and that's due to the care plan

Comment [C54]: Comprehensive care plan compensating for lack of insight

Int: ok

Participant: if they get that care plan just right um, though even though they don't have um um you know good insight into their their their situation they can still do, be do relatively well, um I was going to say that those who've got insight are more likely to do a lot better but then I have thought of a good couple that that is not the case and I just had one that returned and he constantly said that I'm um I haven't got a mental a mental health problem and he presents himself very well and I have to say you even look at him and you think actually did they get it wrong (laughs)

Comment [C55]: Invalid assumption that patient insight is associated with better progress

Int: ok

Participant: however um I did actually catch him having a conversation with himself

Int: ok

Participant: but he has done very very well but even to this day he insists that he doesn't have a mental health problem

Comment [C56]: Patient denial of mental health problems

Int: ok

Participant: so (laughs)

Int: it's interesting isn't it because there is an assumption that more (couldn't be heard)

Participant: (laughs) I think it's really hard because people are all very much individuals and I cant really put them into a I cant really make any concrete um you know differences the main thing like I said is it's them it's their journey

Comment [C57]: Individualised nature of recovery journey

Int: mmm

Participant: and it's how they view their journey how they manage it and it's us keying into the support that they need

Comment [C58]: Patients authority to determine how their journey is managed

Int: (verbal encouragers) yeah

Participant: you know you have to observe and obviously have the history, I think history oh it's really important to have background history

Int: ok

Participant: it really irritates me when we learn things (laughs and couldn't be heard)

Int: yeah ok and it sounds like an obvious question but why is the history so important?

Participant: because we can plan

Comment [C59]: Planning service provision in accordance with historical information

Int: yeah ok

Participant: we can support instead of learning, I mean there are negative parts of someone's history that um (pause) it could easily influence how we treat each individual however I have to say as a team we actually are quite fair and we try to be quite balanced

Int:ok

Participant: um and treat people as we as they come you know and give them that opportunity um

Int: ok

Participant: but it is about preparing ourselves um in advance to you know to deliver the best support we can

Int: ok, and you said before that one of your roles is very much helping the residents integrate back into the community and then what you said about people who've got restrictions and haven't, I suppose what I'm wondering is if there's a difference, do the restrictions influence that integration back into the community in a way? And if so how do they?

Participant: I think restrictions is more containing for um once they've realised actually those restrictions are very real they become focused but that's not in every instance

Int: (verbal encouragers)

Participant: those that are less restricted can be harder to manage but that's literally like I said it's individual

Comment [C60]: Management difficulties in the face of few restrictions

Int: yeah of course

Participant: um but if you've got someone that has very little restriction and their complex needs you know behaviour oh that is really difficult very very difficult

Comment [C61]: Management difficulties in the face of few restrictions

Int: ok and just through your speaking I suppose what is standing out is just the individuality and yeah how you are trying to tailor to lots of different sorts of needs really

Participant: yeah

Int: you've said about a vulnerability being sort of one change in people that have moved here in comparison to the medium-secure unit, um and drawing on that experience you've got as well I suppose what are some of the other changes that you see in the patients who are at different stages of their journey?

Participant: what when they are here?

Int: or even going right back, so (interrupted)

Participant: um (pause) I think for many its accepting their situation

Comment [C62]: Accepting their situation

Int: m huh

Participant: erm you know I'm just thinking about when I was on the ward and often then the patients are quite chaotic

Int: right

Participant: err disturbed, er confused, angry, and I suppose when they get to this point they are looking to put all their life back together

Comment [C63]: Chaos / confusion around symptoms of mental illness

Comment [C64]: Putting life back together again

Int: ok yep

Participant: erm (pause) and I think in the hospital they're quite resistant to being forced to you know forced to remain in hospital

Comment [C65]: Resistant to non-voluntary status

Int: (verbal encouragers)

Participant: and I think they quite often lose all sense of what's going on in that environment

Comment [C66]: Chaos

Barry: Focused coding with axial coding

Participant: a lot of things happened I mean I was I got a certain level of help while I was on Clozapine that's quite effective I had to stop taking it because it nearly killed me yeah

Int: ok

Participant: I had to stop taking it 'cos I had (medical term couldn't be understood) severe (same medical term) and they thought my bone marrow wouldn't recover

Int: ok

Participant: but um I think things started getting even better when they put me on two anti-psychotics also I feel that my work with Simon [psychologist] er has been quite cathartic yeah

Int: ok

Participant: yeah erm because he's a great listener Simon and I think that's been you know the best bit of the journey over time I've just found that my nightmares have gone

Int: ok

Participant: I used to have nightmares every night and erm my the delusions I had

Int: yeah

Participant: you know (pause) and everything else sort of disappeared

Int: so there's a lot of things that have all kind of come together to help get you to where you are at

Participant: yeah

Int: and it would be useful to talk about those and separate them out I suppose

Participant: sure

Int: so thinking, and this might be a difficult question but thinking about where you were at the beginning of your journey and where you are now, what are the main changes that um you think have happened for you?

Participant: erm (pause) well the medications helped me a lot

Int: yep

Participant: I'm quite fortunate apart from what happened on the Clozapine I don't have any er side effects from medication apart from putting weight on

Int: ok

Comment [C67]: Medication as effective

Focused code: positive effects of medication
Sub-category: medication
Category: learning about and managing mental health

Comment [C68]: Negative effects of medication

Focused code: negative effects of medication
Sub-category: medication
Category: learning about and managing mental health

Comment [C69]: Medication as effective

Focused code: positive effects of medication
Sub-category: medication
Category: learning about and managing mental health

Comment [C70]: Appreciating the benefits of therapeutic work

(code needs refining down the line)

Focused code: Psychological input as a valuable part of the journey
Sub-category: attitudes toward psychological intervention
Category: doing work in therapy

Comment [C71]: Medication as effective

Focused code: positive effects of medication
Sub-category: medication
Category: learning about and managing mental health

Comment [C72]: Negative effects of medication, i.e. putting weight on

Focused code: negative effects of medication
Sub-category: medication
Category: learning about and managing mental health

Participant: er also I'm on a diet at the moment

Int: are you

Participant: yeah (laughs) I don't know it's just been (pause) Simon's just been listening to me for quite a long time and it's just I've just talked things through

Comment [C73]:
Focused code: being listened to
Sub-category: support
Category: establishing facilitative relationships with staff

Int: yeah ok and just on the medication (interrupted)

Participant: I can't say there's anything (pause) I don't know nah I've just found it really helps (referring to talking therapy and not medication at this point)

Comment [C74]:

Focused code: expressing in therapy
Sub-category: working through it
Category: doing work in therapy

Int: yeah and we can talk a bit more about that maybe and if you've had help from other people you know in terms of psychology or anything but just in terms of the medication

Participant: yeah

Int: it sounds like medication's helped get your symptoms under control

Participant: yeah

Int: is there any other way you'd describe medication has played a role in your journey?

Participant: well I wouldn't take it when I was in the block in [prison name] I wouldn't take it because I thought they was poisoning me my food yeah

Comment [C75]:

Focused code: Distress
Sub-category: Being in chaos
Category: learning about and managing mental health

Int: ok

Participant: also I thought the prison officers were going to kill me

Int: ok

Participant: you know I thought they were killing other inmates in their cells

Int: m huh

Participant: and er they found me hanging one day yeah I thought they hanged me

Comment [C76]: Being severely mentally ill or distressed

Focused code: distress
Sub-category: chaos
Category: learning about and managing mental health

Int: ok

Participant: but they haven't I've hanged myself yeah

Int: ok

Participant: when I've looked back through some of the notes and that yeah like so you can imagine that if I thought some of them were poisoning me and I was distrustful of everyone yeah

Int: yeah

Participant: the last thing I'm going to take is a yellow tablet

Int: yeah

Participant: like that (signalling a small tablet)

Int: yeah why would you yeah

Participant: so I didn't take any medication and because of that erm I had very very bad hallucinations tactile halluncinations

Int: ok

Participant: where I felt that they were kneeling on my kidneys

Int: ok

Participant: and throttling me and everything

Int: yeah

Participant: I could feel it even I had delusions er halluncinations of the psychiatrist throttling me and I could you know I felt I could feel him throttling me

Comment [C77]: Being severely mentally ill or distressed

N.b. not coded as reluctance to take medication as this seems to be a bi-product of the symptoms

Focused code: distress
Sub-category: chaos
Category: learning about and managing mental health

Int: gosh ok

Participant: they was doing that (exhale of breath) about six or seven times a day I felt it

Int: yeah, incredibly frightening and confusing

Participant: oh yeah

Int: it sounds like

Participant: yeah

Int: so there was a time when you (interrupted)

Participant: you see it didn't bother me I mean when I I hallucinated and heard them say things like we're going to kill you like this we're going to kill you like that it didn't bother me until they started saying that they were going to kneel on my kidneys and burst my kidneys open yeah and after that absolutely terrified me

Comment [C78]:

Focused code: distress
Sub-category: chaos
Category: learning about and managing mental health

Int: yeah understandably

Participant: yeah and I thought they were poisoning me with aspirin because I had tinnitus in my ears I thought I had tinnitus in my ears

Int: ok ok, and as your symptoms as your symptoms reduced then you became able to take the medication you felt more able to take the medication is that what happened?

Participant: well I came here off the [prison name] and I didn't have the tactile hallucinations but I had a lot of because the two weeks I was at [prison name] er they wouldn't give me any sleeping tablets if I didn't take the valitabs

Int: right

Participant: and I was slightly better slightly better

Int: right

Participant: so I took the valitabs yeah and I think because of that when I came here I didn't have tactile hallucinations or anything I just had delusions

Int: yep ok

Participant: erm (pause) er er yes I just had delusions really

Int: what's your current view on medication now?

Participant: well I think it works

Int: mmm

Participant: yeah it works

Int: and do you see it playing a part in your future journey from this point on?

Participant: yeah I don't see myself being on it forever

Comment [C79]: Medication reducing hallucinations

Focused code: positive effects of medication
Sub-category: medication
Category: learning about and managing mental health

Comment [C80]: Medication as effective

Focused code: positive effects of medication
Sub-category: medication
Category: learning about and managing mental health

Comment [C81]: Envisaging a future without medication

Appendix 10: Abridged version of research diary

January 2009

As I consider the ideas presented at the research fair I am torn between pursuing an area I am more familiar with and certainly interested in (forensics) and following-up one of the topics in another area that have taken me by surprise in rousing my interest. I have been thinking about some of the studies which utilise data that is already collected; whilst this is extremely appealing in terms of time commitments I am determined to choose a study that will maintain my interest throughout given the amount of time that will be dedicated to this project.

February 2009

18th February

I met with Brian today to discuss his research idea presented at the research fair: 'stages of rehabilitation after violent offending'. I felt the meeting went well and Brian's passion to explore this area was clear. I left this meeting excited about the prospect of conducting a project in this area- the next challenge is to find a supervisor at Salomons.

March 2009

March 17th

After a telephone call with Sue today, she has agreed to supervise the project and I am feeling relieved – now I need to continue reading around the topic.

w/c March 23rd

I am becoming aware of the broad number of ways the research could be approached; the options seem endless. I seem to be making little progress in refining my ideas on my own and think meeting with both Brian and Sue would help combine the relevant clinical and research considerations that are necessary in this process.

July 2009

31st July

Today I met with Sue and Brian. During the meeting we grappled with numerous research options including qualitative and quantitative approaches with service-users at a wide range of stages of their service contact. Sue and Brian are both willing to be flexible in terms of the project's focus and methodology. They advised me to go away and further weigh up the options against my personal interests. I left this meeting feeling disappointed that I am yet to achieve further clarity regarding my research project. At least I have some more specific areas on which to focus my reading which I plan to commence as soon as possible.

August – October 2009

As I continue to read around the relevant subject areas I have decided to focus specifically on one category of offenders within the heterogeneous population of 'mentally disordered offenders'; offenders diagnosed with severe mental illness (SMI). I have decided to adopt a qualitative approach to the study; given the lack of theoretical research on the rehabilitation of offenders diagnosed with SMI a rich, in-depth study seems to hold great potential. Having weighed up different qualitative methodologies, I have decided to adopt a grounded theory approach. Whilst IPA, case studies and discourse analysis all offer potentially interesting routes of investigation, my reading so far has highlighted the paucity of theoretical accounts of the rehabilitation of offenders with SMI. Therefore grounded theory seems to be the best suited approach.

November 2009

27th November

I attended my MRP proposal review panel today. My responses confirmed my belief that developing a grounded theory is the most appropriate approach to be taking; it was helpful to receive further guidance on my ethics application and ways to ensure quality in qualitative research.

December 2009

2nd December

Today I received confirmation that my proposal has been approved by Salomons; I can now begin to consider the Research and Ethics Committee (REC) application.

10th December

Today I attended a teaching session on grounded theory. This provided an extremely useful insight into the method and its component parts. It helped me begin to think about sampling, sources of data, and the different stages of analysis that are entailed.

January 2010

As I try and firm up all aspects of my research proposal in preparation for my application to the REC, I am feeling confused about the different approaches to grounded theory, e.g. constructivist approaches and more positivist approaches (e.g. Strauss and Corbin). I continue to read around the different approaches and am weighing up which approach may be the most fruitful considering my research aims.

February 2010

I have begun to fill out my REC application and am a little overwhelmed by the amount of work that this form requires. There is a lot of talk amongst trainees about how people have experienced the REC panels; this has not always been positive and my anxieties about what this panel may be like increase.

April 2010

12th April

Today I attended my REC panel. The panel raised some concerns including the amount and types of information on the Participant Information Sheet and Consent Form. Overall I am relieved that the panel is done and I shall await their feedback.

May 2010

I have met with 'Tony' who used to live at the hostel; he kindly agreed to provide consultation regarding the Participant Information Sheet, consent forms, and interview schedule. Tony suggested ways the sheets could be simplified and made more user-friendly; now the challenge is to incorporate this feedback in a way that fits with the requirements of the REC.

I also received feedback from a staff member on the Participant Information Sheet, consent forms, and interview schedule. Overall the staff member felt they were clear and informative; there were no suggestions for amendments.

I have compiled my response to the REC in its entirety and returned it.

June 2010

16th June 2010

Today I received written confirmation that my proposal has been approved by the REC.

July 2010

27th July

Today I received confirmation of R&D approval, great, I am all set to begin recruiting.

October 2010

As a compliment to searching electronic databases, I have contacted some professionals working in relevant clinical areas. Personal contact from Mike Slade (re. recovery amongst forensic populations) and Sarah Allen (working in FMHS in south London) has provided reassurance that I am not missing any areas of literature of relevance to my study. I have also been informed of a booklet containing personal accounts of recovery written by consumers of FMHS. As a preliminary thought I am wondering whether this documentation may be useful in terms of triangulation.

November 2010

I have completed my first draft of Part A and sent it to both Sue and Brian for their comments. It feels like a relief to have some structure imposed on the available literature; I await their feedback and continue to conduct regular searches to ensure an exhaustive review.

I have visited the hostel and gathered the names of residents and staff who are willing to participate in the study. I am really keen to start data collection now.

December 2010

December 6th

I completed my first interview with a resident at the hostel today. I am struck by the amount of information shared by the participant and I am also aware of a sense of sadness about what this participant has gone through and how others have been affected by this and his behaviours. My personal beliefs about offenders' right to 'rehabilitation' will have shaped my reaction to this participant's story; I am likely to have heard some elements of his journey differently to someone who is a stronger advocate of punishment not rehabilitation. This interview was intended to be a pilot interview; the broad nature of the questions felt appropriate for this stage of the data collection process and I don't feel specific changes to the interview format are necessary. However the interview lasted well over 60minutes. I will discuss this further with Sue and need to develop the skills to prevent this happening in subsequent interviews.

In addition to memos, I note the following:

Am noticing the way in which psychotic symptoms obstruct any meaningful interactions with others; for this participant this feels rather drastic. I am struck by Geoff's feeling of not being helped in prison and the extent of distress being caused by his symptoms at this time. At this stage Geoff lacked understanding of these symptoms; line 578 onward Geoff links a later developing awareness of his illness with a desire to move forward.

Additional factors contributing to Geoff feeling as though he was receiving no help include not being listened to by staff and limited relationships with fellow service users at this point.

I am considering that the need for services/staff to control and manage people when they are unwell interferes with the building of patient-staff relationships; perhaps patients feel as though they are being punished for being unwell (if they possess insight that they are unwell).

At the beginning, Geoff deliberately lied to staff that medication was working in order to avoid being given more medication. Geoff recalls various severe side effects of medication at these early stages but how easy it was to disentangle these from other symptoms I am not sure. By the end of the interview, it is apparent that Geoff's attitudes toward and experiences of taking medication have become more positive over time; he has experienced benefits of medication.

I am struck by the pivotal role that patient-staff relations play throughout this interview. Geoff provides detailed accounts of both the helpful and unhelpful experiences that he has had during his journey.

Over the course of the interview I am aware of a shift in Geoff's views of himself and his interactions with others appear to have played a major role in this: at the beginning he thought staff were scared of him, were annoyed with him, and didn't care or listen to him. Over time he has experienced positive regard from staff, people are willing to listen to him, and people external to services accept him, even when they know about his offence etc. Although Geoff has anticipated stigma / rejection, he has experienced acceptance and love from others. For Geoff, rejection from his family has also impacted on his self-concept.

Geoff's developing understanding of his mental illness impacted his beliefs that he was "evil". When he recounts earlier experiences, they appear to have taken on board a different meaning giving his new-found understanding of/ knowledge about his illness.

At various points during the interview Geoff conveys a sense of achievement, he is proud of the progress he has made and the active role that he has adopted. I wonder to what extent this features in the journeys of others.

Geoff conveys guilt and remorse when he thinks about his victim's family.

Geoff conveys past trauma: I am curious as to the extent this is a common feature amongst this population

Geoff's psychologist was very influential during his journey. This positive relationship occurred after several short-lived and disjointed ones; I'm curious about the impact of relationship consistency.

Am aware that Geoff reiterates the severity of his illness at several points during the interview: is this necessary for him as an explanation of his offence?

Constant comparisons: for participants who do not have a faith, is there something else that has served a similar function for them?

December 7th

Having completed my second interview with a hostel resident I am aware of the many differences in both participants' experiences. Given the constant comparison method, it feels positive that there is a great deal of diversity encompassed within these initial interviews. As I transcribe the first two interviews I am already feeling over-whelmed by the variety of themes and ideas that are emerging from the data; however this also feels exciting and I am looking forward to beginning to analyse the data.

January 2011

18th January

I conducted the first staff interview today. I felt this went well and it was interesting to begin to hear staff perspectives on patient's journeys. I was struck by Louise' passion for her job and her dedication to do her best for the residents; I was reminded how the ethos/culture of the one service from which I am collecting data will influence the grounded theory that emerges. Louise spoke about residents' restrictions and the influence of these (memos); Louise acknowledged both the staff and service-user perspectives on this facet and I was reminded of the value of incorporating staff perspectives. Louise also spoke about day-to-day challenges that are faced by hostel residents; the broad array of factors that require consideration at this stage of service-users' journey really stood out for me. I was aware that Louise was hesitant at the beginning of the interview and asked on a couple of occasions if what she was saying was "right"; I was reminded of social-desirability bias and the ways the context of these interviews will inevitably influence what is shared (or not) by staff and residents.

In addition to memos I note the following:

Patients' restrictions (or lack of restrictions) are a focus of dialogue from the start. With some residents Louise gets the 'sense' that they arrive at the hostel thinking they can do "what they want to do"; Louise then goes on to explain how patients are very careful not to breach their restrictions and this does not feel consistent with feeling like they can do "what they want". Therefore I wonder if this is something feared by staff or is a reality experienced by patients; Louise does state that patients having restrictions makes them easier to manage from staffs' point of view. Further exploration of patients' expectations about environmental changes and attitudes toward continuing restrictions could help to elucidate further.

This staff member sees prompting residents to be more <u>independent</u> as one important part of her role.

Whilst coding this interview I am aware that the focus of service's/patient's attention and efforts is changing; it is becoming broader and has shifted from being mainly about mental health and individual factors, to including day –to-day factors emerging in life, e.g. finances, practical factors, and day to day chores. There is a sense of a return to normality.

Reminds me of how previous accounts in the existing literature that adopt a narrow focus, omit some very important aspects of the entire recovery journey.

During coding I become aware of various values of this staff member that likely influence the experiences of residents at this stage of their service contact: Wanting experiences at the hostel to be different to the 'chaos' on the ward / Determined to maintain boundaries and not to get pulled into doing 'too much' for residents (due to belief that this is not helpful in the long run) / It is important for residents to feel listened to / Important for staff to 'do their best'

Staff can fill a gap in patients' experiences of a parental role / maternal role

21st January 2011

I met with Sue to discuss the open coding that I have done so far. We spoke about the importance of action orientation during open coding; Sue pointed out examples of where I could increase the action orientation of codes. I will revisit all open codes so far and amend where necessary before sending to Sue for her to re-check. During our next meeting we will discuss our open-coding of the same interview as a quality assurance check.

February 2011

I have now completed the first stage of data collection (four interviews) and analysis (open coding). Whilst the large number of open codes feels rather over-whelming, until I have more data to further clarify the processes at play, it does not feel possible (or helpful) to impose more structure on the data.

4th February 2011

I met with Sue to discuss open coding. Sue has coded one complete transcript and it was assuring that our thoughts upon 'in vivo' codes were largely similar and seemed to suggest validity of the current coding. She once again helped me to make some of the codes more action oriented, for example 'knowledge and understanding about mental illness' was

changed to 'gaining knowledge and understanding about mental illness'. From the interviews coded so far, certain actions are emerging: Taking an active stance to treatment (e.g. complaining about the system/staff in order to effect change) / Building relationships with staff and service-users / Recovering from the symptoms of MI / Engaging in therapeutic work / Taking on more responsibilities.

In future interviews, it seems important to focus upon internal processes/changes that were experienced. At the moment, data is more heavily focused on the external factors that are maybe more tangible. This raises the issue of patient insight and whether even at this later stage as patients prepare and begin to reintegrate with society, they have insight into the internal and psychological changes that have occurred during their journey.

Sue normalised my feelings of anxiety about the large number of open codes; she explained this is a common experience during the early stages of GT projects and she reminded me of why it is important to avoid imposing more structure on the data at this stage.

25th February

I attended the 'GT support group' with peers from the course today. We spent time discussing the different forms of GT and deciphering the distinctions and similarities between them. This helped to clarify/reiterate the processes I am following given my critical-realist stance. It was also reassuring to converse with others also feeling over-whelmed with the data at this stage; this was normalising.

March 2011

10th March

I conducted the third staff interview today. The staff member had difficulty thinking about residents who were more 'stuck'; this reminded me of a) social-desirability bias and whether it was difficult to talk about the more challenging clients, and b) of the service-specific nature of the emerging theory (see memos).

In addition to memos, I note the following:

Andy mentions poor physical health as a barrier to progress; a dimension that has not yet emerged from any other participants

Andy gives residents a lot of credit for "changing their mind set and their behaviours" and taking action to assist progress through the system is a large theme during coding of this interview. I am struck by the positive tone of the interview. E.g. line 196 onward: turns question about a resident's difficulties into a positive conversation about the determination and strengths he has shown. As mentioned Andy also finds it hard to think of a resident who has become 'stuck' or who has done less well; this reminds me of previous staff comments about adopting a positive focus and emphasising the positive changes and progress that residents have (and are) making. Andy's presentation in this interview could be an in-vivo example of this positive focus in action; I am also remaining aware of social desirability bias.

Family relationships can destabilise by being played out in inconsistent ways over time; can leave resident unsure of where they stand.

Potential functions of faith and spirituality: providing a sense of forgiveness, providing a source of praise and encouragement for steps forward, new friendships and connections, a source of acceptance from others.

I get a real sense of residents 'earning' the increased freedom afforded by progressing through FMHS. As in previous interviews I am left considering the tension between moving forward, thinking about the future and adopting increased responsibilities, and the uncertainties and anxieties that can surround this; from this interview it appears the continuing support, encouragement, and empowerment from staff are crucial in this process.

As with Louise, there is a sense of things being 'different' at the hostel than in the MSU, e.g. Andy talks about residents' feedback about being listened to.

Consistency and familiarity in patient-staff relations again emerges as important.

I get a real sense of patient – staff collaboration during this stage in the journey. Andy talks about encouraging and supporting residents with day to day tasks / situations they face but it is very important for him that decisions are joint and that he is empowering residents in order to prepare them for dealing with future situations. Provides a powerful analogy for this process: "there's the crawling, the standing up falling over, to getting up holding on to

surfaces, to letting go, to actually walking**...**to running or jogging to running". Process of progression and development is very apparent here.

Andy describes the importance of residents understanding about their mental health difficulties and what signs indicate that they might be becoming unwell. He uses previous experiences of working within generic-MHS to make the judgement that some patients within FMHS can find it more difficult to develop this increased understanding, but that it is equally as important with this client group. Even at this later stage in service contact, Andy views it as part of his role to encourage patients to reflect on patterns in their behaviours and symptoms in order to increase understanding/insight.

Andy reflects on a more general sense of 'returning to normality', e.g. being around other people, engaged in 'normal' everyday tasks. However there can be a continuation of 'institutionalised behaviours', I wonder about the functions of patients retaining some of these behaviours (reduce anxieties about everything changing, i.e. retain aspects of previous functioning; lack skills to behave differently; staff will perhaps remain more involved and available). Lines 952/991 – provide examples of residents continuing to rely on staff support and input at this stage.

Towards the end of the interview, Andy shares a less favourable situation in which he describes how his initial interactions with one new resident had been unhelpful. It feels healthy and more valid that Andy is able to discuss this less idealistic situation and provides an example of a consistent/familiar patient-staff relationship enabling both parties to over-come difficulties and to eventually achieve a trusting and safe relationship.

15th March

I conducted two further interviews with residents today and I really feel as though the momentum is picking up now. During the interviews I was aware of the re-emergence of many themes that are already contained within the provisional analyses; it was necessary to remind myself of the importance of remaining open to information that does not 'fit' with the emergent theory during analysis (negative cases).

16th March

Marking the end of the second stage of data collection, I conducted another service-user interview today. During the processes of transcribing and applying focused coding to the second stage data I am beginning to feel more attuned to the prevalent themes and categories within the data although am constantly reminding myself of the need to remain sensitive to new information emerging from the data.

It feels challenging to know how best to organise the data and using the 'long table technique' described by a fellow trainee I have physically grouped open codes (written onto small bits of paper) into groups representing a focused code, and these combine to form sub-categories. I appreciate this is very malleable at this stage and the emerging framework needs to be constantly responsive to issues emerging from the data. It does feel difficult to maintain this flexibility at times when I strongly desire some structure and clarity from the data.

29th March

I met with Sue today and we looked at my focused coding of one transcript. Sue's own coding was largely consistent with my coding and together we discussed some potential ways that sub-categories and focused codes could be collapsed. In particular 'relationships with staff' currently contains many focused codes and we spoke about how the sub-category 'staff don't care' encompasses many of the dimensions emerging from the data. Following our discussions Sue recommended that I revisit all of the second stage data with the aim of discovering new facets and concepts that do NOT fit with the emerging model as currently conceived. It was useful for Sue to re-orient me to the research questions at the core of this project; with the mountains of data available to me, I lose sight at times of the central focus.

I also attended the 'GT support group' today. We discussed the different approaches we were taking to triangulation and definitions of theoretical saturation. It was useful to hear differing perspectives and the discussions about triangulation confirmed that the booklet I have found (OUR STORIES) offers a promising source of triangulation data.

April 2011

I have continued to analyse the data from all eight interviews, and along with Sue's suggestion have reviewed transcripts with the aim of discovering additional elements. This process is so far showing that the codes do encompass the major facets contained within the data.

Now that the April deadlines are over, I feel relieved that I can immerse myself in this project and the data. I continue to develop my Part A and feel as though this is shaping up; feedback from Brian and Sue has supported this.

As I begin to think about the next interviews, I consider the characteristics/experiences of service-users that would be indicated by theoretical sampling. I inform Brian that I would like to conduct two further interviews with service-users awaiting transition to the community; Sue and I have agreed that incorporating the experiences of people at a slightly earlier stage of service-delivery could help to elucidate further processes that occur whilst in low-secure settings and when awaiting the move from secure conditions to the community. Other characteristics that I requested Brian consider when approaching potential participants were faith/spirituality, family relationships/contact, degree of insight into offending and mental health, previous experiences of forensic/mental health services.

May 2011

19th May

I conducted my 9th interview today.

In addition to memos, I note the following during the interview / analysis:

There is a sense of chaos at the beginning of Harvey's story; as for other patients this was perceived as attributable to symptoms not being under the control of the right medication, over time there was processes of experimenting with different medications until a more stable/calm state was achieved.

Negative case: Unlike other participants Harvey finds it difficult to describe the positive effects of medication, for him his compliance with medication appears more attributable to his knowledge of staff members' attitudes and requirements for compliance.

Harvey talks extensively about negative effects of medication; for him they influenced his interactions with other people in the past (dribbling when speaking), and have left him with more permanent scars which he feels are 'embarrassing'. This is similar to other patients but brings in the new dimension of whether patients are warned about these side-effects and helped to manage them or not.

Like others, Harvey has developed an increased understanding of past behaviours and patterns, for example he talks about taking drugs exacerbating his difficulties.

Harvey has experienced 'being well' over time; linking with another sub-category he describes how this influenced him reaching a place where he wants things to be different in his life. Other things have also influenced him reaching a place where he wants to settle down and 'never go back' to his previous behaviours that were responsible for his entry to FMHS: finances, wanting to avoid trouble, for his family.

For Harvey, living independently and learning that he can do things and handle responsibilities has been important in moving forward in his journey. This links with sub-categories of self-esteem and the overall sense of a 'return to normality'.

Like other participants Harvey has experienced the positive /negative influences of peers (Line 246/894 & Line 614). As a result of Harvey's desire for things to be different and to avoid FMHS, he has deliberately altered his friendship networks. Conveys a sense that his new friends are 'real' friends and his old friends don't visit him (as previous).

Relating to the existing category 'Knowing staff are there', Harvey explains that the availability of staff / services provides him with more confidence to try things and to aim for things. There is a sense of him being monitored by those that support him; they are there to provide help when needed. The importance of receiving encouragement from staff is apparent; for Harvey this makes him more determined to continue making progress, and makes him reflect on his own behaviours towards others.

Harvey spends a lot of time talking about his life before FMHS, like other participants he conveys a real sense of regret. He presents an optimistic belief that if he had been patient he would have stayed away from trouble / had a good life.

Negative case: Harvey said he had not had negative experiences with staff during his time in FMHS; I was surprised at this given previous accounts and the centrality and intensity of patient-staff interactions.

(I do note that at other points during the interview Harvey talks about some 'outbreaks' with staff; these were brushed aside as 'nothing important' and perhaps minimised)

Alluding to some strained aspects of relationships with staff, Harvey described how other patients had experienced difficulties with staff (e.g. not trusting staff), but did not describe personal difficulties from his experiences.

Like other participants, Harvey describes an increasing awareness of emotions and developing strategies to manage these

Family: detailed accounts of emotional (line 663) and practical (line 682) support they provide. This has been instrumental in Harvey's progress forward, not only in terms of communicating with services, but in terms of providing emotional support. Harvey is keen to show his family he is making progress/doing well; this provides him with further motivation to progress, to accept the help of others, and to do what he can.

Whilst transcribing and coding this interview I was aware that no new material totally unaccounted for by the existing sub-categories emerged from this data set. After discussing this with Sue, it was agreed that if this was the same for the tenth interview, data collection would cease and I would move onto the triangulation stage.

26th May

I conducted my tenth interview today and given that this may have been my last interview, I felt pressure to gather as much information as possible in order to enhance my current data set. Again, no completely new themes or concepts that aren't accounted for by the existing sub-categories at this stage emerged and therefore it was decided to cease data collection.

A **negative case** emerged from the tenth interview. Like Harvey, Aaron said that he had always found relationships with staff to be positive and supportive and did not recall any difficult aspects of these relationships. I note that neither of these participants had experienced prison; this new data is consistent with the previous indications that for some the sub-category 'staff don't care' is by far more prominent and notable during prison and the very early stages of contact with forensic services.

June 2011

As documented in memos, whilst coding the 9th and 10th interviews I was struck by the ways that data really extended my understanding of existing sub-categories and the ways they influence each other. Harvey provided insight into why family support can be so helpful and assist progress, what factors influenced him reached a place of 'wanting to move on from the old me', and interview data help explicate how relationships with other peers are experienced as supportive at times. This data has increased my confidence that the existing model accounts for the current data and meets Strauss and Corbin's definition of theoretical saturation.

With the emergent model in mind, I have reviewed each of the transcripts and feel pleased that the model accounts for participants' experiences accurately. This selective coding process also reiterated how despite the commonalities and relevance of the same concepts, participants' experiences remain very individual given that they are dependent on the combination and nature of experiences relevant to each category/sub-category.

17th June

Today I attended the 'GT support group' where I took my preliminary results and supporting documentation. It was helpful to have others' views on the draft result write-up. With regards to the preliminary model, others' enquiries encouraged me to explain the data analysis and quality assurance processes employed. It was also helpful to see the alternative ways in which people have presented their results and to consider the pros and cons of these.

20th June

Today I sent out the respondent validation documentation to participants.

July 2011

3rd July

Today I sent off the 'end of study declaration' to the REC, and a brief summary of findings to both the REC and R & D department. It feels rewarding to have some coherent results to share and report to others

Appendix 11: Coded triangulation data take from 'OUR STORIES: Moving on, Recovery and Well-being' (South West London and St. George's NHS Trust, 2010)

1. George's story

I am a man in my thirties. Growing up I got into some bad company, I started taking lots of drugs which I think caused my mental breakdown. I started hearing voices, some scary, some comforting. I came to the Shaftesbury from prison, I wasn't taking my medication properly and I was in a bad way when I was transferred. At my worst, I put a window through on the ward, I spent some time in seclusion and was restrained and injected with medication.

When you're in the ward, you help each other. You're always around someone if you want someone to talk to or sit with, it can help. I tried to keep myself to myself and avoid any trouble but at the same time it was important not to seclude myself completely.

I learnt that it's best not to try and fight your team, you need to keep moving forward, try to meet them halfway at least. They can help you set and achieve goals, together you can take steps towards what you want to do with your life. It's good if the team can be as honest as possible with you, it opens the door. I needed to hear what the team wanted me to do, it gave me a realistic goal.

I tried lots of different things such as pottery, woodwork and gardening. It was helpful, gives you an incentive, something to do. With me, I didn't want to go into half-heartedly, you have to want to do these activities. Try and find a focus, try something new to find out what you want to do, find something you like.

When I left the Shaftesbury Clinic, I went into a few hostels, they helped me out tremendously, gave me a routine with meetings, cooking, cleaning, looking after myself. It might seem like basic things, it's things we all know how to do; it's about fitting it into your routine. It's important to eat properly and keep good hygiene.

I'm here now [in my own flat] because I know what I need to so, to get to where I wanna get to. That's what I work on, I set a little goal, not a goal that is unachievable. It makes me feel better inside myself when I achieve it. I always tried to see the light at the end of the tunnel, seeing that I can get out. I didn't want to stay in hospital, I wanted to be independent and look after myself. It's because I wanted these things that I could have a go at getting them.

The biggest goal I achieved is taking my own medication, which is needed for independent living. When I was in the hostel, that was the thing that helped me reach here. I rely on medication, I've been taking it for 6 years, it would be nice to come off the medication but my doctor says different. Personally, medication sedates the voice, makes it feel controlled. Without the medication, I'd probably be in a different state altogether, which can be pretty intense.

Comment [C82]: Recognising influence of peer relations

Comment [C83]: Chaos

Comment [C84]: Developing supportive peer relations

Comment [C85]: Alludes to potential o bullying and possibly necessity of sticking to norm of 'keeping self to self'

Comment [C86]: Being encouraged by staff

Comment [C87]: Improving communication

Comment [C88]: Developing a focus

Comment [C89]: Adapting to change in environment with continued staff support

Comment [C90]: Sense of 'returning to normality' is very apparent here

Comment [C91]: Developing a focus

Comment [C92]: Wanting things to be different

Comment [C93]: Self-medication as part of 'getting well'

Comment [C94]: Professionals requiring medication compliance

Comment [C95]: Medication works

I've got a good relationship with my community team, it all depends on how you speak with each other, you have to give a little and take a little. Staff have always been helpful to keep me moving on, sometimes it's only little things like making a phone call to help set up everyday things like gas bills. They help me budgeting for a monthly shop. It might seem like simple things, but it's the little things that matter really. They help me out with booking courses and arranging voluntary work for me, I'm trying to get to the stage where I can do this sort of thing by myself, that's another goal to work towards.

Looking at it, I would have liked to have found a way to keep control without the medication, I think they rush into giving medication too fast, it affects how I operate, if I could control myself without medication I'd be a completely different person.

Another thing that I found difficult was the fact that in hospital you have to work to get garden/ground leave. On the one hand, it's good that you're developing it slowly, but for the first few weeks, I hadn't even been in the garden.

In hospital, it was also difficult to deal with when staff leave, particularly when you have to go through the same old stuff with somebody new. It's good to get used to though, change happens and it makes you a stronger person. It develops your communication skills, you can express yourself with other people and get your side across.

Now, I have a greater understanding of my diagnosis of schizoaffective disorder, I see sense in it. Looking back, I can see now how the drugs had a bad effect on my mental state. I count myself lucky I am where I am now. I've learnt that crime doesn't pay, if you can avoid getting into any crime, take that get out. My family have disowned me because of my past behaviour but life goes on, life is what you make it.

Now, I feel like I'm getting there, slowly but surely, I'm on my way to living the life I want to live. I'm happy with life at the moment, I'm in my own flat now, my daily routine is good, which I find important, things are falling into place. I'm involved in a group in the community that helps people deal with similar symptoms I have experienced in the past. I've been clean for 5years, I've been dry for 10years. I've stopped smoking for 2years. The thing that keeps me away from drugs and alcohol is I guess I don't wanna spoil it, it's a good thing to say I've been off it.

The only thing I feel is missing is it would be nice to have a relationship, I feel ready for it. I'm starting to develop some close friendships through the different activities I am involved in now which is a start.

The fact that I'm on a Section 41 gives me restrictions, if I want to go travelling it creates a few problems. I'm nervous that things might go wrong if I went abroad. Although sometimes I feel safer being on a 41, if I did relapse, they can pull me in before I do something silly.

Since being in the community I've developed a keen interest in martial arts and I'm learning gardening as a trade. Take advantage of the opportunities you get given, I've taken some

Comment [C96]: Adapting to change but there is a continuing need for support

Comment [C97]: Control over environment ; lack of control over activities

Comment [C98]: Coming to understand experiences as mental illness

Comment [C99]: Rejected by family

qualifications, I want to build up my C.V. so I can get the necessary business skills to become self-employed.

Things That Helped Me Most

- Concentrate on basic living skills, eat healthily, keep yourself clean and keep yourself active.
- Find a focus, something you enjoy.
- Set yourself small achievable goals and sit down with your team about how you can work towards achieving these.
- Take advantage of the opportunities the OT can offer you, try lots of different things until you find something you enjoy doing with your time.

2. My story

I am a man in my forties. I was at my worst two years before I went into forensics, I was still very unwell when I first went in. I was hearing voices, I was doing a hell of a lot of drugs which I thought would ease the suffering I was going through, but looking back I realise it only heightened my experiences, the voices and the bad thoughts. The voices were very distracting, I felt I was bad company, I lost a lot of friends, they understand now. It was really hard for my family, they didn't understand what was going on.

Before I came to Springfield I was in prison, I was referred to the doctor there who recommended I go back onto medication that I had previously been on, at the time I was too unwell to understand and I didn't think it would do me any good. I agreed to take it though and started to make a bit of progress, but then I was transferred to Shaftesbury clinic.

When I first went in, I felt hopeless, I was lost, I was looking around me at the other people that were unwell. I'd just come from prison, it was a totally different environment. There wasn't much hope to start off with at all, I thought it was the end of my world. I couldn't believe I was in there, I thought I'd be out quickly, but I realise now how ill I was.

After about two months on the same medication, the voices reduced to a faded voice and then they disappeared completely. I'd been struggling with them for two years, banging my head against the wall, screaming for them to go, all of a sudden this 'wonder drug' as I see it, done the job for me. That was like the happiest day of my life, to be able to have a normal conversation and concentrate on what someone was saying to me.

I set myself goals and targets to help me along the way to recovery and I've achieved every goal so far. I knew if I wanted to get better, and get out, I had to do something, I had to comply with my medication and I knew that I couldn't carry on like that or go back to being how ill I was, I never realised how bad I was until I look back now.

Comment [C100]: Realising impact of past on others

Comment [C101]: Feeling hopeless, at this point does not have 'something to aim for'

Comment [C102]: Medication works

Comment [C103]: How 'getting well' was experienced by this person

Comment [C104]: Something to aim for

Comment [C105]: Wanting things to be different

I took a long hard look at the situation I was in, I'd look at other patients and think, why are you still here? You need to change your attitude, the only way to get out is to adhere to the rules and show progress. I decided to take responsibility for myself. There was no one to tell you, people dance around you when you're unwell, they tiptoe around you 'don't worry, you'll get there in the end'. You need someone to tell you to set you mind to getting out and what you need to do to get there.

Comment [C106]: Wanting things to be different

I realised quite quickly that you can't beat the system so I set myself goals, listened to what I was told and went to my groups. I was hoping to get ground leave, it took a bit longer than I expected but I knew I was really unwell so I guess they took that into consideration. That bit of open space really did help though, it was hard to go back in sometimes, especially in the summer. Then progression stared, I moved to unescorted leave, was allowed to have my wife and children visit me in hospital. It took a long time and it was frustrating at times with so many hiccups along the way and kept putting the tribunals date back, but I kept at it and I'm out now.

Comment [C107]: Lack of control over physical environment

Getting off drugs absolutely helped with my recovery, I felt that I was well on the ward for quite a long time, then I stated to go out on leave, I felt I was ready for the world when I was on unescorted ground and community leave. Not having drugs played a big part on me getting to that point.

I'm luckier than others, I have my family who come to visit me and love me. That's where my hope comes from, to get back home and be a father and husband again. My Mum used to make the effort to come even when she wasn't well. I had a couple of friends in there, like other patients who had the same ideals. It helped to have people around you who had the same motivations rather than people in denial, who say they're well but constantly talk to themselves. It helps to take your mind off your own problems, helps to take the depression away, you do a lot of thinking in a place like that, you know, it's hard to go off and be by yourself and have time to yourself.

Comment [C108]: Family sticking by / supporting you

Comment [C109]: Developing supportive peer relations

When my family had left after visits, it was hard to say goodbye. I had no one, general conversation with patients was only about drugs, sex and alcohol. Sometimes it would have been better to have a conversation about the news, just a normal conversation. I often wanted more time with staff to really talk about things. It was hard to tell some staff if you had problems, because you were worried with how the team would react, and you'd wanna move on. It's a shame really, because you'll take the problems out with you if you're not honest with the team.

Comment [C110]: Barrier to improving patient-staff communication

It's so stifling in that place, I felt claustrophobic, getting out into the garden was a godsend, they don't do it enough, you should be allowed out into the garden more. I felt very frustrated and you haven't really got walking space, you're so fed up of being in your room as it is. You have to just keep pacing around and then your thoughts are just running around in your head.

Comment [C111]: Lack of control over physical environment

I've been offered drugs, but I know it contributes to my illness. I managed to say no. I'm happy for that, I feel good in myself for saying no, it was a big achievement.

Comment [C112]: Being proud of own efforts, contributes to building of self-esteem

I don't think there was enough information about what the team were thinking and why they were doing certain things. I had a CPA once every three/four months, I went a long time without hearing anything about my progress. I didn't always find ward rounds very useful, I think they were repetitive and I didn't get seen for long enough.

I think it would have helped to have been told about the progress I'd been making more regularly and how I could go along further. Having specific targets with a key worker was really helpful.

I was elated the day I left Springfield, I couldn't believe my luck. At first, I had difficulties in myself, trying to break out of my shell, and be sociable again. I found myself being withdrawn and not my usual chatty self. It's taken 6months but I feel like my old self is coming back. It's taken a while to get there and I think hospital took that away from me. It's really about getting myself back to the man that I wanna be.

When I first came into a hostel, I was only able to see my wife and kids under supervision, and now I'm allowed to visit the house to see them unsupervised. My next goal is to move back home. I've got three goals left: move back home, get a job and hold it down and live life the best I can and make up for lost time.

I have plans to do voluntary work about helping out in the mental health area, it would be great to have experience and I have plans to set up some sort of visit system for people that don't have family and friends on the outside, it's too lonely in there. I think visits play an important part, if you haven't got inspiration from the outside, you're certainly not getting it on the inside.

I like to go to the pub with the other fellas. I'm only allowed to drink 2 pints a week, I adhere to that, I've agreed with my team. I feel I have more control over my life now, the two pints rule was agreed together rather than the team telling me what to do. You start to learn about responsibilities, making judgement calls about putting myself into risk situations. It's part of the process of getting back into control, testing myself out.

At the moment I work part time, although the job itself is not for me, I'm hoping to find something else and maybe move into full time work as well.

Comment [C113]: Communication barriers between patients-staff

Comment [C114]: Communication barriers between patients-staff

Comment [C115]: Adapting over time to being in a different environment

Comment [C116]: Developing a focus

Comment [C117]: Increasing equality with patient-staff relationships

Things That Helped Me Most

- Take a look at where you are, look around you, know that that is not the place for you.
- Listen to your team, learn from others.
- Don't be tempted by drugs, obey the rules.
- If you want to move on, don't be afraid to ask for help, don't get stuck in a rut with people that are gonna bring you down.
- Opportunities are few and far between I think, you need to take them when you get them.

Appendix 12: Salomons ethical approval letter

Appendix 15: Process of category development

The information below tracks the coding process and the development of categories and sub-categories. During this process, the codes / categories were constantly refined, amended, and renamed on the basis of information emerging from data analysis.

1.Open codes

The following 262 open codes were generated from the first stage of coding:

Gaining knowledge and understanding about past and current mental illness

Confusion around symptoms of mental illness

Ineffective management of illness-related distress

Reliance on medication to manage illness	Negative effects of medication
Being severely mentally ill or distressed	Being well / symptom free
Staff attributing behaviours to mental illness	Desire to be well
Pre-occupation with (mental) health	Wanting to die
Staff not trusting or believing you	
Puzzled about staff's beliefs / motivations	Staff being scared of you
Being a burden to staff	Staff being nasty
Staff ignoring distress	Staff not noticing distress
Staff offering unhelpful suggestions	Staff being unhelpful
Staff not listening to you	Staff listening to you
Not giving away too much with staff	Staff picking on you
Staff arbitrarily dictating	Staff not being sensitive
Staff understanding	Staff not interacting with you
Staff not having time for you	Staff being approachable and available
'them and us' staff – patient relations	Being treated as an equal by staff
Staff acting coercively	Poor treatment by staff

Staff feeling powerful

Staff not explaining

Knowing where you stand

Friendships with staff

Staff actions (or inaction) as a provocation

Staff talking down to you

Building (strong) relationships with staff

Being treated normally

Mutual respect between staff and service users

Reliance on particular staff members

Staff checking on your welfare

Personal address by staff

Staff giving to patients

Feeling cared for by staff

Staff keeping patients safe

Staff being open and honest

Staff instilling belief in own abilities

Staff encouragement to engage in activities

Staff encouraging individuals to be hopeful, i.e. focus on the progress they have made, their future

Staff committing to finding out information for you

Listening to and appreciating a genuine staff member

Frequent staff changes impeding staff-patient relations

Staff changes as frustrating and detrimental to trust and therefore progress

Opening up to a familiar staff member

Assurance that contact with therapeutic staff will be ongoing / consistent

Standing up to staff

Resisting a test / treatment proposed by staff

Bargaining with staff

Taking action to get staff changed

Staff providing residents with boundaries

Consistency enabling trust

The building of trust requires effort

Making a decision to trust a staff member

Having confidence someone can be trusted

Trust enabling the sharing of feelings and experiences

Feeling grateful for staffs' attention

Staff not delivering promises / letting patients down

Lack of trust damaging patients' outlook on the future

Wanting to share with others but not knowing who to trust

Restrictions on material goods

Physical restriction as frustrating and claustrophobic

Loss of personal possessions

Imposed diet restrictions

Fewer physical restrictions

Horrible physical environment

Peaceful, relaxed environment

Safe environment

Homely environment

Environment change triggering motivation and activity

Restrictions as containing and providing a focus

Management difficulties in the face of few restrictions

Peers being out for what they can get

Sharing amongst peers

Being fearful of grassing

Resisting being bullied

Putting on a front due to fears of others' perceptions and responses

Expecting conflict and confrontation from peers

Being separated from bullies

Peers introducing themselves

Increasing interactions with peers

Supporting each other by sharing experiences

Ineffective management of bullying

Bullies having control over you

Blocking out emotions

Inability to cry

Denying / bottling up emotions

Psychology as a box to tick

Appreciating the benefits of therapeutic work

Disclosing traumatic experiences for the first time

Patient change triggering a quieter group / less disclosure

Commitment to attend therapy

Being given time to relax and feel comfortable in therapeutic relationships

Autonomy to come to own conclusions in therapy

Feeling in control of what is discussed in therapy

Access to varied modes of expression Adopting a role involving responsibility

Experiencing responsibility for the first time

Increasing responsibility for day to day tasks

Staff support with increasing responsibilities

Feeling angry about having to take on responsibilities

Difficulties adopting more independence

Increased financial responsibility as a risk factor

Being given responsibility for own medication too soon

Being upset by considerations of victims family's grief

Reduced upset when considering victim's family's grief

Considering the impact actions have had upon multiple others

Realising the enormity of the situation

Difficulties maintaining family contact in restricted conditions

Adjusting to changes in personal relationships

Family providing a link to the real world Avoidance of thinking about family

Family sticking by you

Desire to reconnect with family / establish new familial relationships

Family dynamics as a recurring difficulty Family relationships as destabilising

Being disowned and rejected by own family Perceptions of family hating you

Family members' attempts to keep you restricted

Ongoing friendships with service-users met during the recovery journey

Connections / friendships with non-service users (church)

Acceptance by members of the church who are aware of mental illness / offence

Being cared for by people who know about mental illness / offence

Others being considerate

Realisation that previous acquaintances were not ‘friends’ as was once thought

Previously using the church to obtain money and food

Finding God as a turning point in life Church as helpful

Gradually engaging in Christianity

Faith providing motivation to focus on future

Reason for living has changed – live for god versus living for the weekend / fighting

Fear that commitment to God would wane upon release

Increased commitment to God following release

God keeping you on a straight path Earlier belief about being evil

Learning to understand past self and behaviour as mental illness, not badness

Expressing previous life experiences

The difficulties and pain caused by disclosing previous experiences

Wanting to avoid talking about past experiences

Developing an understanding of oneself and past behaviours

Prisoners resisting the services’ programme Being disruptive in order to get noticed

Ability to consider others’ perspectives

Recognising self as a danger to others

Recognising old lifestyle as a future risk factor

Devising strategies to manage anger Being able to rationalise

Making the decision to be honest / share experiences as part of taking responsibility for getting help / recovering

Patients’ motivation to be helped as a necessary condition for change

Personal dedication / effort involved in ‘getting out’ the system

Wanting to avoid ending up in the same situation as before

Motivating self to achieve qualification

Commitment to achieving small steps towards an overall goal

Lack of future aspirations	Lack of hope
Developing a future-oriented perspective	Looking forward to future progress
Putting life back together again	Seeing the light at the end of the tunnel
Desire to integrate back into the community	Staff being vital to the recovery journey

Expectation that public 'hate' you

Surprise at acceptance of members of the public

Being given a gift from a member of the public

Belief one is incapable of learning

Achievement of a qualification bolstering self-belief / confidence

Increasing confidence and assertive communication

Limited confidence and assertiveness as a trigger for 'using'

Realise personal vulnerability and the need for others' help

Fears of interacting with others	Confronted with tests and temptations
Continuing need for staff support and attention	Fear of relapse / taking a backward step

Taking extreme care not to breach restrictions

Comprehensive care plan compensating for a lack of insight

Invalid assumption that patient insight is associated with better progress

Patient denial of mental health problems	Physical well-being being neglected
Consideration of diet and exercise	Other prisoners self-harming
Believing one deserves to be punished	Anticipating rejection from others
Relief that help is to be received	Being proud of own efforts
Freedom to cook and to choose food	Experiencing job satisfaction
Being blamed by family for mother's death	Blaming self for mother's death

Explaining offence and how it links with symptoms / past experiences

Confusion about one's own reasons for offending

A remaining fear of confrontation	Fear of father

Concealing self-harm (in the past)
Relieving pressure by talking
Resistant to non-voluntary status
Losing sense of what is going on
Practising to confront others (practising to confront fears)
Feeling ashamed about previous victimisation
Art as relaxing
Eager to move on from prison
Unclear expectations of hospital
Stereotypes about hospital
Anger against staff
Difficulties talking when feeling low
Opportunity to achieve qualifications
Medication slowing you down
Encouragement from peers to engage with the hospital programme
Abstaining from previous behaviours; smoking, alcohol and sex
Individualised nature of recovery journey
Access to informal sources of support
Importance of individualised support
Accepting their situation
Patients' authority to decide how their journey is managed
Planning service provision in accordance with historical information
Catching up with age / maturing
Isolation as a risk factor
Labelling self as a murderer
Those who can't open up don't get out
Recognising prison officers' status
Anxiety about what will happen to you
Hope from hearing others' progress
People damage by their own anger
Medication helped to some extent reducing anger
Felt loved when prayer was answered and everything changed
Realisation of need to give up violence in order to get out of the system
Felt staff made an effort for him
Changing who he mixes with
Wanted to do a real course with a certificate
Sharing and opening up through poetry
Poetry as a way to self-understanding
Recognition of two sides to a situation
Request for change of medication being acted upon
Partly medication and partly change in environment that led to relaxing

It meant something that the only people coming to visit were from the church

Importance of gaining self-worth Setting up an AA group

Taking action to assist progress through the system

Lack of control over thoughts and emotional responses

Passive acceptance of not having control

Opportunities to be active / out of cell dictated by others (staff and other prisoner groups)

Gaining control over behaviours Having input to treatment

Expecting unlimited freedom at the hostel Attempts to set realistic expectations

Surprise at the extent of freedom afforded at the hospital

Institutionalisation and expectation of continued support structure

Fast changing realisation that release into the community is not as expected and brings with it difficulties

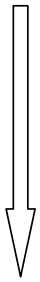
2. Focused coding

Based upon focused coding of further transcripts, the above open codes were condensed into the following focused codes:

Confusion	Distress	Ineffective management of illness-related distress
Medication works	Medication causes problems	Clinicians require medication compliance
Effects of medication as 'proof' of illness	Understanding past and present experiences as mental illness	Being well / symptom free
Self-management of mental illness	Nasty staff exercising power in unhelpful ways	Provocation of anger / aggression
Not getting what you need from staff	'them and us' relations	Being cared for

Being listened to	Being encouraged and empowered	Knowing staff are there
Equality	Patients adopting an active not passive stance	Communication barriers
Transparency	Consistency and familiarity promote trust	Trust enables expression
Building trust takes time and effort	Feeling able to trust staff or not	Unpleasant physical environment
Lack of control over environment, material goods and activities	Increasing freedom	Peaceful, relaxed environment
Difficulties living amongst others in distress	Bullying	Norms and expectations
Support and companionship	Anxieties	Adapting over time
Expectations not met by reality	Continued need for support	Understanding past behaviours
Awareness of emotions and developing management strategies	Aware of impact upon others	Aware of impact on one's own life
It's time to move on from the 'old me'	Purposefully behaving in ways that assist progress	Determined to avoid returning to secure conditions
Anticipating stigma/rejection	Building confidence	Self-worth
Hopeless	Looking forward	Developing a focus
Adopting increased responsibilities	Struggles adopting independence and responsibilities	Increased responsibility as a risk factor
Barriers to overcome	Motivation and commitment to get help	Expressing
Reliving difficult and painful memories	Being afforded time, consistency and autonomy	Deliberately changing friendship networks
Building new friendships	Rejection	Family sticking by and supporting you

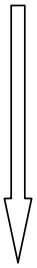
Family relationships as destabilising	Faith/spirituality provides an alternative outlook	Faith/spirituality keeps me focused on a straight path
Acceptance and love of others		



3. Sub-categories

Based upon further focused coding and then axial coding, the focused codes were condensed into 23 sub-categories.

Being in chaos	Taking medication	Coming to understand experiences as mental illness
Getting well	Being supported and encouraged	Increasing equality
Improving communication	Building trust	Control over physical environment
Establishing supportive peer relations	Adapting to environmental changes	Developing self-understanding
Becoming aware of the impact of past behaviours and lifestyle	Wanting things to be different	Building self-esteem
Something to aim for	Taking on responsibilities	Deciding to commit to therapy
Working through it in therapy	Managing friendships	Staff don't care
Family relationships	Drawing strength from faith / spirituality	



4. Categories

Sub-categories were related to six categories; further axial coding, selective coding, and triangulation enabled the categories and sub-categories to be checked and refined.

Learning about and managing mental health

Establishing facilitative relationships with staff

Moving on from prison and early experiences of FMHS

Developing self-direction

Doing work in therapy

Managing wider support networks

Appendix 16: Table displaying categories, sub-categories, focused codes, and example quotes

CATEGORY	SUB-CATEGORY	FOCUSED CODE	E.G. SUB-CATEGORY QUOTES
Learning about and managing mental health	Being in chaos	Confusion	"When you are assessed on the admissions or in prison they say to you why this and why that and you're like I don't know, that's why I'm here"
		Distress	"They didn't need to stitch my cuts because they were like pain to take away the pain in my head"
		Ineffective management of illness- related distress	"I was...put on the healthcare for quite a number of months which is not very helpful...you are banged up 23hours a day"
	Taking medication	Medication works	"I think medications...helped me it's helped me in situations where I was really angry er where I couldn't sleep"
		Medication causes problems	"It did help but it caused problems at the same time...it proper quietened me down and chilled me out and that but it give me like male breast tissue"
		Clinicians require medication compliance	"Generally they [hostel residents] stay on medication, its important they stay on medication"

	Coming to understand experiences as mental illness	Effects of medication as 'proof' of illness	"At first my Mum...she *wasn't* a great believer of mental illness...eventually when she saw I was getting better with the medication**....**she...changed her views on it"
		Understanding past and present experiences as mental illness	"All I knew is that I got intrusive thoughts which is a form of schizophrenia but I didn't know that until I was actually sentenced and got into the system"
			"They [psychologists] were the ones that gave me the understanding of my illness...of how things sort of went wrong and why they went wrong"
	Getting well	Being well/symptom free	"I can think more like my own thoughts...not feeling paranoid**....**I feel normal...I'm living my life"
		Self-management	"I am self medicated from my room...it is...something that I wasn't doing before"
Establishing facilitative relationships with staff	Staff don't care	Nasty staff exercising power in unhelpful ways	"I mean they were picking on me"
			"Some of the times I think they didn't really have respect for us"
		Provocation of anger / aggression	"I could feel myself getting really angry...no-one would help me...no-one would actually listen"
		Not getting what you need from staff	"They were more bothered about me not having a shower for a week**...**than the reason I wasn't having a shower"
		"them and us" relations	"I think they might have thought I was trying things on or something"

	Being supported and encouraged	Being cared for	"She had an enormous amount of compassion**...**and patience unbelievable patience"
		Being listened to	"There's been some good people...some good people that have listened"
		Being encouraged and empowered	"Its empowering them [residents]...and it's important it's their decision and not mine"
		Knowing staff are there	"I've got my primary nurse back at the [MSU name]....she's always there, she's always said to me...if you feel bad or you're feeling like you're in that place... pick up the phone and ask for me"
	Increasing equality	Equality	"I was with this member of staff all the time...doing loads of groups with him and everything**...**we kind of built up a friendship"
		Patients adopting an active not passive stance	"I had a lot of input into my treatment"

	Improving communication	Communication barriers	"There's a part of us [service-users] that don't want to say too much...that thing is going to stop us from moving on"
		Transparency	"You knew where you stood"
	Building trust	Consistency and familiarity promote trust	"At the beginning I didn't really trust them, I didn't trust them at all"
		Trust enables expression	"The more I got to know her the more I opened up to her"
		Building trust takes time and effort	"If you have to start building all that trust up again [with new staff member] you know it's really hard"
		Feeling able to trust staff (or not)	"I thought 'yes', you know, I could really build my trust up in this person...you know I can tell her anything"
Moving on from prison / early experiences of FMHS	Control over physical environment	Unpleasant physical environment	"People cutting themselves...blood in their cells...it weren't nice"
		Lack of control over environment, material goods and activities	"I'd want to be out my cell more and all of that but you can't"
		Increasing freedom	"The freedom of having your own front door key at the [low-secure unit] things like that you know...You had unlimited ground leave...and you get internal phones"
		Peaceful, relaxed	"Can begin to feel a bit more relaxed...it's more a

		environment	homely environment"
	Establishing supportive peer relations	Difficulties living amongst others in distress	"Some people become unwell...start troubling other people...it was stressful"
		Bullying	"It says no tolerating bullying [on the MSU] but that is the one thing I have to say they weren't very good at...they didn't punish it really either"
		Norms and expectations	"You can't tell anybody...you end up with a scar on your face and named a grass"
		Support and companionship	"Give each other support...talk between each other...and share experiences"
	Adapting to environmental changes	Anxieties	"I got to the end of my sentence...was nervous...able to go out...bit nerve racking"
		Adapting over time	"With time you get used to it [environment changes] you know"
		Expectations not met by reality	"They don't understand what it means to come here under restriction...someone sits them down and says well you can't do this...and you can't do that, they still have this sense of well I'm here and I can do almost

			what I want to do”
		Continued need for support	“Looking for high levels of support which is ok because that’s what we’re here for”
Developing self-direction	Developing self-understanding	Understanding past behaviours	“It [therapy] just makes them look at their actions...look at why things happened the way they did”
		Awareness of emotions and developing management strategies	“For instance if you are an angry person you might come up with strategies of how to combat your anger”
	Becoming aware of the impact of past behaviours / lifestyle	Aware of impact upon others	“Thinking about other people’s feelings and the implications of what I’ve done...I was just thinking about myself”
		Aware of impact on one’s own life	“I was only a young man when I went into hospital...now I’m nearly 48”
	Wanting things to be different	It’s time to move on from the ‘old me’	“Over the years I’ve mellowed out... realised it’s not the way to live”
		Purposefully behaving in ways that assist progress	“They [residents] are actually trying to change their mind set and their physical behaviour”
		Determined to avoid returning to secure conditions	“I’ve had urges to do it [cannabis]...but I just don’t do it anymore...know it would set me back”

	Building self-esteem	Anticipating stigma / rejection	"You get stigmas of people...you get labelled certain things like...it goes along with you until you die I suppose"
		Building confidence	"I've become more confident all the time"
		Self-worth	" It's a lot to do with liking myself more**...**I want to get on...I feel like I deserve it more"
	Something to aim for	Hopeless	"I couldn't see the end of the tunnel"
		Looking forward	"Now I think to myself it's time to sort of build my life"
		Developing a focus	"It [college and work routine] keeps me focused on something...keeps me alive in way"
	Taking on responsibilities	Adopting increased responsibilities	"[I've got] a lot more responsibility**...**it's good though...that was the aim of what I went through"
		Struggles adopting independence and responsibilities	" He [a hostel resident] finds it quite difficult to be just independent and do his own thing"
		Increased responsibility as a risk factor	"We've got to a stage where we feel they can self-medicate...then something will happen...so that can you know hinder their progress"
Doing work in therapy	Deciding to commit to therapy	Barriers to overcome	"At first I thought this is silly...I can't be bothered with all this"
			"I was a bit reluctant to sort of open up"
		Motivation and commitment	"You can just...wait for your date...or you can do

		to get help	something about it yourself"
	Working through it	Expressing	"I liked sharing in a way...like opening up with each other and sharing how we felt"
		Reliving difficult and painful memories	"Very painful...I used to write down like for hours...that was very very painful"
		Being afforded time, consistency and autonomy	"They didn't dive straight in there...they wanted more to help me relax and be comfortable with them"
Managing wider support networks	Managing friendships	Deliberately changing friendship networks	"Now I'm picking my friends carefully...I know that to make a friend means a lot...I know the bad ones"
		Building new friendships	"One friend that I've made...he's shown me a lot of unconditional love actually...and kindness"
	Family relationships	Rejection	"Wasn't...accepted by his family...there was no sense of forgiveness"
		Family sticking by / supporting you	"They're there to comfort me...will phone up...arrange an appointment to see staff"
		Family relationships as destabilising	"Service-users can leave and have issues with family"
	Drawing strength from	An alternative outlook	"God was definitely the main reason for...the majority of my shift in the bad things in my life...trying to focus

	faith / spirituality	Focused on a straight path Acceptance and love	on good” “ They [people linked with church] took me out for dinner on Saturday...they were really lovely and they care for me”

Appendix 17: Respondent validation correspondence

Salomons Campus at Tunbridge Wells

20th June 2011

Dear XXXX,

As you may remember, you kindly took part in a research study that I am conducting with Dr Brian McKenzie who works at the [clinic name]. The study is looking at how people experience forensic services and aims to build a theory that explains how patients progress through services.

At the time of your interview I told you that I would send you a copy of my results. I have now completed all of my interviews and I have enclosed a brief description of the preliminary results.

I am extremely grateful for your participation so far and would very much like to hear your opinion about the results that I have enclosed. I will be visiting [hostel/clinic name] in the near future and will contact you to gather any feedback regarding these results.

Thanks once again,

Yours sincerely

Clare Holt, Clinical Psychologist in Training

Department of Applied Psychology

Faculty of Social and Applied Sciences

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A model of the ways patients' progress through forensic services is briefly described below. I have enclosed a diagram that displays the model which contains six main categories: learning about and managing mental health, establishing facilitative relationships with staff, moving on from prison / early experiences of forensic services, developing self-direction, doing work in therapy, and managing wider support networks.

- Individual changes

People make different changes during their journey through forensic services. Some increase their understanding of their own behaviours, some begin to want things to be different in the future, some take on more responsibilities, and some find something to focus on and aim for.

With regard to mental health, as patients progress through forensic services, they gain a greater understanding of their mental illness and the ways this is best managed for them.

- Factors within forensic services

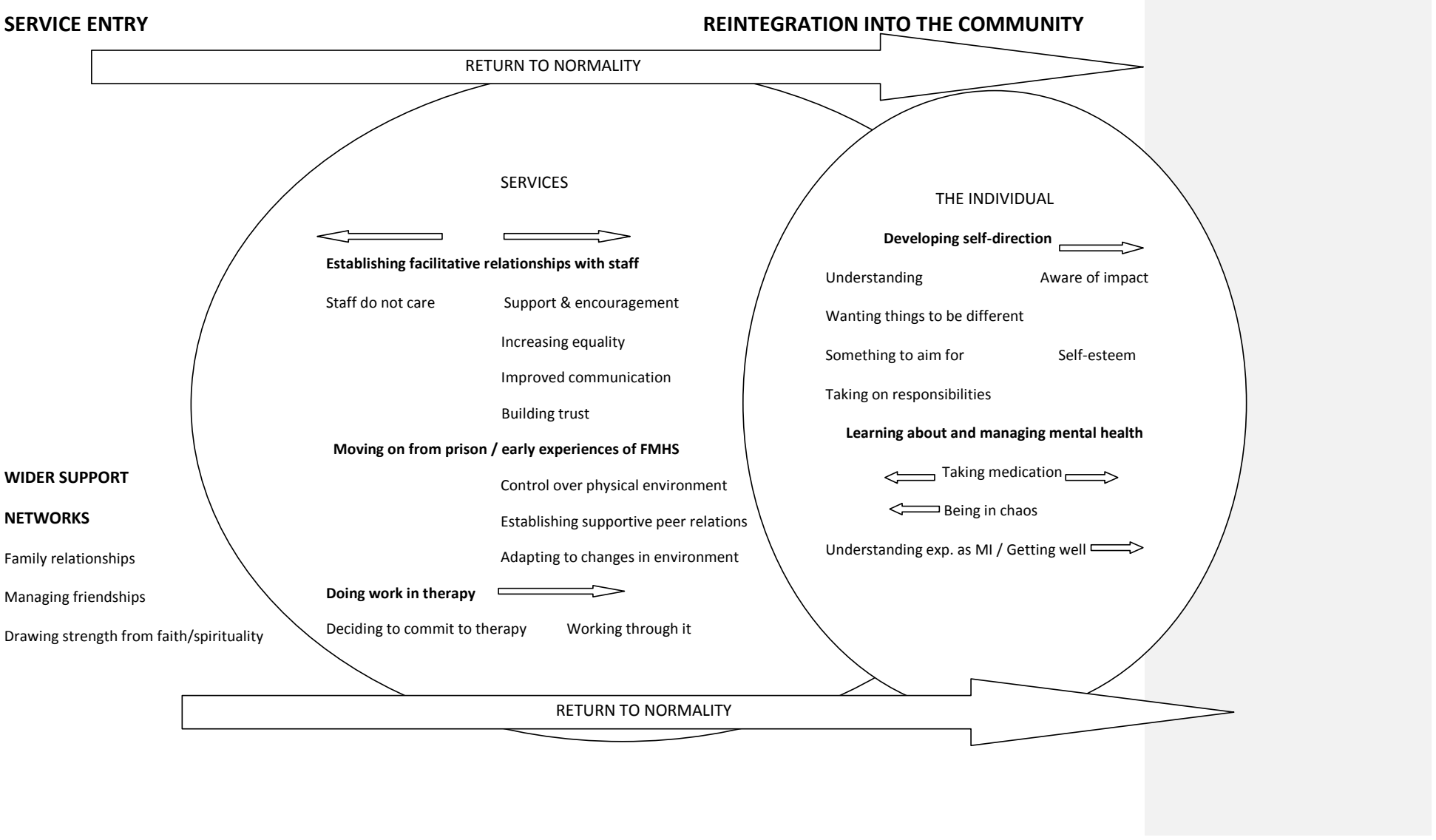
Findings showed that patient-staff relationships have a large impact upon patients' progress through services; these relationships can be very helpful but also unhelpful at times.

During their journey through forensic services, patients live in different types of environment; some of these are unpleasant and unhelpful whilst others are more relaxed and comfortable.

Findings also showed that therapeutic input is an important part of the journey through forensic services. Although engaging in therapy is difficult and challenging, people described how therapy can be very helpful in dealing with past experiences and understanding ourselves more.

- Factors outside of forensic services

Results showed that some key factors outside of forensic services influence patients' progress through services: managing friendships, family relationships, faith and spirituality. Everyone experiences these factors differently; whilst they help some people progress through the system, they cause difficulties for others.


SERVICE ENTRY
REINTEGRATION INTO THE COMMUNITY
RETURN TO NORMALITY
SERVICES
Establishing facilitative relationships with staff
Staff do not care
Support & encouragement
Increasing equality
Improved communication
Building trust
Moving on from prison / early experiences of FMHS
Control over physical environment
Establishing supportive peer relations
Adapting to changes in environment
Doing work in therapy
Deciding to commit to therapy
Working through it
THE INDIVIDUAL
Developing self-direction
Understanding
Aware of impact
Wanting things to be different
Something to aim for
Self-esteem
Taking on responsibilities
Learning about and managing mental health
Taking medication
Being in chaos
Understanding exp. as MI / Getting well
WIDER SUPPORT
NETWORKS
Family relationships
Managing friendships
Drawing strength from faith/spirituality
RETURN TO NORMALITY

Appendix 19: Brief summary of findings sent to the Research Ethics Committee and R&D team

Salomons Campus at Tunbridge Wells

Date: July 3rd 2011

REC reference number: 10/H0706/27

Study title: The rehabilitation pathways of mentally disordered offenders progressing from an acute forensic ward to a forensic hostel.

Dear [chair of REC/ R&D manager],

I am writing to inform you that the above titled research project has now been completed. The research was conducted as originally intended and the research objectives were achieved.

Summary of research and its findings

The UK's increasing population of offenders with severe mental illness (SMI) and the lack of a theoretical account specific to this group provided the rationale for this study which aimed to develop a preliminary model of the ways offenders with SMI progress through forensic services towards reintegration with the community.

Semi-structured interviews were conducted with seven offenders with SMI and three staff members. Grounded theory was used to analyse the data; a preliminary theoretical model contained six main categories that represented influential factors at the individual, service, and wider social network levels.

1. Learning about and managing mental health

As patients progress through forensic services and their symptoms reduce over time, they develop a greater understanding of their mental health, the ways this has affected them in the past, and how this is best managed for them.

2. Establishing facilitative relationships with staff

Findings showed that patient-staff relationships have a large impact upon patients' progress through services; sub-categories depict the ways these relationships can be very helpful but also unhelpful at times.

3. Moving on from prison and early experiences within forensic mental health services

During their journey through forensic services, patients live in different types of environment; some of these appeared to be unnecessarily punitive and unhelpful, especially the prison system, whilst others, partly through being more relaxed and comfortable, and partly through helpful staff communications (as above), assist patients' progress toward reintegration with the community.

4. Developing self-direction

Different individual changes occur during patients' journey through FMHS. These may include increasing their understanding of their own behaviours,

beginning to want things to be different in the future, taking on more responsibilities, and finding something personally meaningful to focus on and aim for.

5. Doing work in therapy

Findings showed that therapeutic input is an important part of the journey through forensic services. Although engaging in therapy was reported as often difficult and challenging, people described how therapy can be very helpful in dealing with past experiences and understanding themselves more fully.

6. Managing wider support networks

Results showed that patients' relationships with some key factors outside of forensic services influence their progress: managing friendships, family relationships, faith and spirituality. Everyone experienced these factors differently; whilst they help some people progress through the system, they cause difficulties for others. Sometimes patients needed to change their social circles in order to maintain progress, but their own family was harder to escape, and could be a blessing or a hindrance to progress.

In relation to the existing literature, results suggest that elements of 'recovery approaches' to SMI and enhancement-based approaches to offending behaviour are relevant to offenders with SMI and have some clinical utility. The preliminary theoretical model suggests that factors at three levels (individual, service, and wider support network) shape the recovery journeys of offenders with SMI, and therefore warrant attention within forensic mental health service delivery.

Give that findings present a preliminary, substantive theoretical account based upon a small sample of service-users and staff members in one service, they require replication with diverse samples of offenders with SMI in different service settings.

Arrangements for publication/dissemination

It is intended that findings will be submitted for publication in a peer-reviewed journal, namely the Journal of Forensic Psychiatry and Psychology. At a service level, findings will be disseminated to staff within the service at the focus of this study, and to residents living at the forensic hostel.

Feedback to participants

A brief summary of findings was provided to all research participants.

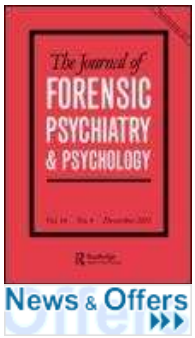
Yours sincerely,

Clare Holt

Chief investigator / Trainee Clinical Psychologist, Canterbury Christ Church University

Appendix 20: Journal guidelines

Journal Details



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