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What are the barriers to recovery perceived by people discharged from a medium-secure forensic mental health unit? An interpretative phenomenological analysis

Simon R. Stuart, NHS Lanarkshire, Scotland
Louise Tansey, NHS Lothian, Scotland
Ethel Quayle, University of Edinburgh, Scotland

Abstract

Within mental health services, the recovery approach offers a strengths-based framework for working with individuals. It is characterised by a focus on facets such as hope and empowerment: however, these may be less applicable to people within the complex context of the forensic mental health system. Very little research exists into recovery among this population following discharge from inpatient care. This qualitative study explored perceptions of recovery, and the barriers to its achievement, as described by eight former inpatients at a medium-secure forensic hospital. Interpretative phenomenological analysis revealed five superordinate themes: Living in the Shadow of the Past, Power Imbalances, Security and Care, Reconfigured Relationships, and 'Recovery' as a Barrier to Recovery. The analysis also allowed for an examination of participants' values, and how these related to recovery processes. Clinical and research implications are discussed, and suggestions are made for the development of the recovery approach within forensic services.

Keywords

Recovery, Community, Forensic, Health Care, Mental Health and Illness, Values

1. Introduction

1.1 *The recovery approach, mental health and values*

Since it was proposed at the beginning of the 1990s, the recovery approach to severe and enduring mental illness has become an increasing focus for anglophone health services (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Commonly defined as a person-centred, strengths-based approach, recovery-focused care broadly involves professionals assisting service users to lead satisfying and valued lives, even if symptoms of mental illness are present (Slade et al., 2014). Nevertheless, given that the approach has its roots in a survivor-led recovery movement which originally stood in opposition to medicalised notions of illness and cure (Anthony, 1993; Deegan, 1988), its adoption by services has led to accusations of the colonisation of once-progressive ideas (Beresford, 2015).

In a seminal discursive paper, Anthony (1993) depicts recovery as a unique, personal process that may involve people addressing or changing attitudes, feelings and values. Drennan & Aldred (2012a) describe individuals' values as providing a sense of meaning, purpose and satisfaction, and such intrinsic reinforcement is arguably key to recovery (Roberts, 2011; Thornton & Lucas, 2011). Within contemporary psychological theory there are two predominant approaches to understanding values. One is a structural model (e.g. Schwartz, 2012; Schwartz, 2011) in which values are essentially viewed as culturally determined guiding beliefs (Schwartz & Bardi, 2001), e.g. self-transcendence and self-enhancement. The other is a contextual model in which values are essentially organising principles for action, more individually defined: basic examples might be intimacy or personal growth (Lundgren, Luoma, Dahl, Strosahl, & Melin, 2012; Plumb, Stewart, Dahl, & Lundgren, 2009). While either conceptualisation fits with the recovery approach, the second might be regarded as more flexible.

Following a systematic review of 97 published papers, Leamy et al. (2011) proposed a conceptual framework for recovery, the central aspect of which is a model of five values-based processes given the acronym CHIME: Connectedness, Hope and optimism, Identity, Meaning in life, and Empowerment. This was used as the framework for a meta-synthesis of qualitative literature, which concluded that, while the CHIME model is well supported, it nevertheless risks overlooking the myriad difficulties described by people in recovery (Stuart, Tansey & Quayle, 2016). More generally, research into recovery can present a philosophical quandary: if recovery is a unique process (Anthony, 1993), any effort to operationalise it or to consider statistical norms risks invalidating that individual nature (Browne, 2006). While admirable attempts have been made to provide valid recovery measures (e.g. Shanks et al., 2013; Silverstein & Bellack, 2008), qualitative methodologies may be better suited to capturing the intensely personal narratives of recovery (Drennan & Aldred, 2012a; Langan, 2010; O'Sullivan, Boulter, & Black, 2013; Roychowdhury, 2011).

1.2.1 *Recovery and forensic services*

While most research into recovery concerns general-adult services, its application in specialist areas of mental health has also been considered. Turton et al. (2011) carried out a qualitative study within eating-disorder, addiction and forensic mental health services, concluding that while the broad themes of recovery were applicable, specific factors relating to individuals' circumstances were important to consider. This might be particularly pertinent within forensic services, an area in which the recovery approach might initially appear to be a difficult fit (Simpson & Penney, 2011).

Forensic mental health services assess, treat and rehabilitate people with a mental illness, personality disorder or learning disability who are involved, or likely to become involved, in the criminal justice system; and who are deemed to pose a high risk to themselves or to others, often because of violent offences which may include homicide (Jacques, Spencer, & Gilluley, 2010; Scottish Office, 1999). Many people who come into

forensic secure care have complex interpersonal and emotional histories, sometimes involving multiple prior trauma (Mann et al., 2014). Effective delivery of therapeutic treatment within any forensic context – prison or mental health facility – has been demonstrated to be contingent on an understanding in which an individual's needs, both criminogenic and psychological, are paramount (Andrews et al., 1990).

Over the past three decades, the development of forensic mental health services in the UK and US alike has been marked broadly by a move away from exclusionary long-term institutionalisation and towards a more integrated model in which a return to the community is the goal. To what extent this has been successful in the US appears heavily contingent on individual states' approaches, with effective inter-agency working seemingly a key variable (NASMHPD, 2014). In a non-systematic review of literature pertaining to community transition from correctional facilities, Visher & Travis (2003) observed that the focus remained on whether or not a person reoffended, as opposed to how well they reintegrated. They called for a renewed research effort in this area, and over the subsequent decade there has been an increased academic focus on humanistic and person-centred approaches to working with offenders in a variety of settings, though this has not necessarily been mirrored in practice (Polizzi et al., 2014).

In the UK, forensic mental health services have moved over the past three decades towards a model which is more coherent with general mental health care, albeit invariably parallel with it rather than integrated (Mullen, 2000). High-, medium- and low-security facilities offer inpatient care and treatment, usually followed post-discharge by multidisciplinary management in the community, frequently in tandem with legal restrictions on a person's freedom (Mullen, 2000; Roychowdhury, 2011). In Scotland, where this research took place, a core element of forensic mental health care is an appropriate level of security for a person at any given time: therapeutic interventions are in theory delivered appropriately at high, medium and low-security care, and post-discharge (Crichton, 2009). To what extent recovery principles form part of the care approach is ultimately the choice of individual National Health Service institutions, as is also the case across the rest of the UK (Clarke, Lombard, Sambrook, & Kerr, 2016; Paden, 2010).

People's lives after discharge can be highly challenging: in an analysis of 550 discharged cases over two decades at an English medium-secure unit, Davies, Clarke, Hollin, and Duggan (2007) found that 38% were readmitted to secure care, and 49% were reconvicted of an offence. The risk of death among the sample was six times that of the general population. A previous study (Maden, Rutter, McClintock, Friendship, & Gunn, 1999) observed a 75% readmission rate. A balance of recovery with risk management is therefore complex (Drennan & Aldred, 2012a; Roychowdhury, 2011), not least because while recovery looks for the best in people, risk-focused services are obliged to consider and manage for the worst (Dorkins & Adshead, 2011). Within recovery generally, 'positive risk-taking' is suggested as a way in which people can be encouraged to gain control in life (Roberts & Boardman, 2013): however, any risk-taking within forensic services is unlikely to be endorsed by legislature or indeed the public, who may have a disproportionate view of the dangers posed by patients (Coffey, 2012a; Mezey & Eastman, 2009).

Nevertheless, there is a growing evidence base for the recovery approach within forensic services. A study involving 75 medium-secure inpatients in English settings found that recovery – as measured by the authors' own, forensic-specific Recovery Journey Questionnaire (RJQ) – predicted treatment motivation and engagement, and social inclusion on the ward, better than traditional quality-of-life measures (Gudjonsson, Savona, Green, & Terry, 2011). However, this focuses on how the recovery journey fits service desires, rather than service users' personal goals or values. Mezey, Kavuma, Turton, Demetriou, and Wright (2010) provide a closer analysis of the forensic inpatient group (n=10) from the Turton et al. (2011) study: using mixed qualitative methodology, they found that themes of medication,

therapy, relationships and security were key to participants' perceptions of recovery, and that traditional recovery concepts such as hope and autonomy were less pertinent. Participants also stated that they felt it would be difficult to find societal acceptance after discharge.

A thematic analysis of interviews with 30 patients in a Canadian forensic hospital suggested that recovery involved a complex integration of involvement in programmes, belief in rules, attachment to individuals, commitment to activities, and concern about treatment duration (Nijdam-Jones, Livingston, Verdun-Jones, & Brink, 2014). The first four themes map closely onto a criminological theory of social bonding (Hirschi, 2002), and may be more imposed than induced. However, the study is notable for its suggestion that understanding more about patients' attachment patterns could be valuable, a point also made in a review article by Mann, Matias, & Allen (2014). Two syntheses of qualitative literature have identified core themes pertinent to recovery within forensic settings (Clarke et al., 2016; Shepherd, Doyle, Sanders, and Shaw, 2016). The former identified six superordinate themes (connectedness, sense of self, coming to terms with the past, freedom, hope, and health and intervention), the latter three (safety and security, the dynamics of hope and social networks, and identity as a changing feature). While both syntheses appear rigorous, the meta-ethnographic approach of the latter arguably offers a more comprehensive engagement with the data. The recovery themes identified have clear echoes of those observed in more general studies of recovery (e.g. Leamy et al., 2011): however, both studies highlight areas that might be specific to, or particularly salient for, people recovering within the forensic system.

The research considered so far is inpatient-based: as noted by Drennan and Aldred (2012b), recovery after discharge is an area requiring exploration. Barnao, Ward, and Casey (2014) present a well-evidenced thematic analysis exploring perspectives on rehabilitation among forensic patients approaching discharge in New Zealand (N=20), although these were still inpatients or people living in low-security 'step-down' cottages at the hospital. Analysis identified both internal (e.g. self-evaluation, agency) and external (e.g. consistency of care) considerations. Coffey (2012a; 2012b) offers a discursive analysis of interviews with discharged forensic patients: while this is not situated directly within the recovery concept, it highlights fears about status, stigma and the difficulties of social integration. An unpublished doctoral thesis by Burgess (2011) used interpretative phenomenological analysis (IPA; Smith, Flowers, & Larkin, 2009) to explore the experience of community readjustment in people discharged from an English low-secure unit, identifying broad themes of identity, change and transition: however, using criteria outlined by Smith (2011), the quality of the analysis was not high. Given that discharge is a potential destabiliser, viewed by some patients with ambivalence (Mezey et al., 2010), further research in this area might be of benefit in understanding what people find challenging, and how services might best assist.

1.3. The present research

Our research set out to explore individual perceptions of recovery, in particular beliefs about barriers to its achievement, in people discharged from secure psychiatric care. Participants were former inpatients at a medium-secure unit (MSU) in Scotland, now resident in the community. The MSU provides acute and rehabilitation care for male and female inpatients, some of whom may have been in the secure forensic mental health system for many years. It had begun to adopt principles of the recovery approach several years earlier, and a working party, including former service users, had been set up to explore and promote recovery implementation (Paden, 2010).

Because the focus of the present research was on participants' own accounts, qualitative methodology was particularly apposite. The primary research questions were: What did participants understand recovery to mean, after their experiences in secure care?

and: What did they perceive as barriers to their recovery? A secondary aim was to explore participants' values: i.e. what they perceived as their core values; to what extent these were congruent with their recovery; and to what extent participants perceived their values to be congruent with the values of wider society. It was anticipated that the research would provide a valuable addition to the evidence base for recovery within forensic mental health generally, and begin to address the post-discharge gap highlighted by Drennan and Aldred (2012b).

2. Method

2.1 Design

The research method was interpretative phenomenological analysis (IPA), an inductive, idiographic approach designed as a way of exploring lived experience, informed by the philosophical principles of phenomenology and hermeneutics (Smith et al., 2009). Epistemologically, IPA is – as its name indicates – interpretivist: rather than seeking to develop an explanation of processes, it is designed to explore meaning and capture common features, making it particularly well-suited for investigating the experiences of a small group with a core context in common (Elliott, Fischer, & Rennie, 1999; Starks & Trinidad, 2007). While it focuses on individuals in context and cannot produce widely generalisable claims, credible IPA may nevertheless allow for a degree of generalisation (Smith et al., 2009).

2.2 Participants and recruitment

Participants were former inpatients at a single MSU in Scotland, resident in the community and under the continuing care of a forensic community mental health team (FCMHT). Inclusion criteria were that they had to be 18 or over, able to give informed consent to participate, and not currently experiencing acute symptoms of severe mental illness, based on the opinion of their responsible medical officer (a consultant psychiatrist). Potential participants were identified by the FCMHT and an initial approach was made by FCMHT staff during routine contact. If people were interested, they were provided with a plain-English Participant Information Sheet and given a minimum of 24 hours (in practice several weeks) in which to consider and decide whether or not they wished to take part. People were encouraged to contact the lead researcher directly if they had any questions. Interviews with consenting participants took place either at a National Health Service (NHS) outpatient clinic or at their homes. Participants completed a written consent form immediately prior to interview.

Eight people agreed to participate and completed the interview process, of whom five were male and three female. Given that participants were recruited from a small population, further demographic and diagnostic details will be kept to a minimum, and no offence-related information will be given, in order to ensure anonymity. Participants were aged between 30 and 60 years, with the modal age group being 35-50. All had been diagnosed with a psychotic illness, and in each case admission to forensic secure care had been precipitated by a crisis event. The mean duration of secure psychiatric admission was 5.5 years, and five people had formerly been resident in high-security care. Some had been discharged for longer than others, but each had returned to the community from the MSU via a gradual process of step-down and re-acclimatisation, and was living independently or in supported accommodation.

2.3 Data collection and analysis

Data were gathered through individual interviews, and a semi-structured schedule was constructed to facilitate this. All interviews were conducted by the lead author, who strove for an open, conversational style in keeping with the principles of IPA (Smith et al., 2009). The interview schedule was therefore used as a flexible topic guide rather than a script, and questions were asked in an open-ended way, with use of active listening and reflection.

Given that the MSU in which they were formerly resident has been a proponent of recovery, it was assumed that all participants would have some familiarity with the approach: however, no formal definition of recovery was used, and participants were invited to consider what 'recovery' meant to them. Interviews were recorded using an encrypted, password-protected digital device, and transcribed verbatim by the lead author. The mean length of interview was 36 minutes.

Transcripts were analysed by the lead author based on the IPA technique recommended by Smith et al. (2009) for a larger sample ($N > 6$). This consisted of six steps:

1. Reading and re-reading a participant's transcript, immersively engaging with the narrative and highlighting possibly pertinent aspects.
2. Analysing the transcript line by line, including detailed observations on descriptions and the use of language, and exploration of concepts and possible (multiple) meanings for the participant.
3. Developing emergent themes at case level: i.e. managing and starting to distil the above into concise salient observations, and starting to consider commonalities, distinctions and possible patterns within the person's data.
4. Moving to the next case, and repeating steps 1-3 for each participant narrative.
5. Exploring further the connections between emergent themes: i.e. continuing each within-case analysis, and introducing simultaneous cross-case analysis. Themes across cases were grouped, distinguished and refined, using interpretative processes including abstraction, subsumption and contextualisation.
6. Developing and producing final themes and superordinate themes for the entire sample, aiming to encapsulate the salient aspects of participants' experience.

While themes were informed by psychological theory and knowledge, theory was not imposed in order to make sense of the data, and all themes remained grounded in participants' experiences as described.

Smith (2011) offers a rubric for ensuring quality in IPA research, including transparency about the procedures used, and the demonstration of sufficient evidence for each theme by way of extracts within the finished text. It is recommended that participants' extracts be individuated, allowing the reader to appreciate individual narratives, and ensuring each voice is represented (Smith et al., 2009). Further recommendations about quality in qualitative work are proposed by Elliott et al. (1999), Yardley (2000) and Chenail (2011), all of which guided this research. The third author is a highly experienced qualitative researcher: they provided advice on the analytical process throughout, and reviewed the analysis by the lead author of four randomly selected transcripts. Within IPA, it is recognised that the process of meaning-making is a dynamic one between participants and researchers, and sensitivity to context is important. To this end, the lead author also produced a reflective commentary addressing contextual issues (Stuart, 2016).

2.4 Ethical considerations

The study was approved by the NHS South of Scotland Research Ethics Committee 01. Recordings were stored in a highly secure computer environment at the MSU, in line with local policies and the Data Protection Act of 1998, with passwords known only to the first two authors. No patient-identifiable data were included in transcripts. FCMHT staff, including responsible medical officers, were kept informed about the progress of the research, including when participant contact was made. Contingency plans were in place in case of any distress or disclosure of risk by participants. It was made clear to potential participants that they could withdraw from the process at any time without giving a reason, including mid-interview: equally, it was made clear to FCMHT staff that participation was voluntary, and no pressure should be exerted upon anyone to take part.

3. Results

Interpretative phenomenological analysis identified five superordinate themes, with between two and four subthemes each. These are displayed in Table 1, which also identifies for which participants the themes were present.

Table 1: Themes and superordinate themes, and the participants for whom they were present (shaded cells).

	P1	P2	P3	P4	P5	P6	P7	P8
1. Living in the shadow of the past								
1.1 Dominance of the events that brought me into secure care								
1.2 Trying to make sense of what's happened to me								
1.3 Becoming something other than my past								
2. Power imbalances								
2.1 Dominance of services and systems								
2.2 Not having a say in my own life								
2.3 Being on the edge of society								
2.4 Finding empowerment and trying to fit back in								
3. Security and care								
3.1 Wanting to feel safe and secure								
3.2 Wanting to care	This theme was endorsed by the three female participants. To preserve anonymity, the gender of individual participants is not reported.							
4. Reconfigured relationships								
4.1 Relationships with others are different now								
4.2 Relationships with others are more difficult now								
4.3 Building new relationships with others (and myself)								
5. 'Recovery' as a barrier to recovery								
5.1 Who decides who's recovering?								
5.2 Recovery vs. cure								

3.1 Superordinate theme 1: Living in the Shadow of the Past

All eight participants acknowledged the enormity of the events surrounding their admission to secure care. Cognitive and contextual sequelae appeared to represent significant barriers. This superordinate theme contained three subthemes, of which one – ‘Becoming something other than my past’ – suggested attempts to overcome the problems that they perceived.

3.1.1 Dominance of the events that brought me into secure care

Five participants suggested that memories of the crisis events that precipitated their admission remained salient, with P7 so uncomfortable that they did not want the interviewer to know anything about their history. Many recollections appeared to be accompanied by emotional appraisals such as guilt and shame (Hellowell & Brewin, 2004). Participants talked of struggling with their past, including prior to the crisis event, and of sometimes feeling overwhelmed or trapped by it. Two stated that, while they had no active suicidal ideation, they felt it would be easier not to be alive:

P3: So much has happened in my past to affect me that sometimes if God gave me a choice that whether you want to live or not, then I would say to him: take me away.

This is not an active desire to die but a sense of weariness; a passive wish to be freed by an ultimate judge. Even when people had been judged by the legal system not to be in control of their actions at the time of their crisis event, there was a sense that some part of them was still responsible, and they struggled to reconcile this with their sense of self. Participant 2 explained:

... you are always scarred, that, that, em, you know [sigh] disruption in your, your, erm, identity ... It's always there. It's sliding back and forward and it's, it's always th- i- [pause] Even though you're not held responsible, it's still you.

The description of being scarred is vivid: a manifestation of both the events and the cognitive after-effects. P2 was highly articulate, and the slightly fragmented nature of their speech demonstrates the difficulty of trying to explain this wound to their valued sense of self. For all participants, the persistence of difficult thoughts and feelings was perceived as an obstacle.

3.1.2 Trying to make sense of what's happened to me

Seven people spoke of trying to make sense of, or rationalise, what had happened to bring them into contact with forensic mental health services, with the impression being that this was an endeavour to which they had devoted considerable time. For all participants, there appeared to be a tension between trying to push away what had happened and trying to accept it. All gave the impression of a lengthy history of difficult events prior to their admission, but some also talked of hope:

P1: What I've been through, I've been so lucky to get where I am, I mean, I ken [people] that have been through maybe less than me and ... [they've] maybe no had a chance in life, ehm, no aware of the things that are available to them.

There is the suggestion that forensic secure care gave them the ‘chance in life’ which had until that point been denied, something generally endorsed by five of the eight participants.

P2 was both grateful for and damning of this, expressing anger at not having received assistance sooner, given that their difficulties began many years before admission:

... and the thing about [MSU] is, it was the first place to have a nice environment, it has multidisciplinary teams where people work together, everything's geared, and you think: that's brilliant [whispering] but it's too fucking late.

Substance use was a major element of the histories of several participants, and some made causal links between substances, mental ill-health and what had happened to them both in terms of their crisis event and previously:

P6: my index offence was, I was-s totally [pause] intoxicated. And I, I can't remember any of it.

P4: I just became [pause] a Jekyll and Hyde with drink and drugs.

These accounts can be understood as questioning agency and responsibility. Participants' sense of self has been damaged: finding ways to rationalise their behaviour can help restore some self-esteem and allow some distancing from the past (Wilson & Ross, 2001), although it cannot make painful memories disappear. For P2, however, there was also the hope that their devastating experiences could yet provide positives for others. This – like, perhaps, P1's recognition of other people's difficulties – points to a valuing of connections with other people; of what P4 sums up as the desire to be a 'good guy'. This value reoccurs throughout the analysis.

3.1.3 Becoming something other than my past

Although the past looms large, all participants described a process of moving away from it to some extent. Three explicitly stated that the way they were living now was an improvement on how life had been before they were inpatients, and two more indirectly suggested this. P3 spoke of being saved:

And, my experiences in the past and, ehm, before coming into [secure care], the experience is so horrific that you know I'd be dead if [clinic] didn't pick me up.

This suggests that although what has happened in the past might be an obstacle, it is not always an insurmountable one. However, it is notable that P3 ascribes agency to services, not to herself.

Five participants stated that no longer using substances was paramount. This allowed for a gradual re-engagement with aspects of life they had missed, perhaps for a long time. Moving on from secure care is a challenging process, requiring personal strength, and gains which might seem small to the observer were achievements of which participants were rightly proud. For some it was appreciated when gains were noticed by other people, particularly family, while for others it was an individual process:

P7: I had a str-, a period of adjustment to go through, and I had to get used to being on my own and not surrounded by people. But I've got through that and I feel much more comfortable being in the community.

P5: I'm true to myself now. I only do things that I want to do, just think are right ... I live my life wi-, sort of reinforcing my own values and that. I don't think I do anything that's illegal, or immoral.

This makes explicit a personal value of morality. Prosocial notions were endorsed by all participants, suggesting they found this way of living rewarding. Nevertheless, the shadow of their history remains, and this subtheme is more about moving away from the past than towards any specific future.

3.2 Superordinate theme 2: Power Imbalances

Being under close supervision by services gave rise to multiple tensions, although this was not the only cause of disempowerment. This superordinate theme consisted of four themes, of which one – ‘Finding empowerment and trying to fit back in’ – again suggested attempts to overcome perceived obstacles.

3.2.1 Dominance of services and systems

Seven participants spoke of the dominance of mental health services, legal systems, or both. There was an impression of always being answerable or beholden to other people.

Interviewer: How do you feel things have been since you left?

P4: They've been torture ... It's like er I've been in the system 17 year, Simon, and it er it's, it prolongs, it's like having toothache, it never goes away, it's always constant, seeing people, doing things, everybody wanting a piece of you.

The experience is exhausting and akin to chronic pain. The word ‘torture’ is troubling, hinting that others actively impose this, and the participant’s use of the interviewer’s name contrasts with the impersonal ‘it’ of the system described. Nevertheless, participants also spoke of the value of some of the restrictions imposed upon them (something explored further in the third superordinate theme). This highlighted tension:

P6: ... I mean, if I'ds-, if I had a-a-ah, an opinion, or, a thought, or an expectation of anything, then I'd speak to [responsible medical officer]. And tell him what I think.

This person denied that anybody was holding them back, but illustrated this using their relationship with the psychiatrist responsible by law for their care. Their freedom can be seen as contextual, bounded by what they are allowed to do by the close and constant attention of powerful others – as will be the case for anybody on a legal restriction order. This was observed for small decisions (two people spoke of how applying for or maintaining a driving licence was complicated by their legal and mental-health status) and for larger goals such as P1’s desire to move nearer to family. Participants also spoke of the chronicity of their involvement with services:

P3: I mean, I've been in, in and out of hospitals all my life since the age of 18 ... so that's about over 30 years in and out of hospitals so you do get institutionalised. And it is difficult...

The subtle shift between the first (‘I’) and second (‘you’) person suggests that this institutionalisation would happen to anybody with such experiences. Involvement with services is perceived as having become inescapable and lifelong, and P2 wondered what impact this had on those services’ perception of them:

So there's that kind of ... ach, you know, here they come again, blah blah blah ... You just feel you're not taken seriously, erm, and it's terrifying to know that people can wield that power.

An anxiety results from feeling that they might be viewed by services as a recurrent problem, rather than as a person with individual needs. Regardless of the accuracy of this impression, it appears that they feel not just disempowered but somewhat dehumanised.

3.2.2 Not having a say in my own life

While the previous theme concerns the power of systems over people, this theme focuses on people's sense of powerlessness over their own decisions. Six participants suggested that their opinions and desires were not understood or were dismissed by others. Partly this was because of legal restrictions, but P2 also suggested that it was understandable for them to feel depressed sometimes, and that it was important for well-meaning services or other people not to invalidate feelings. Participant 4 seemed anxious about the process of moving on, and bluntly expressed their dissatisfaction:

I'm quite disappointed in the system because, it's like I'm telling them, I says, the last thing you should do with me is move me into a flat, I says.

The repetition of 'I says' accentuates their perceived helplessness: they can speak, but they feel they are not heard. They are asking to remain in minimally supported accommodation, but services believe it would be better for them to move on. Again, there is a tension: who knows best, the participant or the service? Four others described situations in which they disagreed with the course of care proposed for them. For services, reintegration involves considering the risk that each person has been deemed to pose, and balancing that with the availability of scarce supervisory resources. For the individuals, however, this professional management can represent a further disempowerment; an obstacle to recovery on their own terms.

3.2.3 Being on the edge of society

This theme arose in interviews with four participants, and appeared particularly salient for those who endorsed it. They spoke of feeling excluded; of struggling to be accepted, and sometimes of giving up trying. In each case this was the result of perceived stigma through being part of the mental health system, the forensic system, or both.

P5: Well like the first few years you're, you're sort of trying to fit in and then you think, I give up. You know, because er, you're just a mental patient to the rest of the world ... I-, I thought, you know, y-, you can't be honest with people about where you've been. So there's no point in trying to fit in, to that sort of world.

This person had stated that they believed they should have been in prison, not in forensic secure care. For them, stigma appears more related to being 'a mental patient' than to having offended, underscored by the disparaging 'just'. Twice in this extract, they suggest that they now inhabit a different world, highlighting a sense of us-and-them which other participants also acknowledged. For P2, this was sadly also noticeable when they had been invited to talk to mental health staff in an expert-by-experience role:

... and after it ehm one of the ehm I think it was a nursing assistant had come up to the head nurse and said, I can't believe that person was a patient ...

And you think, after all the training and 'recovery is possible', people still have the us-and-them [pause] i-, recovery doesn't happen ...

Here it is other people's attitudes which are presented as a barrier to social recovery. No matter what the person themselves feels, others unwittingly exclude them, even when trying to be complimentary.

Difference was manifested in other ways. P8 said that although antipsychotic medication had 'turned it around' in terms of their mental health, the hangover-like side-effects precluded them from permanent employment. As the barrier of their symptoms was removed, another arose. Participants intimated that other people could not necessarily grasp the enormity of their experiences, something most devastatingly summed up by P2:

Everywhere you go, people will go, well, ehm, you know, eh, I'm OK, I'm an OK person, you know, I've, I've got my own demons, but I'm not a- [pause] everybody goes [indistinct; speaking so quickly] but I'm not a murderer, or d'you know what I mean, or I've, I've not done this, you know, that's the bottom line, that everybody will draw. And you're saying: well, I'm there. I am there. Ehm, so it's, it's [pause] it's everywhere, it's, ehm, in culture, you know, e-, everywhere, so you're constantly feeling in, in the ditch.

The unwitting day-to-day language and interactions of people who have not experienced such shattering experiences further alienate those who have.

3.2.4 Finding empowerment and trying to fit back in

This theme was induced from all eight interviews and can be considered a counterpoint – though not a counterbalance – to the power imbalances considered above. People spoke of brief and sometimes more enduring victories, particularly in terms of gaining independence and control. Frequently this meant finding a sense of normality, either on their own or with support from services.

P7: I also get social support to go out. And do swimming and s-, go to the cinema or whatever.

Four participants endorsed the idea of exercise or physical fitness as important. P3 used self-directed support (Scottish Parliament, 2013) to have more say in their social care, while others spoke of the empowerment that came from the most basic freedoms:

P8: But freed-, aye, it is about freedom, aye, and walking about and that. Yeh, yeh. Going for walks at night and that.

The meaning attached to this again highlights a distance between the participants and a society that has not shared their disempowerment. For someone who is legally restricted, even a small sense of control may be highly valued, and normality was viewed as a significant achievement by all participants given their uncommon experiences. However, for P2 this was not enough:

... you're starting to get well when you start to get angry. Because you realise that there's actually things people could have done ... you think, well, what the hell's the point? It's too late now. So there's, there's a bit about that, and that's why I wanted to ... get involved ...

Getting involved with services as an expert-by-experience has given them a way of answering their own question, 'what the hell's the point?' The emotional appraisals of the past, and the sense of injustice, remain, but their response is to change their behaviour in keeping with their values of connection and equality.

Through such discussions, it was possible to begin to instantiate a wider sense of the values that participants associated with recovery. For P2 and P3 these appeared to include connecting with and caring for other people, and equality of care; for P5 honesty and integrity; and for P4, P6 and P8 being part of a community to which they felt they were contributing. P7 talked of the intrinsic reward that came with educational pursuits, while P1 spoke of wanting to become closer to God, and through that empowerment to renew a shared connection with others.

3.3 Superordinate theme 3: Security and Care

This superordinate theme contained two subthemes. It highlights the multiple meanings of the words 'secure' and 'care': how the former might apply to psychological concepts such as attachment and resilience as much as it does to risk, and how the latter might apply to looking after as much as to medical treatment.

3.3.1. Wanting to feel safe and secure

Within the previous superordinate theme of power imbalances, there is an impression that participants often wish to escape from close supervision. Nevertheless, all eight also indicated an ongoing desire for security in some form, and some were more confident than others about their ability to provide this for themselves. When P3 was asked what was their biggest struggle day-to-day, they replied:

Just eh not to be looked after, you know, and just to be in a safe environment where everything's done for you ... I mean, when you're out you're mainly on your own.

During inpatient secure care there was a shift of responsibility away from the person and on to staff, which seems to have been a relief. Upon discharge, responsibility has been returned, and they have struggled: indeed, the suggestion is that they do not feel entirely safe. P4, in shared accommodation, echoed these concerns:

I feel safe and secure in this house ... And that's how it-u keeps me away from drink, keep-uh drugs, because I'm safe and secure. When I stayed myself and that, I became unwell and I didn't feel safe and secure, and took more drink and drugs to cope with it.

There are questions here of resilience and responsibility. P4 seems to be suggesting that their capacity to contain their own emotional responses is limited, and that they are dependent on an external containment which they perceive as being provided by peers, services, and indeed their legal restrictions. Reliance on others to some extent was described by seven of the eight participants, whether this was family for support, services for support, services for medication, or a combination of these. Of all the participants, P5 was most comfortable on their own, but even they valued the security that came with having a sense of predictability and routine.

P1 said they appreciated having people 'holding my hands' as they explored what was available to them after discharge. P3, who had a longer experience of inpatient and outpatient care, used a similar metaphor, talking of the importance of a 'helping hand' as they lived their day-to-day life outside secure care. They also expressed directly an

ambivalence to which other participants alluded, a desire to be securely looked after at the same time as wanting to be free:

I mean, ideally if I could come in for a, er, a two-week break, er, into the hospital, I mean, that would make sure that [pause] I don't want to be in hospital, and when I'm out I want to stay out. Um, but, er, having said that, I do come to [hospital tearoom], I do attend clinics at [unit] still, so there is involvement, they've not let [pause] there's no s-, the safety net isn't gone.

They move quickly from relishing admission to rejecting admission, settling on the compromise of regular outpatient care. Hospital represents both a place of confinement and a place to which one can escape. Inpatient admission offers the rare luxury of security and care, but at the cost of freedom: sometimes this is a difficult choice to make.

3.3.2 Wanting to care

This theme arose from the narratives of the three female participants only. In the interests of anonymity, supporting extracts are not directly attributed here. All three women recognised the many challenges of their own situations, yet each spoke about the importance of helping those whom they perceived as less fortunate. One spoke of how she and her family were rallying round someone who was having difficulties – an echo of the efforts that the family had previously made to try to help them. In this way the desire to help can be seen as repayment. However, two participants spoke of their desire also to help people they did not know:

I mean the other day I took an asylum seeker for a meal out ... people are human beings, you can't just, because, they haven't got the same standards as you, you don't lose your value in, in all this, they're human beings ... I used to argue with my, my folks, they'd say don't give them any [indistinct: money?], they'll only spend it on drink. And I'm saying, well, maybe if it gets them from this day to the [pause] what's he going to do, put it in a deposit down on a house?

There is an overarching value placed on shared humanity, which recurs throughout this analysis. Previous themes are reframed here as applying to others instead of – or as well as – the participants: people being trapped by their past, and power imbalances. In these vignettes, the participants are in a rare position of relative power, and they wish to use this benevolently.

3.4. Superordinate theme 4: Reconfigured Relationships

There were three subthemes within this, each endorsed by all eight participants. The third subtheme again explores attempts to overcome differences and difficulties.

3.4.1 Relationships with others are different now

People spoke of having to renegotiate relationships with family, friends and others, their status as forensic patients affecting both how they perceived other people and how they expected others to perceive them. Three stated that familial relationships had improved following their inpatient treatment, though this was not straightforward:

P3: ... my family now, they ring me every week, I have a good conversation with them and I speak for an hour, you know, and an hour at a time to them, and I tell them what's going on. If I feel upset, I know that um they don't want

to see me in the state that I was in, mouth dribbling and overweight and you know, drugged up to the eyeballs ...

P3 emphasises the fact that they speak to their family for an hour as if this is a newly formalised experience. There is a sense that recovery is as much for the benefit of their family as it is for them, reinforced by the graphically critical way they describe themselves when unwell. Through this we can infer a sense of responsibility or duty to the family, reinforced by the way family is described as a homogeneous, powerful unit. P1 also alluded to responsibility, but saw it as bidirectional:

If she starts making an effort to get her life together, my [relative], ehm if she starts making a bit of an effort then I'll make an effort with her ... if somebody doesn't help themselves, you'll no' help them.

This is a participant who has 'helped themselves', and who feels that they have made significant changes, but it might be that they are beginning to move in a different direction from some of the people in their past. For P5, P6 and P8 this sense of distancing was more pronounced, and the descriptive phrase P8 uses at the start of this extract is compelling:

I've grew up at the wrong life, eh? And I've hanged about all of the dodgy neighbourhoods and that, an- [pause] I've seen guys since I've been out and they've been al-, oh gi's your number and I says ... I'm not giving you my number, and they're like, how no? I says, because I'm wanting a, I'm, I'm doing my own thing now, eh?

Breaking away from the 'wrong life' and the people associated with it is a relational and emotional challenge but also a practical one. As P8 explains, they cannot help but meet acquaintances with whom they no longer wish to associate, adding an extra complication to the process of recovery. P5 took extreme steps to avoid this, moving away from where they had lived, and cutting off all ties with family and former friends. They contrasted this with advice they said they had been given by professionals to stay in touch with family, again highlighting the tension between individual and service-led concepts of recovery.

As community patients, all participants were in ongoing relationships with staff: even those who expressed ambivalence about services in general stated that they had a good relationship with their community psychiatric nurse. Participant 3 said that they felt a familial connection with their clinical team, and four others gave examples of situations in which professionals had adopted a parental role, for example:

P6: I've not had a drink for 12 years.

Interviewer: That's fantastic.

P6: I know. And even the GPs think that's good an' all.

The participant's pride in this has a guileless, almost childlike quality. It is also notable how the interviewer immediately offers praise, responding to and accentuating an adult-child dynamic.

Participants spoke about their perceptions of community and society. Some expressed the wish that people would do more to help each other but there was a general sense of agreement that, in P7's words, 'most people are kind and honest', and every participant expressed prosocial views. P5, who lived the most solitary life, expressed them from a distance:

But you see a lot of nice people out there, y', you know. D-id, I'd, I'm, sort of, what d'you call it, off stage and looking at people, and you see them conducting their everyday lives, and I get quite a buzz out of that.

Although they feel they can no longer play a part on the societal stage, and watch instead from the wings, they nevertheless care about other people and take pleasure in their happiness. This is a complex relational situation and not one necessarily accounted for by traditional recovery concepts.

3.4.2 Relationships with others are more difficult now

Relationships were not just different: every participant gave at least one instance of a relationship being more difficult after discharge, posing another barrier to recovery. Some relationships required additional effort:

P3: I've involved my family, I've involved my friends, I've involved the services ... I've built relationships with everyone, you know. So there's a lot of hard work that goes into it.

The implication is that if they did not put in the 'hard work' themselves, they would not have the care that they do. This might be an ongoing challenge for someone who has struggled with the move back to the community. P6 spoke of a family member with whom they had a troubled relationship: who refused to countenance the idea of any kind of recovery, and who was sceptical about concepts of mental ill-health and their treatment. Like others, this participant desired support after their experiences: paradoxically, the nature of those experiences made support less likely from this relative. Conversely, P2 spoke of family who tried to offer support but – echoing comments about invalidation – failed to understand their experiences:

It's very difficult to explain to people after it. People would try and come up to me and, and, and, ehm, try and say, why couldn't you let [pause] us look after [pause] as if I had [clears throat, pause] my actions had been deliberately against them...

Although P2 said that they felt supported, events surrounding their hospitalisation had naturally affected their wider family. Again, recovery might be hindered by the way that other people respond and behave, and familial support systems may contain fragilities, no matter how strong they appear.

As previously noted, all participants expressed prosocial views. Four participants, however, talked of times when such inclinations had to be tempered, as illustrated by P5 and P2, both discussing instances when they had met new people:

P5: I was saying, there are things about me that you probably wouldn't like to hear and all that, and er I'll need to tell you before I'd even go out on a date with you...

P2: ... and it's very difficult for me because I'm, I'm a very friendly, sociable person, so I'll be out and I'll be talking to people and of course they'll start asking questions, you know, are you married, y'know, y-, and it's, and where's this gap for so many years ...

Both faced a similar dilemma in deciding whether or not to disclose their past.

P5: I would like to be absolutely honest with people but ... when I was with people, their reaction was like terrible.

P2: My instinct is to be honest and truthful, but I can't, I can't do that to everybody, because once that information's out, people can do whatever they want.

They value honesty and authenticity, but both feel that, because of the context in which they find themselves, this is not always possible. There may be occasions when, to protect themselves from adverse reactions, they have to act against their values. Like all the participants, their relationships are circumscribed by the events of their past.

3.4.3 Building new relationships with others (and myself)

Despite these concerns and difficulties, seven participants described examples of positive relationships formed with others post-discharge. Three highlighted improved relationships with family, while P4 spoke of their happiness at being seen by others simply as a neighbour. Six people suggested that they had formed positive relationships with others who had been through similar experiences: given that many of the barriers described above relate to other people's lack of understanding of what the participants had experienced, there are obvious advantages to such relationships. Peer support had been formalised for some participants in group therapy, and for P1 the sharing of experiences was invaluable:

So 10 years of my life was one guy who was talking about his life, he spoke about my life. So I was able to connect with that ... sitting in they groups is powerful.

Once again, connecting with other people is valued and, in this case, empowering. P5 was the only person not to describe any valued interpersonal experiences post-discharge, but they did indicate an improved relationship with themselves. They had deliberately broken all ties with their past, rejecting not only their former behaviour but their former attitudes to the wider world (the 'it' in this extract):

Back then I did what everybody else did and I took the drugs and the alcohol and blocked myself off from it. 'Cos I'm thinking it's shit. Everybody says it's shit so it must be shit.

They had subsequently found a sense of peace through increased engagement with their surroundings:

I'm embracing my world, which is the world around me ... I've noticed so much in the last [number of] years in particular, than I've ever noticed.

They spoke of a conscious engagement both with the natural world and with day-to-day activities such as doing their shopping. Despite their rejection of formal therapy, what they were describing was in effect mindful engagement with the present (Kabat-Zinn, 2003). Ideas of intrapersonal growth and a new understanding of the self were also endorsed by participants 1, 2, 6 and 8, although in these instances they were more clearly associated with direct therapeutic input.

3.5. 'Recovery' as a Barrier to Recovery

The fifth superordinate theme, induced from all eight interviews, consists of two subthemes concerning the idea of recovery itself. The sense that people make of the concept may, paradoxically, be an impediment to its achievement.

3.5.1 Who decides who's recovering?

Seven people alluded to a tension between services' conceptualisation of recovery and their own. The only participant who did not was P2, who had developed an understanding of the wider recovery movement through their expert-by-experience work. The rest described instances in which 'recovery' appeared to be a concept owned or even imposed by others, as opposed to one generated by and belonging to them. As such it could be perceived as a goal to be met, rather than an ongoing process.

P3: [Staff member] er normally talks about recovery. And although I don't feel like I've recovered or am recovering, ah, I'm sure the progress seen by everyone is recovery. Although I don't feel it myself.

Interviewer: ... what would you say that concept of recovery means, to you?

P3: When you're enjoying life, you're erm enjoying getting up in the morning, um, when errr, you're participating in uhm [pause] er, things out there, um, like [pause]. But I, I think, i-, eh, for me anyway, I, I don't think it's a recovery, it's, it's, eh, it's a means to an end, just to pass the day, just to get through the day.

P3's faltering syntax suggests that the question of what recovery means is not an easy one to answer. They recognise that they are making progress in the eyes of others, and that some aspects of what they are experiencing may fit the definition of recovery as described by staff, but this is not 'felt', possibly because intrinsic reward is missing. Again, the impression is of movement away from aversive stimuli such as cognitions pertaining to the past – doing something 'just to get through the day' – rather than appetitive movement towards what is desired, and one problem may be that what is desired is not clear. P4 highlighted a discrepancy between practical and emotional aspects of recovery:

Because they say I'm that well ... and able and capable and all that. But they only see the fi-, the practical side. They don't know the emotional side. And that's what gets me.

P4 considered themselves 'recovered', and their fear was that a change in context would permanently undo this. For them, recovery is a discrete event, not a process involving both forward and backward steps. Three people made reference to recovery involving stepwise movement in one direction, and gave the sense that progress could be measured in terms of how many groups or sessions of therapy had been attended. This sits uneasily with any definition of recovery as involving valued social and personal outcomes. For P5, meanwhile, recovery was a concept that simply did not apply:

P5: I just don't accept that as a word. You know, what I had to do after my index offence was sober up. An- that's what I had to do. And so once you've did that, that was that. As far as I was concerned.

Interviewer: I suppose some people would see that process, of sobering up, as recovery.

P5: Yeh, but I'd sobered up in 24 hours.

This leads to the second element of this superordinate theme.

3.5.2 Recovery vs. cure

That recovery is not synonymous with cure is an essential facet of the widely accepted definition (Anthony, 1993). P2 appreciated that this could be a difficult distinction for people to understand:

... recovery does not mean cure, just like if you, supposing your arm chopped off, ehm, you will recover but you won't have your arm back.

Objectively, this is an excellent metaphor for recovery, but P2 had chosen to explore the concept and had developed a sophisticated understanding. The other participants were less invested in recovery per se, and five indicated that, for them, recovery meant being asymptomatic: a focus on 'recovery from' at the expense of 'recovery in' (Davidson & Roe, 2007). P7 stated: 'I can control my symptoms and do things that I like to do,' yet reiterated: 'I don't feel as though I've made much of a recovery yet. I've still got mental health problems.' There is a sense of mutual exclusivity here: recovery can begin only when their mental health problems end. Aspects of P7's diagnosis mean they were likely to be more rigid in their approach, but this view was echoed by others:

P3: ... and now, seven years on, I'm still not, not recovered from my past experiences ...

Interviewer: ... do you think those past experiences are something it would be possible to recover completely from or not?

P3: No, not for me ... not for the many people that er come through [MSU].

The operative word, made explicit by the interviewer but intimated by the participant, is 'completely'. P3 states, understandably, that what they and others have experienced is too overwhelming to allow for complete recovery. This should not preclude progress within the broad recovery paradigm – an ongoing process on people's own terms – but this is not something that P3 feels to be feasible either. 'Complete' recovery – binary, all-or-nothing – appears to be what the majority of participants' desire, and the process-driven, individualised consumer model does not necessarily feel like an adequate alternative.

4. Discussion

4.1 Summary of results

This study explored perceptions of recovery described by eight people formerly resident in a medium-secure unit in Scotland. The primary research questions were: what did participants understand recovery to mean after their experiences in secure care; and what did they perceive as barriers to their recovery? Secondary questions investigated participants' values; to what extent these were congruent with their recovery; and to what extent they thought their values were congruent with those of wider society. Five superordinate themes emerged from an interpretative phenomenological analysis: Living in the Shadow of the Past, Power Imbalances, Security and Care, Reconfigured Relationships, and 'Recovery' as a Barrier to Recovery. Together, these support the general suggestion that recovery within forensic settings is a complex and challenging process (Mann et al., 2014; Mezey et al., 2010; Simpson & Penney, 2011), although it should of course be borne in mind that the study specifically explored barriers. As might be expected, there is overlap with the themes identified in the inpatient-focused meta-syntheses of Clarke et al. (2016) and Shepherd et al. (2016), neither of which had been published when our analysis was conducted. However, our results suggest a number of discharge-specific issues, of which power differentials may be particularly pertinent.

4.2. Values and positive aspects of recovery

Asking participants about their values revealed something about what they perceived as positive aspects of recovery, and three superordinate themes – Living in the Shadow of the Past, Power Imbalances and Reconfigured Relationships – contained subthemes that suggested hopeful aspects of recovery. These were ‘Becoming something other than my past’, ‘Finding empowerment and trying to fit back in’, and ‘Building new relationships’, endorsed by all participants.

The CHIME framework of Leamy et al. (2011) offers a summary of what are broadly accepted as the appetitive elements of recovery (Connectedness, Hope, Identity, Meaning, Empowerment). Our participants’ prosocial values map onto the theme of connectedness: even P5, despite their distancing from other people, saw value in others’ happiness. The helping role desired by the female participants echoes the concept of generativity within criminological theory: a desire to give back to society, in keeping with what might be a fundamental value of caring about other people (Maruna, 2001). All of our participants displayed hope and optimism in some form: even P4, who appeared most fearful about their future, found some happiness in their present situation. However, none of the participants described a straightforward process of positive thinking and aspiration: P8, perhaps the most optimistic, still described significant setbacks along the way. This is in keeping with a balanced, difficulties-aware conceptualisation of recovery processes. All eight participants reported finding some element of empowerment in what they were doing, although this appeared difficult to attain. Even if values-congruent action is accepted as a lifelong process (Hayes & Pierson, 2005), the participants’ context provided additional challenges to the achievement of meaningful goals: most people, for example, would not face legal restrictions on moving to another part of their country of residence in order to be nearer family. In the present research, issues of identity are maybe best summarised by the difficulties in achieving what Smith & Garcia (2012, p.111) call ‘the move from mentally disordered offender to person’. Identity is frequently an overarching theme in IPA research (Smith, 2004) and will be considered further below.

4.3. Barriers to recovery

For the participants, recovery is complicated by what Mezey et al. (2010) call the dual stigma of historic mental illness and historic offence. A large part of this is contextual: for as long as people are in the care of forensic mental health services, those services will be keenly aware of risk, with concomitant restrictions made upon what a person is legally able to do. The question of positive risk-taking is therefore fundamental here (Roberts & Boardman, 2013): to what extent are services willing to encourage values-congruent behaviour – e.g. engagement with new activities or social groups – rather than simply to say ‘no’ as the most straightforward risk-averse approach? This is a question beyond the scope of this paper, but we hope that the discussion here provides fertile ground for further exploration.

However, there is an intrapsychic element to barriers too. Participants were dealing with the cognitive sequelae of their histories, frequently in the form of difficult emotions. Psychologically, attempts to suppress these are likely to have a counterproductive effect (Wenzlaff & Wegner, 2000) and it is likely from some accounts that there was a tendency towards depressive rumination (Watkins, 2008). Making sense of what has happened appeared to be a recurrent challenge, conflicting with the forward-looking notions of optimism and empowerment inherent in the recovery approach. Furthermore, considering their histories, it is likely that some participants were experiencing ongoing cognitive aspects of complex trauma (Courtois, 2004; Herman, 1992), including shame and other emotional appraisals related to the event that brought them into secure care (Crisford, Dare, & Evangeli, 2008; Gray et al., 2003).

Dorkins & Adshead (2011) propose that, because of their histories, the previous identities of some forensic patients are spoiled beyond recovery. In this case – as Arenella (2015) asks about recovery in general – there is a semantic question: what is it that we hope people will ‘recover’? Generally, participants wanted to look forward, even if that was difficult: as Dorkins & Adshead (2011) suggest, the challenge is building a new identity, not rebuilding or redefining an old one. Whether concepts of identity within the recovery approach are sophisticated enough to account for this is unclear. The superordinate theme of Power Imbalances also suggested a loss of agency, and perhaps even of personhood: the move to what Coffey (2012a) describes as an enduring risk identity.

The review by Mann et al. (2014) states that problems with attachment are prominent within forensic populations, and traumatic experiences over the lifetime may be related to increased attachment insecurity (Cozzarelli, Karafa, Collins, & Tagler, 2003). In this context, complex patterns of care-seeking – for example the ambivalent attitude to services explored in the superordinate theme of Security and Care – become increasingly understandable (Courtois, 2004). Mann et al. (2014) further posit that relational difficulties linked to insecure attachment might make it difficult for forensic patients to articulate their needs, and that they may perceive encouragement to take personal control as the removal of the security they desire: something demonstrated within participants’ narratives. Laithwaite and Gumley (2007), in a qualitative study with inpatients at a high-secure hospital, propose that some people saw the hospital as a secure attachment base; for some participants in the present study, discharge felt like a severing of links, and continued contact with the forensic community team was no substitute for the security and care provided on the ward. Within attachment theory, a secure base allows for exploration of the wider environment, which involves some degree of risk-taking (Carr, 1999). Forensic patients, however, are unlikely to be encouraged to take risks, and community staff’s role becomes akin to that of an over-protective parent. At the most fundamental level, a power imbalance is enshrined within the forensic patient-staff relationship, preventing people from the kind of fully agentic, self-efficacious empowerment which the recovery approach encourages (Silverstein & Bellack, 2008).

Ironically, then, people may be disempowered by discharge from secure care. They remain beholden to the risk-focused structures and strictures that dominated their lives as inpatients, but without the welcome containment and social support offered by the ward; furthermore, they may be prevented from engagement in employment or other personally meaningful activity because of symptoms, medication side-effects, culturally embedded public attitudes or simply because it is easier for services to say ‘no’ (Coffey, 2012a). Being accepted by, and involved in, one’s community is a vital aspect of social recovery (Smith & Garcia, 2012): for our patients, this was likely to be a significant challenge, as the superordinate themes of Power Imbalances and Reconfigured Relationships suggest. For some, the only way they could conceive of recovery was to deliberately distance themselves from the communities they had once known, or to hide aspects of themselves from those communities in which they now found themselves.

The question might therefore be asked: within a recovery context, are we asking too much to expect participants’ individual values and motivations to outweigh the pressures of context? The recovery approach as it is commonly conceptualised is agentic and requires personal responsibility for change (Roberts & Boardman, 2013). It would be understandable if people disempowered by their situation and struggling with the burdens of the past did not readily accept this responsibility, particularly if they have internalised a strong risk identity. This is further reflected in the tensions inherent in the final superordinate theme, ‘Recovery’ as a Barrier to Recovery. The majority of our participants appeared not to desire recovery so much as reinvention or cure.

4.4 Clinical implications

It is not possible simply to generalise from the present research to any wider population of forensic outpatients. However, Polit and Beck (2010) suggest that the informed reader can evaluate the extent to which the results of a qualitative study may be transferable elsewhere: on that basis, and in the context of existing literature, some clinical implications might usefully be explored.

The findings remind us that recovery is not straightforward or linear. Each participant described ongoing elements of struggle and difficulty, both cognitive and contextual, alongside positive experiences of recovery. Optimism is a fundament of the recovery approach, but it might be overly seductive: in short, recovery may not look like professionals want it to, and realism is vital (Stuart et al., 2016). Just as recovery does not preclude symptomatology (Anthony, 1993), nor does it preclude acute episodes of distress in people most severely or chronically affected by mental ill-health: and in the forensic system, it might be expected that service users are severely affected and historically traumatised (Mann et al., 2014; Witvliet, Knoll, Hinman, & DeYoung, 2010). Nevertheless, we would propose that the recovery approach remains fundamentally valuable to forensic clinicians. It offers a broad framework for values-congruent behaviour and, vitally, encourages staff always to think about patients as people (Gudjonsson, Webster & Green, 2010). This might encapsulate the most important implication for services: the necessity for informed realism about what each individual can achieve, and an honest, ongoing dialogue with them about this. Through such dialogue, people's prosocial values might also become explicit (as was the case with all our participants); once values are explicit, there is the possibility for newly values-congruent behaviour, especially if this can be supported by a risk- and recovery-aware forensic service.

Recovery had different meanings for different participants, and one response might be that the approach needs to be more clearly defined. However, this might be too simplistic. Recovery has to be experiential as well as propositional: people need to feel it as well as know about it. This did not always appear to be the case, and fostering intrinsic reinforcement by exploration of patients' values might be a way to address this therapeutically (Wilson, Sandoz, Kitchens, & Roberts, 2011). Just as our phenomenological approach to analysis involved an attempt to understand participants' values in the context of their experiences – and vice versa – so might a phenomenologically informed approach to psychotherapy. Such an approach seeks not to pathologise or medicalise, but to understand an individual's experience of being-in-the-world, and how this involves the interaction of contextual variables (e.g. social and economic) with the intrapsychic (e.g. values and cognition) (Young, 2010). While phenomenological therapy has traditionally been conceptualised as standing in opposition to cognitive-behavioural models of therapy (CBTs), this may be an unhelpful dichotomy, especially if the 'cognitive' aspects of CBTs are understood as ongoing attempts to construct meaning in context (Corrie & Milton, 2010). Mindfulness-based approaches may also be conceptualised as phenomenological, in that they emphasise an awareness of being in each moment (Kabat-Zinn, 2003; Young, 2010). Arguably, then, phenomenological therapy is more a stance than a theory, and third-wave developments in CBTs such as Acceptance and Commitment Therapy (ACT) – a mindfulness-based, values-focused approach – may offer great scope for the exploration of multi-faceted concepts of the self and the pursuit of intrinsically rewarding values (Hayes et al., 2006). The ACT approach of cognitive defusion may also offer a workable alternative to cognitive restructuring, which could be particularly challenging given the nature of forensic patients' experiences. However, substantial research is needed into ACT's effectiveness with this population (Howells, 2010) and, as described above, the problem of contextual obstacles to values-congruent action remains.

More generally, the question of trauma-informed psychological treatment is pertinent in light of our results. Trauma-informed psychotherapy cannot be guaranteed at all secure units: practitioners with an informed understanding of trauma therapy, such as clinical psychologists, might therefore usefully work with other professionals who are adopting a recovery approach, to provide training, support and direct input. This includes an awareness of the impact of a person's own historic behaviour, and the possibility of compassion-focused work in response (Witvliet et al., 2010). Access to psychological therapy as part of a discharge care plan would be optimal for many patients (Palermo, 2014): while this increases pressure on services and would require additional investment in specialist clinical psychology, it might – as in so many areas – bring longer-term gain (Wells, 2010).

Hagan & Smail (1997a, 1997b) argue that it is futile and even cruel to expect psychological change in any person without providing them with the resources to bring about that change. They propose a technique called power mapping: a graphical way in which people can make sense of their situation using environmental, social and political factors, and to explore different avenues by which they might obtain empowerment in keeping with personal values. It is an approach more associated with community psychology than clinical psychology, and there is no obvious therapeutic evidence base: however, Harper and Speed (2012) suggest that it may be used by clinicians as a way of identifying structural facilitators of recovery. Within forensic services, this could feasibly allow for the exploration of opportunities while acknowledging the impact of legal restrictions. Ryle and Kerr (2002) note that power mapping can be integrated with Cognitive Analytic Therapy (CAT), which is increasingly used within forensic services and with people who have experienced complex trauma (Calvert & Kellett, 2014).

Finally, peer support may be a valuable model for services to explore (Gilmartin, 1997). Participants spoke of the value of this, and paid peer-support workers – people with lived experience as forensic service users – could be a valuable addition to any community team. However, Slade et al. (2014) caution that services must value such workers equally with other staff – and, at a more fundamental level, offence histories may act as a barrier to employment in this area. Mann et al. (2014) describe a weekly group for forensic patients approaching discharge or already discharged, allowing for the regular discussion of practical and emotional challenges, and the development of supportive relationships and friendships. If power differentials can be suitably managed, such groups have the additional advantage of offering re-empowerment at a small collective level (Line, Marsh, & Cooke, 2014; Rose, 2014).

4.5. Directions for further research

All of the areas outlined above lend themselves to further practice-based research by clinical psychologists and other disciplines. In particular, given the increasing focus within clinical psychology on trauma-informed work (DCP, 2014), trauma-focused research within a recovery paradigm appears pertinent. Small- or single-N studies reporting different interventions would be a valuable addition to the wider evidence base: something particularly important where the power-mapping method of Hagan and Smail (1997a) is concerned.

There is likely to be value in further qualitative research asking for whom the recovery approach works, and by what processes. Jamieson, Taylor, and Gibson (2006) provide an emergent grounded theory of the transition from secure care to independent living based on interviews with clinical staff. A grounded-theory design using interviews with patients could be used to explore the processes of recovery in more detail, and would be a fruitful follow-up to the current project provided it could be carried out on a large enough scale to meet the methodological criteria (Smith et al., 2009). National clinical psychology training programmes and professional networks may be able to facilitate a multi-site, multi-researcher study.

Discussion of context, power and exclusion places the focus as much on systemic and societal issues as on individual intervention. Davidson & Roe (2007) argue that there is a lack of understanding of mental illness generally in societies, and propose that programmes of community education might improve this. Jamieson et al. (2006) suggest that every effort must be made to establish a more critical understanding of what 'community' actually means in community care, and qualitative research with those involved both directly and indirectly (e.g. neighbours) with people discharged from secure care would be a valuable approach, albeit one with potential ethical difficulties. Co-production of research between clinicians, academics and service users is increasingly a focus for services (McKirdy, 2015), and interested service users might be encouraged to become directly involved in the design and implementation of any such work. Service-user involvement at the development and design stage of research can bring a number of benefits, such as different perspectives on priorities and outcomes, and further empowerment and participation of people outwith traditional professional networks (McKirdy, 2015; MacInnes, Beer, Keeble, Rees, & Reid, 2011). This would be in keeping with the service-user-focused fundamentals of the recovery approach.

4.6. Limitations of, and reflections on, the present study

Philosophically, the lack of service-user input into the design and implementation of this research is its biggest flaw. The balance of power remains with the researchers: while qualitative research allows for marginalised voices to be heard, it was nevertheless a professional researcher who analysed and presented those voices in this study, and a 'them and us' distinction remains (Barnao, Robertson, & Ward, 2010). Consultation with representative service users at the planning stage might have allowed for different perspectives on the topic guide and on the secondary research questions. Respondent validation of results (Malterud, 2001), for example via a representative focus group, was not achieved in the present study, but can hopefully be included in future research. As with all focus groups, care would need to be taken to ensure a balanced range of views: given that recruitment to the present study was not straightforward, this may be a challenge. It would also be important to ensure that forensic service users did not feel coerced into discussing issues about which they did not want to talk.

Given that recruitment was not straightforward, we are profoundly grateful to the eight people who agreed to take part. Ideally within an IPA study, information would be included about each participant to illustrate more clearly their individual contexts (Smith et al., 2009). In this research, issues of anonymity were very much to the fore, and the decision was made to minimise detail that might identify anyone. While the narratives and opinions of those who took part cannot be taken as representative of any wider population, people articulated a range of experiences and opinions. Nevertheless, the narratives of those who declined an invitation to participate, or who were not able to take part, would have been of equal value and may have provided different perspectives. All medium-secure units are not the same, and certain facets of the setting in which this research took place – how step-down to lower security is facilitated; the therapeutic milieu – will have affected the findings to some extent.

The attempt to explore participants' values as part of a qualitative study looking primarily at barriers to recovery was ambitious, and not entirely successful. Little was learned, for example, about congruence between participants' values and what they believed to be the values of wider society. This may be because participants found these more abstract questions less interesting or engaging than the more personal discussion about their own recovery which preceded them: service-user input into the topic guide might have been one way of addressing this. More generally, the focus of the research on barriers to recovery is perhaps indicative of a traditionally pessimistic approach to work in the forensic

and offence-focused areas (Farrall, Lightowler, McNeill, & Maruna, 2013): future IPA work might therefore explore facilitators of recovery.

4.7. Conclusion

Despite its flaws, we believe that this is a valuable study which begins to explore the hitherto neglected area of recovery after discharge from forensic secure care. Difficulties may be a key but overlooked process within recovery: for former forensic inpatients, these may be magnified, and our research suggested various barriers, both cognitive and contextual. Davidson, O'Connell, Tondora, Styron and Kangas (2006) raise the important question of whether 'recovery' is a term most service users would choose to use: for the majority of our participants, there appeared to be a discrepancy between the optimistic tenets of the recovery approach and their lived experience. A focus on intrinsic reinforcement – on values – might therefore be of clinical benefit. Pragmatism is vital, but further change remains possible, both individually and systemically (Harper & Speed, 2012; Slade et al., 2014). While it is unlikely that any forensic service adopting a recovery approach would do so naively (Drennan & Aldred, 2012a), we hope this research will inspire further research and discussion.

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The authors declare that there is no conflict of interest.

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