Recovery of offenders formerly labeled as not criminally responsible: Uncovering the ambiguity from first-person narratives

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Abstract

The recovery paradigm is a widely accepted strength-based approach in general mental health care. Particular challenges arise when applying this paradigm in a forensic context. To address these issues, the present study examined recovery based on first-person narratives of offenders formerly labeled as not criminally responsible of whom the judicial measure was abrogated. Eleven in-depth interviews were conducted to obtain information on lived experiences and recovery resources of this hard-to-reach and understudied population. The interviews focused on recovery and elements that indicated a sense of progress in life. Key themes were derived from the collected data. Descriptions of recovery resources followed recurrent themes, including clinical, functional, social, and personal resources. Participants also reported ambiguous experiences related to features of the judicial trajectory. This was defined as forensic recovery and can be seen as an additional mechanism, besides more established recovery dimensions, that is unique to mentally ill offenders.

Keywords: abrogation, mentally ill offenders, recovery, lived experiences, qualitative research

Introduction

Recently, the recovery paradigm has gained importance in mental health care in most Western welfare states, inspiring practitioners, policy-makers, as well as researchers (Amering & Schmolke, 2009; Lietz, Lacasse, Hayes, & Cheung, 2014; Loos et al., 2017; Slade, Oades, & Jarden, 2017). Recovery provides an alternative perspective on mental health care that expands the traditional medical model, which is based on classification, (pharmacological) treatment, and psychotherapy, and is aimed at curing and alleviating symptoms. In reaction to what is perceived as an overly narrow biomedical approach, the recovery movement is client-centred, based on individuals' needs and practices that reflect clients' valued activities (Thornton & Lucas, 2010; Vanderplasschen, Rapp, Pearce, Vandevelde, & Broekaert, 2013; Vandevelde, Vander Laenen, Van Damme, Vanderplasschen, Audenaert, Broekaert, & Vander Beken, 2017). This approach provides common ground to residential and outpatient services for developing community-based initiatives that challenge traditional structures, practices, and established beliefs in mental health care.

One of the first and most frequently cited definitions describes recovery as "*a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful, and contributing life, even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness.*" (Anthony, 1993, p. 527). A core component of recovery is its focus on strengths rather than on deficits and limitations. Despite the absence of a scientific consensus on the course and characteristics of recovery, it is accepted as being a lifelong, non-linear, dynamic, and personal process that encompasses several life domains and in which individuals regain control over their lives (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; NIMHE, 2005). Lived experiences, expectations, and future perspectives of people with a mental illness are stressed as guiding principles for

clinical, functional, and social recovery. Clinical recovery refers to cure and the absence of symptoms, while functional and social recovery refer to restoring physical, psychological, and social functioning and regaining a valued position in society, respectively (Resnick, Fontana, Lehman, & Rosenheck, 2005). The idiosyncratic nature and subjective accounts of the recovery process are captured by the term ‘personal recovery’ (Resnick et al., 2005; van der Stel, 2012). The scientific research community has adopted this perspective in studies conducted about and by (former) service users concerning their lived experiences in mental health care (e.g. Ashcraft & Anthony, 2007; Brown & Kandirikirira, 2007; Biringer, Davidson, Sundfør, Ruud, & Borg, 2016).

Although numerous recovery theories and models have been developed within the field of mental health, knowledge of recovery among mentally ill individuals who committed criminal offences is almost nonexistent. Within the criminal justice domain, recovery has mainly been theorized and studied in relation to addiction and has often been linked to desistance research (Best, Irving, & Albertson, 2017). Research on drug-using offenders suggests that desistance is subordinate to recovery (Colman & Vander Laenen, 2012), since these individuals view themselves primarily as drug users rather than as offenders. A recent study on desistance among mentally ill offenders revealed that respondents’ experiences of desistance and recovery showed striking similarities (Van Roeyen, Van Audenhove, Vanderplasschen, & Vander Laenen, 2016).

The few available studies on mentally ill offenders and recovery describe impediments rather than reconcilability between recovery and forensic assets (Dorkins & Adshead, 2011; Henagulph, McIvor, & Clarke, 2012; Mezey, Kuvuma, Turton, Demetriou, & Wright, 2010; Pouncey & Lukens, 2010; Simpson & Penney, 2011; Viljoen, Nicholls, Greaves, de Ruiter, & Brink, 2011). In these studies, the judicial status or label, clients’ self-image, setting- or treatment specific characteristics, compliance, and social desirability were found to be

obstacles to recovery. Reviews on personal recovery in forensic settings (Clarke, Lumbard, Sambrook, & Kerr, 2016; Shepherd, Doyle, Sanders, & Shaw, 2015) identified several factors that facilitate this process, including feelings of safety, security, and hope; the availability of social networks; and progress in terms of identity change, gaining a sense of connectedness and self, coming to terms with the past, and experiencing freedom and symptom reduction through pharmacological and psychotherapeutic interventions.

It has recently been acknowledged that a shift towards strength-based approaches may also be appropriate for criminal justice-related interventions (Andrews & Bonta, 2010; Barnao, Robertson, & Ward, 2010; Barnao & Ward, 2015; Barnao, Ward, & Casey, 2015; Barnao, Ward, & Casey, 2016; Barnao, Ward, & Robertson, 2016; Robertson, Barnao, & Ward, 2011; Vandevelde et al., 2017; Ward, Yates, & Willis, 2012). Although, developing strength-based approaches in forensic contexts is challenging (Ward, 2013), the aspect of being able to live a fulfilling life may be important for enhancing individuals' well-being (Bouman, Schene, & de Ruiter, 2009) and decreasing recidivism in the long run (Ward, Mann, & Gannon, 2007). Several authors have emphasized the importance of a clear distinction between a recovery approach in general and forensic mental health care (Aga & Vanderplasschen, 2016; Corlett & Miles, 2010; Dorkins & Adshead, 2011; Drennan & Alred, 2012; Ferrito, Vetere, Adshead, & Moore, 2012).

A conflict of interest may arise when applying the recovery paradigm as a strength-based framework to offenders with mental illness (Mezey & Eastman, 2009; Hillbrand, Young, & Griffith, 2010; Pouncey & Lukens, 2010), since it requires a transformation of ideas and practices. In a forensic context, this translation is even more challenging since the holistic, complex recovery approach for mentally ill offenders demands a shift from causal, linear, and risk-based indices to dynamic, personal, and societal processes. Drennan and Alred (2012, p. 15) added 'offender recovery' to the recovery model of Resnick et al. (2005), which refers to

"*the subjective experience of coming to terms with having offended, perceiving the need to change the personal qualities that resulted in past offending, which also creates the future risk of reoffending, and accepting the social and personal consequences of having offended*". This process focuses on the offending behavior and the individual responsibilities of the offender and is considered as imperative (Drennan, Wooldridge, Aiyegbusi, Alred, Ayres, Barker, …, & Shepherd, 2014) but contradictory to the tenet of personal choice in mental health recovery.

This tension between recovery and forensics highlights the multifaceted nature of recovery among mentally ill offenders, who have a mental illness but are simultaneously subjected to law enforcement and mandatory treatment (Simpson & Penney, 2011) owing to the societal responsibility to reduce risks (Shepherd et al., 2015). This dichotomy has been described as *dual* or *secure* recovery (Corlett & Miles, 2010; Dorkins & Adshead, 2011; Drennan & Alred, 2012; Ferrito et al., 2012). In order to address the aforementioned paradox, the present study investigated recovery based on first-person narratives of mentally ill offenders of whom the judicial measure was abrogated. A narrative of personal experiences is a sequential, ordered statement concerning events linked to the biography of the subject (Labov & Waletzky, 1967) and "*draws selectively on lived experience*" (Presser, 2009, p. 179). Such accounts have seldom been included in the criminological and forensic-psychiatric literature (Livingston, 2016), but may shed light on factors that facilitate recovery and may provide recommendations for improving support for mentally ill offenders. In particular, we aim to identify resources for recovery in this population.

Methods

Internment measure in Belgium

Under Belgian law, people can be 'interned' if they are considered not criminally responsible for an offence they have committed. These persons are deemed unaccountable due to a mental

illness (Vandevelde, Soyez, Vander Beken, De Smet, Boers, & Broekaert, 2011). Participants were eligible for this study if the internment measure was abrogated at least 6 months prior to the interview. The measure has a twofold goal: protection of society and provision of appropriate treatment and care (Heimans, Vander Beken, & Schipaanboord, 2015). The Commission for the Protection of Society (CPS) is responsible for the implementation of the measure and decides whether and when the person will be (un)conditionally released (Jeandarme, Habets, Oei, & Bogaerts, 2016). People who are subject to the internment measure in Belgium can be assigned to various types of mandatory treatment in penitentiary services, secure forensic-psychiatric facilities or general mental health care settings (inpatient as well as outpatient), depending on the degree of protective measures and support needed (Vandevelde et al., 2011; Rowaert et al., 2016). The duration of the internment measure is undetermined; at the time of this study, it could be terminated based on a decision by the CPS if it was deemed that the mental state of the offender had sufficiently improved (Act of 1 July 1964 on the Protection of the Society against Abnormal and Recidivist Offenders, §1, art. 18). This act was still in effect at the time of the study, but has been replaced by the Act of May 5, 2014 which became effective on October 1, 2016. One of the main reasons for this reform was numerous convictions of the Belgian State by the European Court of Human Rights. The most important objective of the new penal code is to avoid incarcerating mentally ill offenders through construction of an integrated network of forensic mental health services.

Sampling strategy and participants

In order to recruit participants, patient and family associations of people with mental illness, inpatient and outpatient mental health care agencies, forensic-psychiatric units, services for people with intellectual disabilities, a law office specialized in advocating on behalf of mentally ill offenders, the CPS, and other organizations were contacted regarding the present study. Staff members were asked to distribute an information leaflet and inform potential

participants about the study. Those who were interested in participating were asked how they preferred to be contacted by the researcher in order to schedule an interview. Nine participants were recruited in this manner, while two contacted the researcher directly after reading the leaflet on the website of a patient and family association. All participants who agreed to be contacted by the researcher received an explanatory letter about the purpose of the study and course of the interview.

All participants (nine men and two women) were living in Flanders, the northern Dutch-speaking region of Belgium. The mean age of the participants was 49 years (SD: 8; range: 36–62 years). The internment measure had been abrogated between 6 months and 4 years before the interview, with the duration of the measure ranging from 4 to 19 years. Seven of the 11 participants lived independently—one person lived in an illegally inhabited garage, two in an open ward of a general psychiatric hospital, one in a private service, and one in a service for persons with disabilities.

Data collection

Study participation was voluntary. Location and timing of the interview were chosen by the participant. One participant was accompanied by his personal assistant. Prior to the interview and signing of an informed consent form, the researcher provided an extensive verbal explanation about the study and interview course. All participants received a €20 gift voucher before the interview in recognition of their contribution.

Given the exploration of lived experiences of a known subject area, in-depth interviews grounded in narratives were deemed most appropriate for data collection (Ricœur, 1976). To this end, a topic list with open-ended questions was made based on a review of the literature on recovery in general and forensic mental health care. The extent to which the topic list was used during the interview was determined by participants' narratives; as such, the sequence of questions was not fixed (Van Male, 2011). The interview consisted of a conversation focusing

on recovery and elements that were acknowledged as being important for the feeling of progress in life (e.g. Leamy et al., 2011; Tew, Ramon, Slade, Bird, Melton, & Le Boutillier, 2012). Additionally, life quality and satisfaction were addressed. All interviews began with the open question "How are you?" and ended with respondents summarizing the three most important supporting factors allowing them to proceed in life. Basic demographic data were collected at the end of the interview. Data collection ended when theoretical saturation was reached, meaning that no new insights or themes were identified, and no new topics appeared in relation to a category of data (Strauss & Corbin, 1990). Interviews were carried out between June 2015 and January 2016, and ranged in duration between 00:46:30 and 2:01:56, for a total of 15:43:32. The study design was approved by the ethical board of the Ghent University Hospital (Belgian registration number B670201422068).

Data analysis

Given the exploratory nature of this research, we considered that an inductive thematic analysis was appropriate (Mortelmans, 2011). This method identifies, analyzes, and reports patterns by organizing and describing the data in detail (Braun & Clarke, 2006). We used a qualitative data analysis software package (Nvivo Pro 11) to organize and analyze the data. All interviews were transcribed verbatim. First, the narratives were reviewed repeatedly to gain insight into the content. Common codes were identified (Bogdan & Biklen, 2007) by one Master's-level student and two authors, who initially coded two different sample interviews. Data that supported these codes were discussed until a consensus was reached on a common tree structure. The 11 interviews were then coded by two authors individually, applying this common tree structure. The separate analyses were compared, discussed, and integrated. Overarching themes were exposed by the principal researcher (first author) and a co-author, in accordance with the identified codes. These emergent themes were then discussed with the

principal researcher and two authors of this paper. This yielded 17 superordinate themes, which are described below (see table 1 for a summery).

Results

Recovery resources were considered using important facets of recovery in the general mental health literature as a guideline (Leamy et al., 2011, Resnick et al, 2005; van der Stel, 2012)—i.e., clinical, functional, social, and personal resources. The ambiguous role of the judicial label is discussed, since this is a critical aspect of recovery for mentally ill offenders.

Clinical recovery resources

Medication—More than half of participants identified taking medication (including psychopharmacological agents as well as medication for somatic complaints) as an important recovery resource. Although general physical health and reduction of mental illness symptoms are important aims of taking medications, respondents mentioned their complaints such as fear, stress, and/or hearing voices.

> *"Medication is no golden bullet, but I need to say that it can help you to balance your spirit and orientation in time." (Participant 3)*

Residential treatment services—For four participants, new insights were gained by attending therapy sessions in residential care, which they attributed to the indispensable role of talking during these sessions. The presence of staff and other patients with whom it is possible to informally converse was seen as an advantage of residing in a hospital. One person referred to being in a service as supportive:

> *Researcher: "Is it helpful to be here?"*
>
> *Participant 2: "Yes, yes, especially because I can't drink here. And, there are people surrounding you and it's constructive. At home it's not like that."*

Formal health care—Mental health care was an important topic in every narrative. Participants assigned a protagonist role to staff in these settings, considering them as

supportive if they made time for the respondent and showed genuine interest in his/her story. Three participants emphasized the importance of being given multiple chances in case of non-adherence to treatment instead of being sent to prison as helpful. Two stated that they did not have any expectation of staff other than their being present, although their presence was reported to be helpful. In addition, informal contacts with professionals were considered more valuable than scheduled activities.

> *"The informal conversations helped me to proceed. […] A mentor was assigned. If we made a formal appointment, it was not okay. But if she asked me to do something on the ward, where I could do her a favor with, then I did it. […] Most of the nurses there were polite, friendly and correct. Fantastic." (Participant 1)*

Three participants added that their general practitioner (GP) was a helpful resource both in the past and at present; frequent contacts with or access to a GP facilitated their recovery process.

Functional recovery resources

Financial situation—Participants frequently mentioned their financial situation. They believed that more financial resources would enhance their autonomy, since it would allow them to go on a vacation or save money for future expenses. Participants further argued that they would like to have more money to be able to support family and friends. Some mentioned difficulties with regards to this life domain, although they stated that this did not negatively affect their immediate well-being.

Daily activities—Spending the day in a purposeful way was mentioned in several narratives. Participants reported a multitude of reasons why structured activities were helpful. One was that it provided peace of mind, but a way to pass time also contributed to an activity being considered as helpful. Others considered daily pursuits such as reading, writing books, or attending lectures as beneficial for understanding oneself or a certain context. Several participants engaged in these activities not only to gain insight into specific health-related

topics, but also for the social contact. Being creative comprised all of the above-mentioned reasons for which daily activity was a resource for recovery.

> *"Painting and drawing didn't belong to my strengths before. But nowadays when I feel the need to say something, I say it with paint." (Participant 9)*

Ten participants mentioned employment as an important element of their recovery. They made a clear distinction between paid employment and volunteer work, as the former represented greater progress according to three participants. However, only one participant had a paid job at the time of the interview.

Practical resources—One practical resource was mobility. Five participants indicated that a car, moped, or driver's license would enable them to experience progress in life. Access to the internet or having a mobile phone were also mentioned by three participants as tools to access recovery resources. These media were considered meaningful primarily to maintain social contacts, although an internet connection was also helpful for translation or listening to music. Most of these practical resources reflected the need to increase the opportunities for connecting with others, and were thus closely linked to social resources.

Social recovery resources

Helping others—Several participants emphasized the importance of helping instead of hurting others, referring to direct and indirect victims of their past offending. According to them, being supportive reflects progress in life.

> *"Ah, but that's what I want to reach: to set myself aside and forget about what happened with me, because I moved forward from the past. I set myself aside, but not everything, and I do my best to help people with problems." (Participant 7)*

A related theme was participating in activities originating from respondents' lived experiences, which was mentioned in three narratives. One participant supported a peer who was still subjected to the internment measure, while another gave lectures on the experiences

of being subjected to the interment measure and visited patients in the secure hospital where he had been treated. A third person published a book on lived experiences and psychosis.

Social network—The social network was another theme that was part of the social process of recovery. The majority of participants considered having a good relationship or regular contact with their (ex-)partner and family as extremely valuable. One person emphasized the importance of setting a good example for her children.

> *"It is always possible that my children get sick too and that's a negative point. It's better to set a good example for them: I got sick, but I can have a good life." (Participant 11)*

Besides their (ex-)partner and family, friends were also part of the respondents' social network. According to several participants, recovery was about developing prosocial contacts and avoiding 'bad friends', which were defined as those with whom they associated while offending; this was in contrast to good, positive friendships, which were prolonged and supportive relationships. The majority of respondents had a limited prosocial network, consisting of their (nuclear) family, partner, and a small group of friends; however, it was nonetheless viewed as a resource for recovery, since it offered stability and a sense of connection and prevented them from offending:

> *"[A partner is important], because you can say: I'm doing this for her. I want to do it for her." (Participant 3)*

A sense of belonging—Seven participants referred to affective components of connectedness, which they described as being able to be yourself without fear of being different, giving them a feeling of being accepted. Experiencing this type of support from staff, friends, or family lowered the threshold for requesting help or support in the future.

> *"He believed in me and I believed in his approach in regard to my needs. He did it with his heart and soul to help me proceed. Thanks to X [Criminal Justice staff member] I*

was able to cooperate in a good way, also with the criminal justice system. Like [discussing together]: how can we prevent you from re-offending?" (Participant 4)

Personal recovery resources

Personal development—Participants mentioned education as a resource for personal development and described learning to increase self-awareness and understand and control feelings and behavior as very meaningful. One participant stressed the importance of studying to understand context.

> *"I am someone who wants to understand things and reads and studies them. Even if something belongs to the past, I keep paying attention to the theme because of my societal conscience and the fact that some of my acquaintances are still interned. I could proceed due to my self-study." (Participant 1)*

Some learning processes started with but went beyond the individual and were related to interpersonal contacts—e.g., the development of a normative attitude while communicating with others.

Acceptance—The majority of participants mentioned that they accepted their current situation. Some indicated that 'letting go of the past' was essential to feeling satisfied with their life. This acceptance resulted for one participant in an open and honest attitude in relationships and at work. Also, abandoning the pursuit of 'the ideal life' was a way to proceed: several participants mentioned their desire to focus on maintaining the equilibrium they had reached.

> *"I have reached an equilibrium, a golden mean. But psychologically, I understand that I will not regain a healthy life, but I can stay alive for my children... Life is not perfect, but you can't despair. Because despair, that's like, … , despair means death. I thought about what's important for me and what I am able to do." (Participant 11)*

Autonomy—Willpower was featured as an important resource for recovery. Two participants stated that in addition to having aspirations, the willingness to pursue them was meaningful. With regards to this topic, the importance of autonomy was strongly emphasized.

> *"If you don't need anyone for it, it's more valuable, I think. When it's your own motive and you can decide to begin and stop on your own." (Participant 9)*

Tranquility and rest—Several respondents identified rest as a resource for recovery; six discussed seeking and/or getting the rest they desired or needed. Their definition of rest varied from staying in bed to reducing contact with friends. Three persons cited meditation as a way of seeking tranquility; for three others, rest was associated with going (more often) on vacation.

> *"I have a lot of contacts. […] But I can always mention that I don't feel well and they understand. From time to time, I say: stop, I need rest. That's no problem." (Participant 4)*

Ambiguous role of the judicial measure

All respondents mentioned the dual role of the internment measure in their lives and in their recovery process.

Measure of internment—Several participants stated that the moment the internment measure was imposed was helpful. They indicated that at some point in the past, they felt the need for appropriate treatment, but needed coercion to gain awareness of this need.

> *"If I wouldn't have been interned, I would be six feet under by now. Perhaps I would have caused a family tragedy, arms trade, drug trade…" (Participant 4)*

Nevertheless, most participants had ambiguous feelings about the further course of the internment measure and questioned its efficiency given its dual influence on their lives.

> *"Researcher: Did the interment help you?*

Participant: [silence] Good question. On the one hand, I dare to say that you end up a little bit better, stronger. But on the other hand, it's a wound you get due to society. It heals, but you don't forget it." (Participant 1)

This ambivalence was mostly due to the indefinite period of the internment measure; the uncertainty was burdensome and stressful for participants. Additional stress was caused by the feeling of being constantly tracked and by the possibility of being re-incarcerated.

> *"Internment […]. It impended over me and then I was released from prison. Being stressed the whole day: something is going to happen, police is bent on finding me." (Participant 3)*

Four participants referred to the probationary period with limited release as well as to the final release from prison as indicators of recovery. Several participants stated that they externalized the prescribed conditions and complied with regulations only in anticipation of the termination of the internment measure. A minority internalized the restrictions after adjournment of the measure; two participants reported that they still limited themselves by adhering to the conditions, although they no longer had to do so.

> *"Unless I don't need them anymore, my conditions stay in my head […]. Not for supporting others, not to show what I'm worth, but for myself, to avoid problems." (Participant 7)*

The final adjournment of the internment measure was considered as a recovery resource. However, the way in which participants experienced the adjournment as a resource differed: for some, it directly impacted their functioning and living situation, since they no longer had restrictions and had regained their civil rights. For other participants, the end of the measure was beneficial for their societal functioning—e.g., being able to apply for a job. Three participants stated that they were only able to start their life when the measure was abrogated. One person disclosed that the stigma of being not accountable disappeared with the end of the

measure; another emphasized that being able to put the stigma into perspective was essential for overcoming it.

> *"I suffered from an overpowering fear and stress, because I constantly thought I had to re-enter prison. I always had that same thought, that people could read from my face that I was a .... It seemed like I was marked." (Participant 11)*

Several participants indicated that the internment measure still affected their life satisfaction in that they tried to build a constructive life by avoiding the behaviors that would lead them to the same dead end:

> *"I try to direct my life […] in the right direction. You can always be led astray again, but at those moments you should know who you can ask for to receive some encouragement." (Participant 3)*

Incarceration—Except for one person, all participants stayed in prison for a substantial period of the internment measure. Most of them looked back on this period with mixed feelings. Three participants experienced its deterrent effect as helpful, although they expressed some equivocation.

> *"On the one hand, the rough edges are smoothed off, […] but on the other hand, prison cultivates the revolting characteristics that I already had in me." (Participant 3)*

Five participants reported that imprisonment was helpful only to a limited extent. Some mentioned that their imprisonment contributed to their personal development and provided opportunities to prove themselves in a positive sense—e.g., quitting drug use. Furthermore, observing individuals who were incarcerated for more serious criminal offenses was considered as an aid because it showed the participants that it would be detrimental to emulate the behavior of these inmates. Imprisonment was also considered as helpful because it afforded the participants with an opportunity to reorganize their lives; they talked about taking time to rest and about the structure and regularity they experienced during detention.

Additionally, the possibility of spending the day in a purposeful way during imprisonment was seen as helpful. Six participants discussed the value of work during incarceration. Furthermore, participants talked about the importance of taking a walk or participating in other outdoor or leisure activities. However, a positive relationship with other inmates was stated as a prerequisite for participation in any activity. Three participants considered the presence of a psychosocial service or support team specifically for mentally ill offenders as very helpful and described it as an accurate response to their needs and demands during imprisonment that focused on practical support—e.g., offering work and leisure activities, helping to write or read letters, or assisting in applying for permission to contact family or friends—rather than on addressing mental health issues. Participants considered release from prison as an important step in the recovery process.

The victim—Another forensic element that emerged from the interviews as a possible resource was the role of the victim. One participant stated that the fact that his victim survived the offence allowed him to move forward. Two participants recounted the restorative effect of contacting the victim, indicating that it was the victim that chose the form, frequency, and intensity of the contacts. Although the course of the encounters was not according to the participants' preferences, they nonetheless considered that having this contact allowed them to move forward.

> *"Y. [victim and family member] is always welcome, but I will not push her to decide to contact me or to live with me. I will try to take my responsibility and try to love, but I cannot force it." (Participant 3)*

Belief in the measure as a resource—While exploring the accounts about internment as a resource, it became clear that participants referred to their own attitude of believing in the usefulness of the measure. They considered their willingness to succeed as a requisite for a successful judicial trajectory, and indicated that encountering others with the same motivation

and belief in their potential was helpful. For example, members of the CPS and the probation officer were mentioned as being supportive and helpful. Five participants expressed appreciation for being treated humanely by the CPS or the probation officer and for the fact that these individuals believed in them.

Discussion

By exploring 11 first-person narratives of mentally ill offenders formerly labeled as not criminally responsible, this study assessed resources that helped these individuals to move forward in their recovery process. As for other mental health populations, we can conclude that recovery is an ongoing journey that consists of experiences that are unique to each individual. Our results indicate that there are common factors that facilitate the recovery process that are consistent with recovery literature in general mental health care (Leamy et al., 2011; Resnick et al, 2005; van der Stel, 2012), including clinical, functional, social, and personal resources. However, specific resources emerged that can be attributed to the particular judicial trajectory of mentally ill offenders.

Recovery process

Although the recovery paradigm does not assume that clinical recovery is needed in order for an individual to be considered as being ‘in recovery’, this study identified three key components of this recovery form as important resources that facilitate this process: taking medication, staying in a residential treatment setting, and the relationship with formal health care. The desire of participants to live a healthy life was reflected by their adherence to taking medication and how they valued the reduction of somatic symptoms. The participants stated that a positive relationship with professionals—e.g., their GP—played a crucial role in their recovery. This is in accordance with previous findings of the importance of cooperative engagement with staff for individuals with psychological problems who were following a

compulsory treatment (Andreasson & Skärsäter, 2012; Danzer & Wilkus-Stone, 2015; Hayward & Finlay, 2009).

Recovery could also be gauged by a set of functional resources. For example, overcoming financial shortage was perceived as an important means of regaining autonomy (Biringer et al., 2016), although money was not seen as indispensable for a fulfilling life. Other key components of functional recovery were identified that corresponded with findings from other studies (Andresen, Oades, & Caputi, 2003; Leamy et al., 2011; Resnick et al., 2005; Schrank & Slade, 2007); for instance, engaging in meaningful daily pursuits supported recovery by fostering hope. In addition, establishing structured routines was crucial for recovery (Doroud, Fossey, & Fortune, 2015); as such, the importance of having an occupation was repeatedly mentioned.

The third superordinate theme, social resources, encompassed 'helping others' as well as the existence of an informal network, with certain practical conditions as prerequisites and a sense of belonging as a goal. Previous research has also stressed the importance of trusted relationships for the recovery process (Tew et al., 2012). In the present study, participants strongly endorsed the physical as well as the intangible affective component of connectedness—i.e., 'a sense of belonging'. They valued 'simply being' or being able to go to a place where they could be themselves—e.g., a place they could call 'home', day care center, or workplace. Hagerty and colleagues (1992) stated that having a connection with the environment gave individuals a sense of belonging. This physical dimension refers to meaningful places in a person's life, which has been defined as 'place attachment' (Fullilove, 1996) and plays a critical role in individuals' mental health, sense of well-being, and recovery (De Ruysscher, 2016).

The participatory dimension of the results was related to citizenship. The majority of participants experimented with ways to regain a position in society, which was repeatedly

emphasized as important. For respondents, the idea of citizenship was not founded in normative ideas such as re-entering the labor market (Kal, 2001), but rather in voluntary contribution as a societal engagement—e.g. giving lectures to students, writing a book, or participating in scientific research. Interrelatedness and social inclusion were important for individuals to proceed in life. Research on recovery has found that social exclusion is the last component from which offenders recover (Ware, Hopper, Tugenberg, Dockey, & Fisher, 2007), indicating that the social dimension of the recovery process is the most difficult to promote.

Personal development, acceptance, autonomy, and tranquility and rest were repeatedly emphasized as personal recovery resources. Personal development can enhance the subjective experience of well-being, since education and self-awareness are linked to acceptance of the actual situation (Clarke et al., 2016; Young & Ensing, 1999). Autonomy was highlighted in many of the narratives. The emphasis on this factor by participants could be attributed to the importance of reestablishing ownership of and control over their own lives, since they were deprived of these elements during the imposition of the measure, especially in the case of imprisonment (Liebling & Crewe, 2012). In addition, the possibility of resting or finding peace of mind was seen by some respondents as a way of coping with symptoms of their illness or as a means of reestablishing their psychological balance. Experiencing a sense of calmness was highly valued. This could be related to the opposite past experiences during the course of their illness (Young & Ensing, 1999).

'Forensic recovery'

The narratives in this study showed significant similarities to mental health recovery, but also presented aspects that were specific to involvement in the criminal justice and forensic care systems. These elements define the particular recovery process for mentally ill offenders—i.e., forensic recovery (Aga & Vanderplasschen, 2016), which includes recovery from the

impact of the offence (Ferrito et al., 2012) as well as the judicial trajectory—e.g., the indeterminacy of the internment measure. Based on our findings, forensic recovery may include but does not necessarily imply offender recovery (Drennan & Alred, 2012).

The judicial measure was of critical importance for the respondents, although their feelings on this point were highly ambivalent. On the one hand, the status was considered as a positive resource. For example, participants discussed imprisonment as a resource for their personal development (e.g., to structure their life or as a pathway to treatment). This is in accordance with previous research conducted in Belgium (To, Vanheule, De Smet, & Vandevelde, 2015; De Smet, Van Hecke, Verté, Broekaert, Ryan, & Vandevelde, 2015). However, participants also expressed that although it was lifesaving, the internment measure was hard to bear as time passed owing to the indefiniteness. This was also discussed in a study on patients' experiences with community treatment orders by Dawson and colleagues (2003), who reported that the measure was "*mainly negative really, but it saved my life*" (p. 251).

Forensic recovery can be considered as a consequence of mentally ill offenders being positioned between the care and justice systems (Prior, 2007), which leads to additional obstacles as compared to mentally ill individuals who have not committed offences (Simpson & Penney, 2011). One additional obstacle is the double or even triple stigma (LeBel, 2012); that is, besides being '*patients*' or '*addicts*', mentally ill offenders are also seen as '*offenders*' (Mezey et al., 2010). It is possible that individuals internalize these labels, resulting in self-stigma (Corrigan, Watson, & Barr, 2006; LeBel, 2012; Mingus & Burchfield, 2012; Slade, Amering, & Oades, 2008). Related to this issue, participants tended to restrict the conceptualization of their own recovery process, perceiving events linked to judicial progress (e.g., release from prison) as advancing their recovery. They also considered basic rights and prerequisites for mental health recovery (e.g., housing) as achievement-related rewards for being stable and not being at risk of reoffending or a risk to society. Thus, the judicial labeling

perpetuates (self-)stigma even for individuals who are in treatment (e.g., in general mental health care). Positive relationships with staff—especially through informal contacts—could promote feelings of self-worth and counter the stigma experienced by mentally ill offenders (Barnao, Ward, & Casey, 2015; Mezey et al., 2010).

In the present study, some participants set limitations to their own behavior even after the measure had been abrogated by complying with former conditions. The majority had a limited social network. This is consistent with earlier findings that individuals who experienced stigma more frequently isolated themselves, although this did not include familial interactions (Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001; Perlick et al., 2001).

The need to help others and 'to give something back' to society was a key theme in the narratives. Ferrito and colleagues (2012, p.340) reported that this 'form of repayment' was "*generativity to the experience of hope, which is a key feature of the recovery process*". A study on desistance found that this was critically important because it is "*a message to the community that the offender is worthy of further support, and to the offender that s/he has something to offer that is of value to others*" (Bazemore & Erbe, 2004, p.45).

Mentally ill offenders are also faced with the stigma of the judicial measure, which is often embodied by practical obstructions such as restricted access to the internet or suspension of their driver's license. If these obstacles to re-integration are not tackled, it will be difficult to overcome the challenges of rehabilitation and desistance and provide support to offenders so that they can change themselves (McNeill, 2012).

Strengths and limitations of the study

The present study has a number of strengths and limitations. One strength is that it provides important insight into theories of recovery since it was based on first-person perspectives (Barnao et al., 2015; Dorkins & Adshead, 2011; Mezey et al., 2010; Turton et al., 2009;

Viljoen et al., 2011), which reveals the realities faced by this vulnerable population with respect to various life domains.

A limitation of the study is the small sample size, which is attributable to the fact that we studied a hidden population that is no longer followed by the judicial system and is often reluctant to be contacted regarding their experiences. Nonetheless, we were able to recruit a diverse sample of individuals who were formerly labeled as not criminally responsible for in-depth interviews about their past and current recovery experiences. In addition, our study focused on the situation in Belgium and its specific interment procedure; as such, the findings may not be generalizable to other settings. On the other hand, other countries have similar approaches to dealing with individuals who are labeled not criminally responsible; moreover, our findings regarding 'forensic recovery' are in agreement with the international literature on this topic. Despite the dynamic nature of recovery processes, data collection was limited to a single interview; repeated follow-up interviews may provide additional insights into the long-term tenability of the findings.

Finally, there is still a theoretical void and a lack of empirical evidence which moderates suggesting forensic recovery as a rehabilitative strategy. Also, Barnao and Ward (2015) warn that a consistent comprehensive rehabilitation framework is needed instead of a blended model of approaches and interventions, which could create more conceptual and practical obscurity. To obtain further clarity into the concept of 'forensic recovery', future studies could focus on mapping the gradual changes and turning points in this process by engaging forensic mental health service users. In addition, the concept of 'forensic recovery' and recovery could be explored within a mandatory context, which could deepen our understanding of its (in)compatibility with mainstream mental health recovery. More generally, research on the intersection of special needs education, psychology, psychiatry,

criminology, and law could provide additional insight into the influence of imperceptible labels on the recovery process.

Conclusion

This exploratory study focused on the paradoxes of two seemingly incompatible paradigms—recovery and the forensic context—based on the experiences of mentally ill offenders formerly labeled as not criminally responsible. The study identified several resources for recovery by focusing on individuals' lived experiences, which were largely in accordance with previous knowledge of recovery in general mental health care. However, our study highlighted the ambiguities experienced by these individuals in their recovery at the intersection of mental health care and the criminal justice system, as illustrated by the concept of 'forensic recovery', which is an aspect of the recovery process that concerns particular forensic elements and dynamics, such as how a judicial measure can contribute to personal development. Acknowledging personal goals associated with affective components, the social network, and practical and financial issues was found to be especially critical for facilitating the recovery process.

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Table 1 Summery of the main themes

Clinical recovery resources	Medication Residential treatment services Formal health care
Functional recovery resources	Financial situation Daily activities Practical resources
Social recovery resources	Helping others Social network A sense of belonging
Personal recovery resources	Personal development Acceptance Autonomy Tranquility and rest
Ambiguous role of the judicial measure	Measure of internment Incarceration The victim Belief in the measure as a resource

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