

Forensic Mental Health Service Users Narratives of Recovery

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Declaration and signature of candidate	
<p>I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.</p> <p>I confirm that the decision to submit this thesis is my own.</p> <p>I confirm that except where explicitly stated, the work has not been submitted for another academic award.</p> <p>I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.</p> <p>Signed: _____ Date: _____</p>	

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Dad, this is dedicated to you.

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Preface

This thesis comprises three papers; a literature review (paper one), an empirical research paper (paper two), and an executive summary (paper three). Papers one and two have been written for publication in *Psychology, Crime and Law*. General submission guidelines for the target journal have been followed, however for the purposes of thesis submission font size 12 and extended left hand margins have been used to adhere to University submission guidelines. Additional content included for the purposes of thesis review, including non-standard headings will be removed prior to manuscript submission to the target journal. Guidelines for submission can be found in Appendix A.1 on page 42.

Thesis Abstract

This thesis aims to explore the recovery experiences of forensic mental health service users. In doing so, it seeks to add to the small but growing field of literature exploring the application of recovery principles in forensic settings.

Paper one is a review of the current literature, synthesising the recovery experiences and perceptions of forensic mental health service users. A total of 10 papers were included in the thematic review. Five themes were identified; hope; connecting with others; meaningful occupation, roles and identity; the powerful environment of the hospital; and coming to terms with the past and diagnosis.

Paper two is an empirical paper which explores the recovery stories of five male participants who had been detained in a low secure forensic service and discharged into the community. A narrative analysis reveals the shared personal, community and dominant cultural recovery narratives. Counterstories were also identified. The findings are discussed in relation to the clinical implications, in particular how to work within a cultural narrative of openness about mental illness stories, but secrecy around offending narratives. Further research implications are also discussed.

Paper three is an executive summary which seeks to provide an accessible summary of the empirical research paper. This provides an overview of the research, highlighting the key points and salient information in terms of clinical implications for service delivery in a forensic context.

Paper 1 – Literature Review

What does recovery mean for patients from secure forensic services? A Review of the Qualitative Literature

Word Count: 7,842

Abstract

There is a limited but growing evidence base exploring the utility of recovery approaches within a forensic setting. Much of the literature identifies the unique and specific challenges in applying recovery principles in forensic settings. This review aims to provide a comprehensive and contemporary synthesis of the recovery experiences and perceptions of forensic mental health service users. Relevant electronic databases and grey literature sources were searched and a total of 10 studies that fit the inclusion criteria were included in the thematic synthesis. In adherence with Critical Appraisal Skills Programme frameworks (CASP, 2013) and guidelines from Elliott, Fischer and Rennie (1999) and Yardley (2000) on qualitative research, a critical appraisal tool was developed in order to evaluate the papers included in the review. The thematic synthesis identified five themes: hope; connecting with others; meaningful occupation, roles and identity; the powerful environment of the hospital; and coming to terms with the past and diagnosis. A critique of the analysis is offered and clinical practice and research implications are discussed. In particular, the importance of future research prioritising the voice of the forensic mental health service user is imperative if we are to understand their perspective of recovery.

Key words: *recovery, forensic mental health, secure care, literature review.*

Introduction

Recovery

The recovery paradigm in mental health has grown over recent years and the concept has become dominant across mental health service provision (Leamy Bird, Le Boutillier, Williams, & Slade, 2011; Slade, 2009; Slade, Oades & Jarden, 2017). It has been described as a guiding vision of service provision amongst practitioners, researchers and policy makers, as well as service users (Department of Health, 2001; Shepherd, Boardman, & Slade, 2008; Turton et al., 2011). Recovery is a word that has had many definitions and remains something of a contested term. However, a widely accepted definition from Anthony (1993, p. 527) states that recovery is:

A deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the 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.

Recovery is a dynamic and personal process, anchored in the experience of the person who becomes empowered to achieve a fulfilling and meaningful life (National Institute for Mental Health in England, 2005). The approach emanated from the survivor-led recovery movement in the 1990s, which opposed the traditional medical model. There are now many recovery based initiatives within a range of services in the UK (Royal College of Psychiatrists, 2007). Shepherd et al. (2008) highlight that personal recovery from mental health difficulties is often an explicit goal within services. Services that are recovery-oriented have been identified as being able to deliver better mental health and social outcomes for service users (Warner, 2010). The Sainsbury Centre for Mental Health (Shepherd et al., 2008) has

stated that recovery 'is an idea whose time has come' and provides a new rationale for mental health services.

The literature on recovery approaches is dominated by studies describing various aspects and processes of recovery from mental health settings and contexts that exclude specialist mental health services. There have been models of recovery suggested, such as Andresen, Caputi and Oades' (2006) model of the stages of recovery or Drennan and Alred (2012) four-facet model, and research aiming to describe the key principles of recovery, such as Repper and Perkins (2003). Other qualitative research has explored service users' accounts of recovery, for instance with community mental health service users (such as Doherty, 2011), and recovery from schizophrenia (Davidson, 2003). Further research has explored recovery in the context of service users' relationships with professionals (such as Borg & Kristiansen, 2004). What is largely absent from the literature is an exploration of recovery within more specialist fields of mental health, including forensic settings (Turton et al., 2011).

Recovery in a Forensic Mental Health Context

Forensic services pose a unique challenge for the recovery approach. It has been argued that forensic settings are amongst the most difficult places to apply recovery principles (Drennan & Wooldridge, 2014) and that forensic patients are amongst the most difficult to engage (Davidson, 2002). Several authors (for instance Cromar-Hayes & Chandley, 2014; Dorkins & Adshead, 2011; Mezey, Kavuma, Turton, Demetriou & Wright, 2010) highlight why it is especially challenging applying recovery approaches to service users in forensic settings. This includes the inevitable impact on recovery from being legally detained; compromising choice and control over treatment, the impact on hope and optimism, and the forensic process of confronting maladaptive patterns of behaviour and identity. Some authors have described a "double" stigma (Brooker & Ullmann, 2008; Drennan & Wooldridge, 2014), emanating from the complex interplay of both mental health and detainment within criminal justice systems. Decisions around treatment are likely to be dictated

more by the need to manage risk to the public, than by the choices and wishes of the service user (Maden, 2007). The restrictions, sanctions, risk, and detention of forensic service users result in a tension between the setting itself and application of recovery principles. This is particularly as there are specific issues with empowerment and autonomy within forensic services (Pouncey & Lukens, 2010; Simpson & Penney, 2011). An important component of recovery is the focus on strengths; however the evaluation of deficits and limitations are imperative within forensic services.

The literature highlights the many obstacles to recovery for forensic patients including the setting itself, patients' status or image, labelling and social factors, motivation and adherence, or treatment-specific factors (Dorkins & Adshead, 2011; Henagulph, McIvor & Clarke, 2012; Mezey et al. 2010; Simpson & Penney, 2011; Viljoen, Nicholls, Greaves, de ruiter & Brink, 2011).

Despite the challenges, there is a growing body of literature that explores the ways forensic services can embed recovery principles. In relation to clinical applicability, two important papers have recently explored the perspective of the professional; Drennan and Wooldridge (2014) and Dorkins and Adshead (2011). Both papers highlight the unique challenges in undertaking such a task; however both stress the importance of engendering hope and the role of professionals working within these settings as being central to recovery. In considering this, it could be concluded that careful and specific adaptations to what is already known about using recovery approaches could reduce some of the tensions between risk management and meaningful recovery.

Rationale for Review

There is a paucity of research into what recovery means for the forensic service user (Coffey, 2006). Cromar-Hayes and Chandley (2014) recommend that further research from the perspective of service users is necessary. The literature from this perspective is emerging but limited. Olsson, Strand and Kristiansen's (2013) qualitative study in Sweden

explored the views of service users within a maximum security forensic psychiatric clinic. Research exploring forensic service users' perspectives on recovery from the UK has largely been conducted within high secure settings, including Moore, Lombard, Carthy and Ayres (2012), Cromar-Hayes and Chandley (2014), and Ferrito, Vetere, Adshead and Moore (2012). Mezey et al. (2010) conducted their research in the UK with service users from a medium secure setting, exploring definitions, experiences, and perceptions of recovery. When reviewing this body of literature a number of themes emerge, including the concept of hope, the role of relationships, barriers to recovery, honesty and stigma.

Two recent reviews provide a context for the current review. Shepherd, Doyle, Sanders and Shaw (2016) aimed to develop a model of the personal recovery process that was specific to forensic mental health service users. Three key themes were synthesised: safety and security as a necessary base for the recovery process, the dynamics of hope and social networks in supporting the recovery process, and identity work as a changing feature of the recovery process. The authors noted that there was a necessity for further qualitative studies to contribute to the knowledge gained from their review. The current review aims to address some of the limitations identified by the authors, who highlighted the small number of primary sources included.

In Clarke, Lombard, Sambrook and Kerr's (2016) review, six superordinate themes were identified representing the forensic service user's recovery perspective: connectedness, sense of self, coming to terms with the past, freedom, hope, health and intervention. The authors concluded that connectedness and a sense of self were particularly important as facilitators of recovery. The current review aims to address some of the limitations of this paper, notably the absence of a replicable search strategy. Furthermore, the current review aims to provide an update on these papers, offering a synthesis of the literature from 2014 onwards. Both Clarke et al. (2016) and Shepherd et al. (2016) include literature only up to 2014.

Aims

This systematic review aims to provide a comprehensive and contemporary synthesis of the recovery experiences and perceptions of forensic mental health service users. It is hoped that the current paper will add to the growing evidence base that is in its early stages, but has arguably gathered impetus over recent years. As such this review is timely in identifying what is currently known.

Research question: What does recovery mean for a forensic mental health patient?

Method

A qualitative literature review was carried out to explore the existing research relating to recovery from the perspective of forensic mental health service users. The review was conducted in a systematic and reproducible way (Booth, Papaioannou & Sutton, 2012). The literature search was performed by the author on 8th December 2017 and the appraisal and analysis was also completed by the author. In order to enhance replicability and rigour of the literature search, a quality control sift at the article title stage was also completed by the author's academic supervisor, yielding a high degree of consensus (94%).

Search Strategy

The meta-search engine EBSCOhost was utilised in this review. Table 1 details the databases that were searched using EBSCOhost. No additional results were obtained by searching alternative databases.

Databases Searched:
<ul style="list-style-type: none"> • Medline • Academic search complete • CINAHL (Cumulative Index to Nursing and Allied Health) • PsychInfo • PsychARTICLES • SportDiscus • Ebook Collection

Table 1. EBSCOhost databases included in the search

The search strategy, including search terms, and results are detailed in Figure 1. Truncations were used when appropriate, such as recover*. In order to avoid the results being skewed by publication bias, a hand search of the grey literature was conducted using Google Scholar. This produced a very large number of results (approximately 16,900). It was not possible to screen all. It became apparent that beyond the first 70, results did not relate to the review and so it was considered appropriate to cease screening beyond the 400th result. Although a large number of results were produced in the hand search, this proved an important exercise as an additional six papers were identified, of these four were included in the final review. Search results were subjected to a three stage screening process to determine eligibility in relation to the inclusion and exclusion criteria; screening the title, then the abstract, and finally a full paper screen.

Inclusion and Exclusion Criteria

Inclusion criteria for the review were:

1. Qualitative or mixed methods papers where service users express their views on recovery
2. English language publication
3. Forensic/secure mental health service settings (including current and discharged patients)
4. Adult research

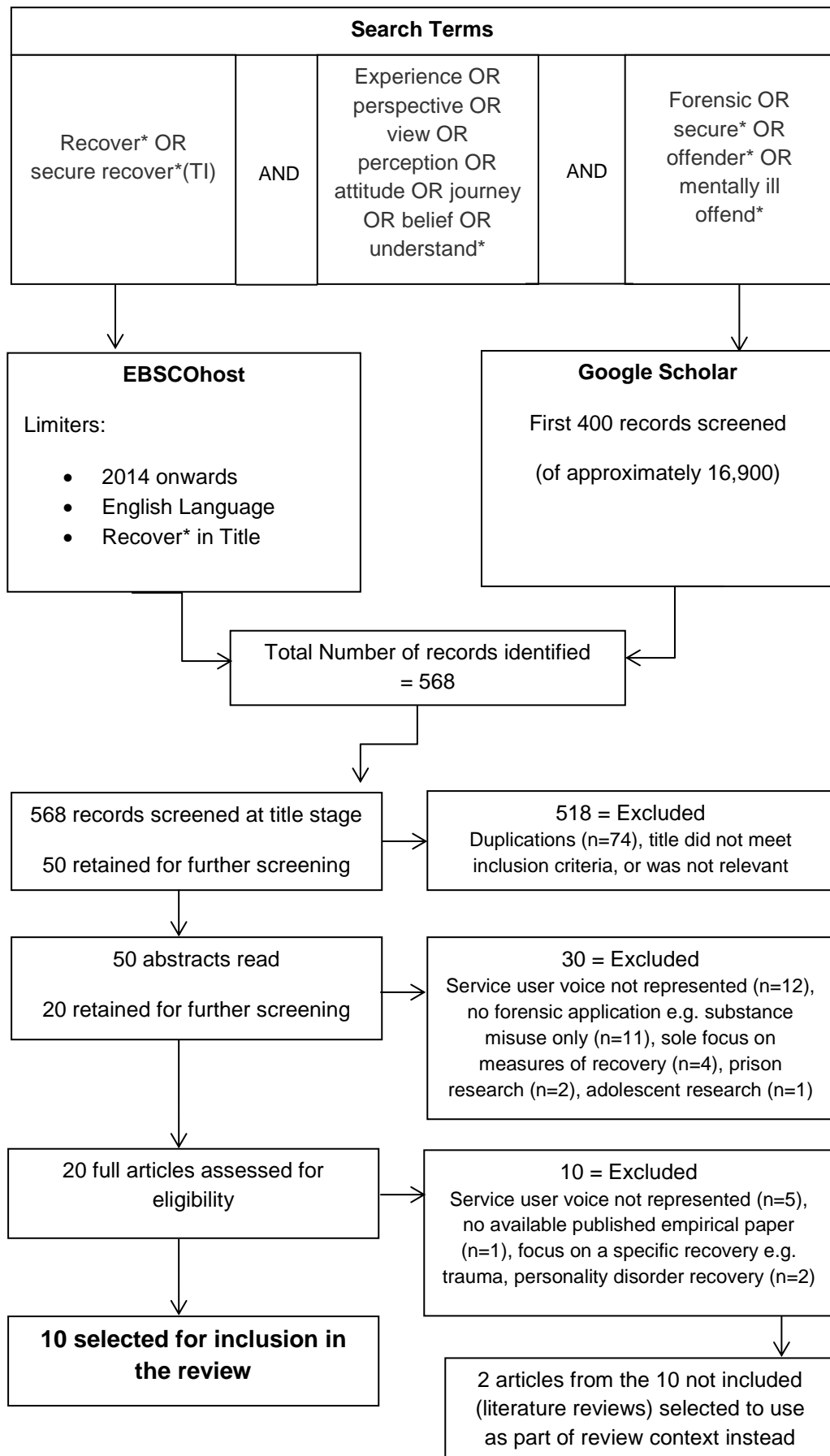


Figure 1. Search Strategy and Results

Exclusion criteria included:

1. Quantitative papers or papers relying solely on measures or clinical definitions of recovery
2. Secure settings that are not for mental health patients (e.g. prison)
3. Substance use disorder related recovery only
4. No clear representation of, or access to, service user experience.
5. Juvenile/adolescent research.

Qualitative papers were deemed most appropriate for inclusion in the review in order to ensure that the direct perceptions, views and experiences of recovery from forensic service users were accessed. Mixed methods papers were included, so long as the qualitative results included an expressed inclusion of service user perspectives. Generally, papers were excluded from the review due to not representing service user voice, or because they did not have an application to, or were not from, a forensic context.

Quality Criteria

A key element of the screening process was assessing the quality of the literature included in the review. Once the final papers were identified, they were subjected to a quality appraisal process. Critical appraisal is the process of evaluating the strengths and weaknesses of research in order to consider the value (Yardley, 2000; Young & Solomon, 2009). For the present review, a critical appraisal tool was developed, combining the leading guidelines for critical appraisal of qualitative research, namely Elliott, Fischer and Rennie's (1999) guidelines, Yardley's (2000) guidance on characteristics of good quality research, and the qualitative checklist from the Critical Appraisal Skills Programme (CASP, 2013). A three-point scoring system was developed in order to assess the quality of the papers in the review against each criterion (Appendix A.2).

Results

Description of studies

Ten papers were included in the review. Seven studies took place in the UK, one in Belgium, one in Sweden, and one in Canada. Most of the studies (six) took place in high secure settings, one in a medium secure setting, and one in a low secure setting. Two were across high, medium and low secure settings. All of the studies were qualitative papers, with the majority of papers using thematic analysis, two using interpretative phenomenological analysis (IPA), one using content analysis and one case study. Semi-structured interviews were the most common data collection method; however one study used focus groups and another analysed clinical material derived from therapy group notes. A summary of each paper is provided in Table 2.

Critical Appraisal

Overall, the studies included in the review were of reasonably good quality. The critical appraisal tool was developed in order to gauge the transparency and validity of the findings, rather than with the intention of excluding potential papers. This is essential if the findings from this review are to be utilised in order to identify clinical implications and future research. Appendix A.3 details the scores from critical appraisal process, illustrating how each paper scored on the different quality criteria and provides an overall mean score. This mean score provides an indication of the overall quality of the paper; however it is important to note individual strengths and weaknesses of each paper.

Authors & Year of Publication	Title	Location & Setting	Sample	Aims	Method	Findings/Themes	Mean Quality Score (0-2)
McKeown, Jones, Foy, Wright, Paxton & Blackmon, 2016	Looking back, looking forward: Recovery journeys in a high secure hospital.	UK, High-security hospital	30 staff, 25 service users	To explore how people make sense of recovery and experiences of recovery oriented assessment and treatment initiatives within the hospital.	<i>Recruitment:</i> purposive sample reflecting demographics of hospital <i>Data collection:</i> semi structured interviews or focus groups <i>Analysis:</i> Thematic analysis	<ul style="list-style-type: none"> • Meaningful occupation • Valuing relationships • Recovery journeys and dialogue with the past • Recovery as personal responsibility 	1.3
Clarke, Sambrook, Lumbard, Kerr & Johnson, 2017	Recovery in a low secure service.	UK, Low-Secure unit	6 male patients, aged 32-59.	To explore the lived experience of recovery for patients detained in a low secure service. To capture the subjective meanings that patients ascribed to recovery.	<i>Recruitment:</i> convenience sampling <i>Data collection:</i> one to one semi-structured interviews <i>Analysis:</i> Interpretative phenomenological analysis (IPA)	<ul style="list-style-type: none"> • It's a journey • We're vulnerable in here • Loss • Relationships with staff • Hope 	1.9
Chandley & Rouski, 2014	Recovery, turning points and forensics: views from the ward in an English high secure facility.	UK, High-Secure Hospital	1 male, account of service user detained in Ashworth hospital	To offer an example of recovery in a high-secure setting. To combine an individual account of recovery and the academic literature.	Case study - biographical account of recovery.	<ul style="list-style-type: none"> • Things that have happened on Croft Ward • Relationships • Qualities in others that helped • Turning points • Hope and future plans • How I contribute • What recovery means to me • Things I would change • After here 	0.8
Nijdam-Jones, Livingston, Verdun-Jones & Brink, 2015	Using social bonding theory to examine 'recovery' in a forensic mental health hospital: A qualitative study.	Canada, forensic mental health hospital with low, medium and high-security	30 inpatient participants (24 males, 6 females)	To understand the qualities identified by patients as being important and meaningful to recovery	<i>Recruitment:</i> convenience/purposive sampling <i>Data collection:</i> semi-structured interviews <i>Analysis:</i> thematic analysis	<ul style="list-style-type: none"> • Involvement in programmes • Belief in rules and social norms • Attachment to supportive individuals • Commitment to work-related activities • Concern about indeterminacy of stay 	1.5

		units				(First 4 themes mapped onto Social Bonding Theory)	
Olsson, Strand & Kristiansen, 2014	Reaching a turning point—How patients in forensic care describe trajectories of recovery.	Sweden, maximum-security forensic psychiatric clinic	10 participants (8 men, 2 women), aged 26-62	To explore how forensic patients who had decreased their assessed risk of violence experienced their turn towards recovery	<i>Recruitment:</i> convenience/purposive sampling <i>Data collection:</i> semi-structured interviews <i>Analysis:</i> Content analysis	Turning points towards recovery divided into three domains: 1. The high risk phase: <i>facing intense negative emotions and feelings</i> 2. The turning point phase: <i>reflecting on and approaching oneself and life in a new way</i> 3. The recovery phase: <i>recognising, accepting and maturing</i>	1.6
Skinner, Heasley, Stennett & Braham, 2014	Can Motivational Groups Promote Recovery in Forensic Settings?	UK, High-security hospital	7 male participants, aged 23-57	Service evaluation exploring whether a pre-therapy motivational group can contribute to the recovery process.	<i>Recruitment:</i> convenience/purposive sampling <i>Data collection:</i> focus groups <i>Analysis:</i> Thematic and saliency analysis	<ul style="list-style-type: none"> Gaining confidence Hope Gaining control and taking responsibility Identifying strengths Social Support 	1.6
Madders & George, 2014	"I couldn't have done it on my own." Perspectives of patients preparing for discharge from a UK high secure hospital.	UK, High-security hospital	9 patients in the discharge preparation stage at Rampton High Secure Hospital	To explore factors influencing discharge preparation from the perspectives of patients.	<i>Recruitment:</i> convenience/purposive sampling <i>Data collection:</i> individual semi structured interviews <i>Analysis:</i> thematic/saliency analysis	<ul style="list-style-type: none"> Trust and support Feeling empowered Journey of self-acceptance, hope and lived experience Skilling-up Getting to know the Medium Secure Unit Feeling disempowered and unvalued Issues with the system Anxiety about endings Stigma and society 	0.9
Stuart, Tansey & Quayle, 2017	What are the barriers to recovery perceived by people discharged from	Scotland, Medium-Security hospital	8 former inpatients, 5 males and 3 female, aged between 30 and 60	To explore individual perceptions of recovery, particularly beliefs about barriers to its' achievement.	<i>Recruitment:</i> convenience/purposive sampling <i>Data collection:</i> individual semi structured interviews	<ul style="list-style-type: none"> Living in the shadow of the past Power imbalances Security and care Reconfigured relationships 	1.9

	a medium-secure forensic mental health unit? An interpretative phenomenological analysis.				<i>Analysis:</i> IPA	<ul style="list-style-type: none"> • 'Recovery' as a barrier to recovery 	
Aga, Laenen, Vandeveld, Vermeersch & Vanderplasschen, 2017	Recovery of Offenders Formerly Labeled as Not Criminally Responsible: Uncovering the Ambiguity From First-Person Narratives.	Belgium, various settings	11 participants (9 men, 2 women), aged 36-62	To examine recovery based on first-person narratives of offenders formerly labelled as not criminally responsible	<i>Recruitment:</i> purposive sampling <i>Data collection:</i> in-depth interviews grounded in narratives <i>Analysis:</i> thematic analysis	<ul style="list-style-type: none"> • Clinical recovery resources • Functional recovery resources • Social recovery resources • Personal recovery resources • Ambiguous role of the judicial measure 	1.2
Adshead, Ferrito & Bose, 2015	Recovery After Homicide: Narrative Shifts in Therapy with Homicide Perpetrators	UK, High-security hospital	Data generated by 41 individual patients over a 10-year period. All male perpetrators of homicide. Age range 19-63.	To explore how discussion of the index offence fits into recovery paradigms and how reflection of offender identity relates to recovery	<i>Recruitment:</i> convenience/purposive sampling <i>Data collection:</i> clinical material obtained from a therapy group (notes taken following the group based on therapist recall) <i>Analysis:</i> thematic analysis	<ul style="list-style-type: none"> • Coming to terms with having offended: identity change • Abnormal mental states and identity • Therapist roles in facilitating narrative change 	1.0

Table 2. Overview of studies

The quality scores derived using the critical appraisal tool ranged from 0.8 to 1.9, with scores possible from 0 to 2. Two papers scored below 1. More generally, the lower scoring papers lacked details of ethical issues, accounts of reflexivity, and lacked appropriate credibility through quality checking. This is particularly important as most of the research was conducted by professionals as the lead researcher, conducting research within their place of work. The lowest scoring papers did not mention any ethical considerations (Adshead, Ferrito & Bose, 2015; Chandley & Rouski, 2014), whereas other papers noted where they sought approval from, but did not elaborate on other ethical considerations (Aga et al., 2017; Madders & George, 2014). The papers that were of the highest quality provided a more comprehensive discussion around ethical considerations including the approvals gained, acknowledgement of risk issues, and importantly; given the setting; informed consent and data protection procedures (Nijdam-Jones et al., 2015; Olsson et al., 2014; Skinner et al., 2014; Stuart et al., 2017).

Reflexivity is an imperative part of qualitative research. Without identifying and disclosing potential sources of bias and without understanding the authors' values and assumptions, the research cannot be transparent and credibility is affected (Elliot et al., 1999). Few papers fully considered this and it is largely neglected across the papers included in this review. Four papers made no reference to reflexivity (Adshead et al., 2015; Chandley & Rouski, 2014; Madders & George, 2014; Olsson et al., 2014). It is unfortunate that Adshead et al., (2015) did not comment on reflexivity, as their research analysed clinical material obtained from a therapy group for offenders convicted of homicide. The data was generated from notes made by facilitators following each group session, however there is no critical examination of how this may have influenced the results obtained and ultimately on the research's credibility. Other papers noted briefly either the role of the researcher in their place of work and the link between recruitment, or acknowledged the role of the researcher in the data analysis process but did not expand on this (Aga et al., 2017; Nijdam-Jones et al., 2015; Skinner et al., 2014). The papers that scored the highest noted the backgrounds, contributions and positions of the researchers in relation to the participants

and data, as well as commenting on the process of reflexive diary keeping (Clarke et al., 2017; McKeown et al., 2016; Stuart et al., 2017). McKeown et al., (2016) also discussed the approach of the research team in the context of wider initiatives on recovery.

Most papers explicitly stated the aims and purpose of the research and adequately described the methodology and recruitment strategy. The papers were variable in terms of descriptions of data collection methods. The highest scoring papers provided interview schedules and descriptions of methodology enables replication (Clarke et al., 2017; Nijdam-Jones et al., 2015; Olsson et al., 2014). Only one paper did not score anything on this subscale; Chandley and Rouski's (2014) case study, in which part of the paper was written by the participant providing his account of his recovery whilst in a high secure hospital. Although the paper provides a valuable first-hand account of recovery from a forensic setting, the authors do not adequately describe how the participant and co-author became involved in writing the paper. As such, the reader is left having to make assumptions about this, giving rise to questions about transferability of the findings and discussion.

For the most part, the papers demonstrated a commitment to grounding their findings in examples and representing the voices of service users in their findings. The highest quality papers provided relevant quotes from participants anchored in their themes, and also provided visual representations of their findings (Clarke et al., 2017; McKeown et al., 2016; Stuart et al., 2017). Olsson et al.'s (2014) findings distinguished three distinct 'turning points' for recovery, although it is unclear how the authors arrived at these distinct points. Adshead et al.'s (2015) paper combines the results and discussion. Presenting the results in this way leads to a diluting of the service user's voice, as at times it is not clear what is the opinion of the authors and what is the voice of the service users.

All but one paper (Chandley & Rouski, 2014) attempted to provide some quality checking of their research by acknowledging strengths and limitations, and generally this was done to an acceptable standard. The

papers were more variable in terms of their ability to identify the impact and contribution of their research. Generally, most of the papers linked their findings to existing research. Higher scoring papers also identified clinical practice implications and were specific about future research (Chandley & Rouski, 2014; Clarke et al., 2017; Olsson et al., 2014; Skinner et al., 2014; Stuart et al., 2017). Of particular note Olsson et al. (2014) provided a table which illustrated the link between the research findings and each specific recommendation for forensic nursing practice.

Synthesis of Findings

The process of synthesising the findings of research is essential to generate novel understandings. Data synthesis intends to develop understandings of a phenomenon across a range of different studies (Thomas & Harden, 2008). The findings in this review aim to highlight both the commonalities in the findings, as well as the diversity. Where papers presented the views of both service users and others, only service user data was included. In order to synthesise what is known about forensic recovery Thomas and Harden's (2008) Thematic Synthesis was utilised. This involves identifying recurrent themes across the literature and drawing generalised conclusions. There are three stages to this type of synthesis (Thomas & Harden, 2008):

1. Free line-by-line coding of the findings from primary studies
2. Organising 'free codes' into related areas in order to construct 'descriptive' themes
3. Development of 'analytical' themes – going beyond the content of the original studies.

The synthesis generated five analytical themes of recovery: hope; connecting with others; meaningful occupation, roles and identity; the powerful environment of the hospital; and coming to terms with the past and diagnosis. Table 3 illustrates each analytical theme, and its relationship to free coding and descriptive themes. Appendix A.4 illustrates the contribution of each study to the themes and their relative mean quality score.

Analytic Theme	Descriptive Themes	Examples of Free Coding
Hope	Making sense of recovery as a journey	Recovery as a pathway. No fixed end or start. Journey as guiding. Hope for journey to continue. Moving from past to present.
	Realistic hope	Certain things you can and can't do. Acknowledging limitations of future.
	Abandoning the 'ideal'	There will be barriers. Feeling that 'normality' won't be the same. Feeling hopeful despite limitations. Recovery does not mean cure.
Connecting with others	Relationships with staff	Not just any relationships but trusting relationships. Humanising. Relationships with staff as the main starting point.
	Relationships with peers	Peers as evidence recovery is possible. Comfort from others stories.
	Relationships beyond the hospital	Importance of family. Recovery as equally important for family.
	Developing new relationships and renegotiating old relationships	Moving away from antisocial and towards prosocial peers. Both offending and mental health acting as a stressor on current relationships.
	Helping others	Wanting to establish a positive connection with others. Be more than violence.
Meaningful occupation, roles and identity	Role as a patient	Shifts in identity. Shock of being an offender-patient.
	Occupation	Importance of structure. Occupation as providing an important role.
	Strengths and learning new skills	Realisation of strengths. Learning skills to move towards new identity.
	Confidence	Therapy/group work as a source of confidence. Teaching/supervising others.
	Goals and new roles	A need to have goals. Goals emerging from new identity.
The powerful environment of the hospital	Control over decisions	Lack of involvement in care leading to powerlessness. No control over decisions.
	Physical and procedural security	Physical environment as powerful. Inescapable risk. Trauma of admission.
	Cooperating with the system	Coercive measures=not cooperating. Rebelling against the dominant view.
	Length of stay	Uncertainty over length of stay leading to powerlessness. Having no say.
	Risk vs safety	Being around violence encourages violence. Hospital as providing safety.
	Medication	Medication as an important part of recovery. Having to tolerate medication.
Coming to terms with the past and diagnosis	Coming to terms with offending and mental health diagnosis	Process of taking responsibility. Attempting to understand past. Narratives and storytelling of past as important in recovery. Putting the offence behind them.
	Stigma	Trapped by the past. Not being able to escape the perceptions of others. Views of others being grounded in offence.
	Tension between confronting and forgetting past	Letting go of the past. Reflection on past as both helpful and distressing. Feeling stuck.

Table 3. Analytic themes, descriptive themes and examples of free coding

Theme 1: Hope

Being hopeful about the future, both in terms of recovery from mental illness as well as moving on from offending were central to the recovery journey. Hope was linked to recovery being a journey, something that continues beyond the confinement of the hospital and being central to the future lives of patients (Chandley & Rouski, 2014). In this sense, recovery is not an event in isolation but a process that patients engage in throughout their life. One patient in Stuart et al.'s (2017, p. 19) research reflected that "recovery does not mean cure". Hope counteracted negative associations with the past and being defined by offender and patient roles (Chandley & Rouski, 2014; Clarke et al., 2017). For some, hope was anchored in developing new identities and disassociating from previous identities (Adshead et al., 2015; Clarke et al., 2017; Madders & George, 2014) and for others being realistic was key in being able to be hopeful and think positively about their future (Olsson et al., 2014; Skinner et al., 2014).

For some, the length of their stay in services directly impacted on their hope for the future (Olsson et al., 2014). The uncertainty of time of treatment duration negatively affected patients' hope for the future and recovery more generally. Being able to engage positively with the community beyond the security of the hospital was important in providing hopeful and realistic expectations of what life may be like upon discharge (Clarke et al., 2017). Abandoning idealised notions of what the future may be like was also important for some patients (Adshead et al., 2015).

Theme 2: Connecting with others

This theme appeared in every paper, and describes how imperative it is for individuals to achieve a sense that they are connected with others and have successful support networks. Many participants reflected on the importance of relationships with staff to facilitate and support their recovery. Trusting, accessible, reassuring and supportive relationships with staff facilitate

recovery (McKeown et al., 2016), whereas negative relationships led to patients feeling isolated, powerless, devalued and believing there is an 'us and them' divide (Olsson et al., 2014). Interactions with staff that were humanising and treated the individual as a person were an especially important vehicle for recovery (Chandley & Rouski, 2014). Positive connections with staff provided a basis for developing positive self-belief (Madders & George, 2014).

Several papers highlight the significance of positive relationships with fellow patients, often providing an example of recovery as possible (Madders & George, 2014). For others, connections with their peers provided a more genuine source of support (Nijdam-Jones et al., 2015). Furthermore, peer connections reduced isolation and enabled an enhanced overall sense of connectedness to others (Skinner et al., 2014). Patient's in Adshead et al.'s (2015) study reported finding some solace in connecting with others experiencing the same issues as they do.

Relationships beyond the secure environment were necessary for recovery, specifically being able to maintain relationships with family and friends. For some, recovery was as much for the family as it was for the patient (Stuart et al., 2017). Many participants noted the negative impact of the secure environment on maintaining relationships. For some, the isolating effect of the hospital and the stigma associated with being a secure forensic patient led to disrupted and severed relationships (Nijdam-Jones et al., 2015). Other patients were able to maintain connections with family, friends and loved ones and this was important in overcoming isolation and achieving acceptance (Chandley & Rouski, 2014). Stuart, Tansey and Quayle's (2017) study highlighted the process of renegotiation of existing relationships that must take place, as perceptions of the person are affected by their status as a forensic patient.

As well as the challenge in maintaining and renegotiating existing relationships, the importance of developing new, pro-social connections was central to recovery for some patients. For instance Aga et al. (2017) found that recovery meant avoiding friendships and connections with peers

associated with offending, and developing relationships with positive friends who supported their goals for recovery. An interesting finding within this theme was that, for some, it was helpful to develop new positive relationships with others that were anchored around the patient helping others, or acting as a mentor (Aga et al., 2017; Chandley & Rouski, 2014; Stuart et al., 2017). It appears that being able to care for and support others provided some sense of recompense for the harms perpetrated in the past (Stuart et al., 2017).

Theme 3: Meaningful occupation, roles and identity

Throughout the accounts from forensic patients the developing sense of identity was central in the journey of recovery. For many participants, the negative and traumatic experiences that led to them becoming a forensic patient had a lasting and significant impact on their identity. Entering into the role of an offender patient negatively impacted on individuals' self-esteem and sense of self (Chandley & Rouski, 2014). Conversely, having an identity not defined by offender or patient roles was useful in providing optimism about recovery (Clarke et al., 2017).

Engaging in meaningful occupation appears to be an important part of developing a new and positive role. Many participants spoke about the benefits of achieving structure and an enhanced sense of self through meaningful occupation (McKeown et al., 2016). For some this was through structured programmes within the hospital (Nijdam-Jones et al., 2015), others enjoyed peer activities (Chandley & Rouski, 2014), while others discussed being purposeful in passing time such as reading or writing (Aga et al., 2017). Meaningful occupation was a daily source of recovery in this sense. Employment was also a significant part of their recovery, both currently and as part of their future hopes and plans.

Learning and obtaining new skills, as well as setting goals, served an important part of developing a positive sense of self. Having clear goals for the future provided a realistic pathway for recovery (Clarke et al., 2017).

Realisation of personal strengths provided a framework to explore possibilities for future roles (Olsson et al., 2014). Learning and acquiring new skills represented the potential to live meaningfully beyond the role of an offender patient (Madders & George, 2014). Access to training opportunities was experienced as “opening doors to recovery” (Nijdam-Jones et al., 2015, p. 164).

Theme 4: The powerful environment of the hospital

Detainment within the physical environment of a secure setting led to individuals feeling disempowered. There were perceptions of the hospital as powerful, having a sense of control over patients (Madders & George, 2014). Physical and procedural security measures of the environment are the most obvious expression of the patients’ freedoms being lost; something that patients felt was not in line with a recovery focused approach (Nijdam-Jones et al., 2015). Olsson et al. (2014, p. 509) highlighted the environment is “emotionally cold”; one where problems are perpetuated rather than where recovery feels possible. Stuart et al. (2017) stress the impact of the dominance and power of both the legal and the mental health system upon patients. Patients are in a position of powerlessness, simply by the nature of the systems and environment.

There were several ways participants illustrated feelings of powerlessness. Patients often described having little or no control over decisions relating to their treatment, leading to feeling that recovery was coercive (Madders & George, 2014; Olsson et al., 2014). Having influence over decisions enabled individuals to have a sense of personal responsibility and gain more control (Skinner et al., 2014). Stuart et al. (2017) highlighted that when patients did express opinions and desires; these were not heard or misunderstood, leaving them helpless in challenging the power of the hospital. Other papers noted the success of initiatives in achieving some sense of agency over patients own recovery, such as Recovery Star (McKeown et al., 2016). However, Clarke et al. (2017, p. 68) noted that for their participants My Shared Pathway contributed to a loss of power and control, rather than

enhancing it because outcomes are not always clearly defined and this can lead to a sense that 'the goal posts are always shifting'. Madders and George's (2014) study highlights the link between this theme and the theme of hope, as patients who felt the discharge process was not collaborative reported feeling hopeless and "stuck" in their recovery.

Within this theme there is a sense that cooperation with the system and recovery agendas more generally, facilitate better recovery outcomes (Clarke et al., 2017). However, this often comes at the expense of sacrificing power to the establishment. For instance, knowing that any freedom or privilege gained through cooperation is only permitted within the boundaries enforced by the hospital. Alternatively, for participants in Nijdam-Jones et al.'s (2015) study, hospital rules benefitted recovery as they provided structure.

Theme 5: Coming to terms with the past and diagnosis

For many participants, engaging in a dialogue with the past is an important vehicle for recovery (McKeown et al., 2016). This is a double process, involving acknowledgement of both the patients' offending and their mental health diagnosis (Skinner et al., 2014). The recovery journey is one that appears to start with engaging in a narrative to make sense of and develop insight into the patient's past (Stuart et al., 2017). Coming to terms with offending involves taking responsibility, as well as recognising how the offence has impacted on identity and sense of self (Adshead et al., 2015). Being able to put their offence behind them appears an important stage in the recovery process (McKeown et al., 2016). For many, engaging with therapeutic interventions is necessary to come to terms with and move on from the past (Clarke et al., 2017).

The stigma associated with being an offender patient leads to a sense that the person is cut off from society and 'trapped' by their past (Madders & George, 2014; Stuart et al., 2017). For some, detainment within a secure forensic environment results in an inescapable labelling process that impacts upon their ability to move on and recover (Madders & George, 2014). For

Adshead et al.'s (2015) participants committing an offence when mentally unwell had resulted in a denial of the "normal", and means that patients can no longer claim to be "ordinary". Making sense of the reasons why they came into forensic mental health services enables individuals to begin this process of moving beyond their past (Stuart et al., 2017).

There appears to be tension between the process of trying to come to terms with and accept the past, both in terms of offending and diagnosis, and trying to dissociate from and resist reflection on the past (Stuart et al., 2017). The process of acknowledging offending and discussing the past is painful and distressing (McKeown et al., 2016), yet is also helpful at the same time (Clarke et al., 2017). Individuals can have a sense of feeling stuck between confronting and forgetting their past and deciding which is most helpful for their recovery.

Discussion and Conclusions

This review of the qualitative literature aimed to appraise and synthesise the literature on the recovery experiences of forensic mental health patients. The appraisal demonstrated the varied quality of the literature included in the review. Some papers were effective in grounding their results in participants' experience, which is essential if we are to understand how patients experience recovery for themselves. However, in general the literature was poor at identifying and addressing ethical issues. There was a paucity of reflexivity across the papers as a whole. This makes it difficult for the reader to understand the researchers' perspective and contribution to the research process. However, the papers included in the review have provided some valuable insights into how patients view their recovery from forensic services.

The results indicate there are commonalities in the journeys of the offender patient and within general mental health care (Leamy et al., 2011; Resnick, Fontana, Lehman & Rosenheck, 2005). According to Andreson et al. (2003) hope represents the first stage in the recovery process. Forensic patients

experience recovery as a journey where being hopeful is important. It appears however, that hope for forensic mental health patients links to realistic ideas about the future, being able to disassociate from their past, and connecting meaningfully with society beyond the hospital environment. Hope is centred around being able to develop an identity not defined by offending or diagnosis.

Support networks enhance individuals' sense of connectedness and reduce feelings of loss and isolation. However the results highlight the challenges that forensic patients face in maintaining and renegotiating relationships. Social support is considered an important facet of recovery in general mental health literature (Shepherd et al., 2008). Forensic patients must not only overcome barriers to maintain and repair existing relationships affected by their detainment, but have the additional task of developing new, pro-social connections supportive of recovery. An interesting finding is the desire to develop connections with others that can provide patients with a sense of repayment or recompense for past behaviour. Relationships within the secure environment are essential in the recovery process, and developing connections within the hospital provides a vital sense of identity and belonging. Much value was placed on relationships with both staff and peers and there is an emphasis on accessible, trustworthy relationships.

Meaningful occupation and roles within the hospital led to feeling hopeful about achieving positive roles in the future. Occupation serves as a protective factor, enabling patients to feel they have purpose, a positive role and structure. This was achieved through various means. It is therefore important to consider the wide reaching nature of occupation and meaningful roles in this context. Another important aspect of this theme was being able to learn new skills, which impacts upon a developing sense of self. Being denied access to this was detrimental to recovery, affecting the hope the individual has for their future.

The identification, measurement and control of risk within the context and setting of secure care will always be fundamental to forensic services. For the patient, the physical environment was an ever-present reminder of this

leaving them feeling powerless and controlled by the hospital. This is exacerbated when patients felt not included in decisions about their life or care. There is an interesting theme within this around cooperation being supportive of recovery processes but recalcitrance having a negative impact on recovery. The power imbalance is implicit within this; recovery goals must be agreed by the hospital and in order to recover the patient must agree their pathway and goals for recovery. This leads to questions surrounding who sets the goals for recovery and how in practice individual differences in recovery can be supported and considered.

Recovery journeys included recovery from both mental health difficulties, as well as from offending. Mezey et al. (2010) describe this as the dual stigma, and the results of the present review support the notion that there is a dual recovery task for the offender patient. The tension between confronting and moving away from the past is complex; extremely painful yet necessary for recovery. This review highlights the barriers faced by offender patients in achieving recovery and illustrates the additional tasks that they undertake in the recovery process. As such, it is in line with previous research that indicates that there are particular challenges and considerations in applying recovery principles in forensic settings.

Limitations

Although an attempt was made to include grey literature, all of the papers included in the final synthesis were from published, peer-reviewed papers. As such, this review may be replicating publication biases that exist in the literature. It is possible that there is a lack of grey literature in this field; however it is also possible that the search strategy did not effectively identify grey literature sources.

This review included papers that represented both staff and service user perspective. Although only the perspectives from service users were included in the synthesis for this review, papers including both staff and

service user views can lead to a 'diluting' of the service user voice. This is interesting considering that one of the findings of the review is that forensic patients often feel isolated and unheard in terms of their own recovery goals and pathway.

Generally, the quality of the papers was good; however there was a lack of effective and appropriate consideration of ethical procedures, particularly reflexivity. It is suggested that, given the population, this is important in ensuring that research in this field is ethically sound.

This review was carried out by a Doctoral student under supervision. The researcher aimed to achieve some quality control, by gaining a second opinion from their supervisor at title sift stage. However, the researcher did not have the resources or time to ensure this level of quality control was completed throughout, potentially limiting the rigour of this review. The researcher completed the critical appraisal and analysis independently followed by supervision at a later date. It is important to acknowledge the reflexive stance of the researcher. Achieving a full separation from the researcher's own previous professional experiences, personal assumptions and values is challenging. The researcher has a background of working in forensic settings and therefore may have brought potential biases to the review. Attempts have been made to be transparent throughout; however it is important to acknowledge possible bias.

Clinical Implications

This review highlights that recovery for people in forensic mental health services considerably overlaps with recovery in general mental health settings. However, there are additional recovery tasks and processes that are the source of tension and difficulty. This is in line with previous research highlighting the challenges in applying recovery principles in a forensic setting (Cromar-Hayes & Chandley, 2014; Dorkins & Adshead, 2011; Mezey et al., 2010). Knowledge of these challenges can enable clinicians to consider how to support patients to achieve a sense of hope that is anchored

in a realistic conception of their future. Developing a trusting relationship that centres around seeing the person beyond their diagnosis or index offence is paramount in providing a platform for recovery. Increasing connectedness and providing opportunities for positive meaningful roles should be key goals. It is important to ensure that patients have an active role in setting their own recovery goals and outcomes, which are clearly defined so that setting recovery goals *for* the patient is avoided. One of the findings highlights the value patients place on developing new positive relationships that revolve around helping and supporting others. This provides further support for Recovery College initiatives and mentorship programmes.

Research Implications

This review demonstrates the positive steps taken in understanding recovery from the perspective of the forensic mental health patient. However, it is important to continue to add to this evidence base; specifically it is recommended that more research grounded solely in the voice and experience of the service user will enable clinicians to understand the factors patients themselves see as important for recovery. It would be beneficial to identify the recovery stories of patients that have used forensic services and have moved into the community. If recovery is a journey, it is imperative to understand how patients' journeys continue beyond the secure environment.

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Appendix A.1: Journal Submission Guidelines – Psychology, Crime and Law

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Editors: Professor Theresa A. Gannon, Professor Peter J. van Koppen, Professor Jeffrey Neuschatz

Relevant Instructions and Guidelines for Authors

- APA (American Psychological Association) Reference Style
- Structure: Manuscripts should be compiled in the following order: title page (including Acknowledgements as well as Funding and grant-awarding bodies); abstract; keywords; main text; acknowledgements; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).
- Author details. Please include all authors' full names, affiliations, postal addresses, telephone numbers and email addresses on the title page.
- A non-structured abstract of no more than 200 words.
- Inclusion of 5 keywords.
- Disclosure statement. This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research.
- No suggested word limit. Please include a word count for your paper.
- Please use any spelling style consistently throughout your manuscript.
- Please use single quotation marks, except where 'a quotation is "within" a quotation'. Please note that long quotations should be indented without quotation marks.
- Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for color, at the correct size). Figures should be saved as TIFF, PostScript or EPS files.
- Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.
- Equations: If you are submitting your manuscript as a Word document, please ensure that equations are editable.
- Units: Please use SI units (non-italicized).

Appendix A.2: Quality assessment tool

This quality assessment tool was developed from Elliott, Fischer, & Rennie (1999), Yardley (2007), and from the qualitative CASP checklist (CASP, 2013).

1. Explicit aims, methodology and purpose
2. Recruitment of participants and situating the sample
3. Data collection methods
4. Rigorous analysis
5. Commitment and grounding in examples
6. Coherent presentation of findings
7. Reflexivity
8. Ethical issues acknowledged/addressed
9. Credibility, quality checking
10. Impact and contribution

A 3-point rating scale was used to rate the quality of each paper against each criterion:

Score	Description
0	Does not meet criteria
1	Meets criteria somewhat, but with issues and shortcomings
2	Largely meets criteria well, with some minor issues or shortcomings

Appendix A.3: Quality Appraisal

Paper	Quality Criteria	Notes on Appraisal	Score (0, 1, 2)
McKeown, Jones, Foy, Wright, Paxton & Blackmon, 2016	Explicit aims, methodology and purpose	Clear rationale. Aims explicitly stated. Context of 'recovery champions' explicitly stated. Methodology appropriate. Situates research in context of literature on High security recovery.	2
	Recruitment of participants and situating the sample	Rationale for purposive sample justified in terms of being representative of different aspects of diversity for the hospital. No descriptive data provided, but rationale given for this. No account of specifically how participants were approached.	1
	Data collection methods	Difficult to replicate. Data collection guided by a list of topics devised by research team in consultation with recovery champions group. Process of devising list explained but list of topics not stated.	1
	Rigorous analysis	No discussion of process of thematic analysis and how the team arrived at themes.	0
	Commitment and grounding in examples	Quotes explicit from either service user or staff for each theme and balance is achieved in this.	2
	Coherent presentation of findings	Quotes embedded within themes, verbal narrative of the themes offered.	2
	Reflexivity	Notes contributions, background and positions of researchers and approach of research team situated in wider recovery initiatives.	2
	Ethical issues acknowledged/addressed	Limited discussion of anonymity and reduced demographic information, no other ethical issues identified	1

Clarke, Sambrook, Lumbard, Kerr & Johnson, 2017	Credibility, quality checking	More than one researcher and brief mention of using the Recovery Champions group to discuss themes with. Details and processes not provided however.	1
	Impact and contribution	Recommendations for future research but not specific about this. No explicit practice recommendations. Links to wider literature.	1
	Mean Score:		1.3
	Explicit aims, methodology and purpose	Aims clear and explicit, design and methodology justified and appropriate	2
	Recruitment of participants and situating the sample	Explicit and replicable, grounded in IPA. Demographics given. Inclusion/exclusion criteria clear	2
	Data collection methods	Interview schedule provided. Clear and replicable data collection.	2
	Rigorous analysis	Discussion of IPA grounded in theory, process explained and validity and quality assurance discussed.	2
	Commitment and grounding in examples	Themes grounded in quotes –many provided. Quotes are appropriate and link well.	2
	Coherent presentation of findings	Representation of superordinate and sub-themes from analysis clear and also provided visually.	2
	Reflexivity	Discussion of reflexive journal, triangulation discussed	2
	Ethical issues acknowledged/addressed	Explicit statement of where approvals were gained. Choice to participate discussed in context of secure setting, but could be worth further discussion	1
	Credibility, quality checking	Triangulation and validity explicitly discussed. Strengths and limitations explicitly discussed.	2

	Impact and contribution	Clinical implications explicit and grounded in literature base. Future research identified and specific	2
	Mean Score:		1.9
Chandley & Rouski, 2014	Explicit aims, methodology and purpose	Purpose provided in abstract and aims discussed, but would benefit from being expanded. Biographical account, rationale for case study approach partly explained	1
	Recruitment of participants and situating the sample	Situated in literature and context of narratives and the individual perspective. No discussion of how the author giving his account came to be involved in the article (other than being a patient) – why him? How is he representative?	1
	Data collection methods	No explanation of how author went about generating his account	0
	Rigorous analysis	Links findings from biographical account to previous research a little.	1
	Commitment and grounding in examples	Commitment to the account and space given to the voice of service user author. Written in first person narrative.	2
	Coherent presentation of findings	Biographical account as almost standalone – discussion could use more information and data from the account.	1
	Reflexivity	Not explicitly clear what role the lead researcher took in the generating of the information for the case study.	0
	Ethical issues acknowledged/addressed	None identified	0
	Credibility, quality checking	None discussed	0
	Impact and contribution	Clinical implications explicitly discussed and set in policy contexts.	2

		Mean Score:	0.8
Nijdam-Jones, Livingston, Verdun-Jones & Brink, 2015	Explicit aims, methodology and purpose	Aims clear, context explained, makes links between recovery and social bonding theory in introduction. Methodology appropriate. Explained in context of a broader mixed methods evaluation.	2
	Recruitment of participants and situating the sample	Clear eligibility criteria. Descriptive data provided.	2
	Data collection methods	Procedure explained and examples of questions given. Replicable process.	2
	Rigorous analysis	Analysis process described and referenced. Highlighted differences in themes. Some themes more detailed than others.	1
	Commitment and grounding in examples	Last theme not as detailed as others, but generally well balanced with quotes relevant to each theme.	1
	Coherent presentation of findings	Clear integration of quotes to themes. Clear statement of findings in terms of themes. At times, it would have been beneficial to expand on how the quote relates to the theme	1
	Reflexivity	Coder and researcher completing analysis identified but no other discussion beyond this. Relationship between researcher and participants not clear	1
	Ethical issues acknowledged/addressed	Details of approvals gained and process of informed consent.	2
	Credibility, quality checking	Discussion of checking preliminary findings with a subgroup of 6 participants. Consultation with experienced qualitative researchers during coding in research team. Discussion of strengths/limitations	2
	Impact and contribution	Discusses results in relation to social bonding theory, as well as considering attachment perspectives. Makes no explicit recommendations for clinical practice or future research	1

		Mean Score:	1.5
Olsson, Strand & Kristiansen, 2014	Explicit aims, methodology and purpose	Clear, explicit aims. Qualitative approach justified and linked to aims. Makes specific link to why transitions are important to focus upon and links this to recovery.	2
	Recruitment of participants and situating the sample	Explains context of recruitment in terms of setting. Inclusion criteria stated. Demographics included in text.	2
	Data collection methods	Replicable, clear, questions provided	2
	Rigorous analysis	Clear explanation of this, illustrative table of back-and-fourth analysis process.	2
	Commitment and grounding in examples	Quotes provided for each theme, relevant and anchored in theme	2
	Coherent presentation of findings	Results split into three distinct 'turning points' although unclear how arrived at these 3. But good explanation of each 3. Discussion structured into a narrative but the link between this and findings isn't explicit - confusing	1
	Reflexivity	None	0
	Ethical issues acknowledged/addressed	Ethical considerations discussed including approvals, consent and confidentiality.	2
	Credibility, quality checking	Description of use of research team and co-authors in checking data and themes –although no explicit description of this process. Credibility explicitly mentioned. No checking with participants. Limitations acknowledged	1
	Impact and contribution	Table of the contributions along with recommendations provided – very clear	2
		Mean Score:	1.6

Skinner, Heasley, Stennett & Braham, 2014	Explicit aims, methodology and purpose	Sets in context the motivational group and its relationship to the treatment pathway. Explicitly states the broad aims of the program are linked to recovery. Situates current evaluation in context of others completed. Aims stated, methodology appropriate.	2
	Recruitment of participants and situating the sample	Clearly states who was recruited and from where. Table of demographics provided.	2
	Data collection methods	Procedure clearly described, theory cited. Didn't include exact questions, but did include topics.	2
	Rigorous analysis	Good clear explanation of process, referenced analysis.	2
	Commitment and grounding in examples	Not as many examples and quotes provided as other papers. Sometimes quotes provided to explain both themes and subthemes but other times quotes just on subthemes.	1
	Coherent presentation of findings	Presented themes and subthemes clearly, although some themes don't have subthemes. Visual would have been helpful	1
	Reflexivity	Acknowledged that researchers who facilitated focus groups were also involved in analysis, but not bias and roles beyond this.	1
	Ethical issues acknowledged/addressed	Ethical considerations discussed; consent, approvals, information sheet, debrief	2
	Credibility, quality checking	Acknowledges limitations. No checking with SU.	1
	Impact and contribution	Links to recovery and group aims back in discussion. Makes recommendations for service development and future research	2
	Mean Score:		1.6

Madders & George, 2014	Explicit aims, methodology and purpose	Explains context of hospital, importance of discharge and transitions. States aims. Recovery is key word but not explicitly linked in introduction and purpose	1
	Recruitment of participants and situating the sample	Defines discharge preparation stage. Included reasons for refusal. No detail other than the hospital and being at preparation stage	1
	Data collection methods	Lacking in detail – no information on interview structure and schedule	1
	Rigorous analysis	Brief description of stages of thematic analysis but lacking detail, no account of who was involved in analysis and how consensus reached. Nine themes	1
	Commitment and grounding in examples	Some themes only had one quote – enough to be a theme in it's own right? Other themes more embellished in examples.	1
	Coherent presentation of findings	Some themes appear similar – e.g. disempowered/unvalued and issues with the system.	1
	Reflexivity	Not discussed	0
	Ethical issues acknowledged/addressed	States consulted with trust research governance but not specific about approvals and process. Consent mentioned briefly	1
	Credibility, quality checking	Discusses some limitations, but no acknowledgement and discussion of quality checking	1
	Impact and contribution	Makes recommendations and situates in current knowledge but again no explicit link to recovery.	1
	Mean Score:		0.9
Stuart, Tansey & Quayle, 2017	Explicit aims, methodology and purpose	Clearly situates study in recovery context, covers a lot of previous research and policy context. Clear aims and purpose, methods appropriate	2
	Recruitment of participants	Inclusion criteria included, procedure clearly explained. Some demographics	2

	and situating the sample	given and rationale for not including many.	
	Data collection methods	Process clearly explained, no topic guide given, clear step by step IPA process explained	2
	Rigorous analysis	Step by step analysis explained as well as efforts to maintain rigour. Themes make sense and work well – makes links between superordinate themes	2
	Commitment and grounding in examples	Anchored in quotes –some have more than others and some have just one quote	1
	Coherent presentation of findings	Table to present themes and superordinate themes – very clear.	2
	Reflexivity	Roles of research team identified, reflexive diary kept	2
	Ethical issues acknowledged/addressed	Approvals discussed, risk acknowledged, informed consent, data protection discussed – detailed in comparison to other papers	2
	Credibility, quality checking	Transparency discussed, large section acknowledging limitations and offering reflections	2
	Impact and contribution	Makes recommendations and highlights lots of clinical implications - links to future research	2
	Mean Score:		1.9
Aga, Laenen, Vandeveld, Vermeersch & Vanderplasschen,	Explicit aims, methodology and purpose	Highlights gaps in literature, explains why first person narratives are important and later in article links this to their design.	1
	Recruitment of participants and situating the sample	Explains eligibility and who was contacted to recruit participants. Process described. Some demographics given.	2

2017	Data collection methods	Process is clearly described. No provision of open ended question examples or topic list, but clear data collection process described.	2
	Rigorous analysis	Use of data analysis software package to organise and analyse data (need to justify this?), explained role of research team – talks about ‘common tree structure’ without a lot of explanation – a little confusing	1
	Commitment and grounding in examples	Some subthemes did not have participant examples	1
	Coherent presentation of findings	Table to represent themes visually – results considered using facets of recovery in general mental health literature as a guideline – why?? No clear explanation of this	1
	Reflexivity	Acknowledges roles of researchers in analysis, doesn’t comment on impact of using software package on process/results	1
	Ethical issues acknowledged/addressed	States approval gained, no other ethical issues mentioned – eg. Paid for participation	1
	Credibility, quality checking	Does include strengths and limitations but makes omissions in this	1
	Impact and contribution	Discusses results in terms of general implications in reference to literature, doesn’t make explicit recommendations for practice beyond general implications	1
	Mean Score:		1.2
Adshead, Ferrito & Bose, 2015	Explicit aims, methodology and purpose	Explains why the focus on this particular group of offenders, explains why narratives are important. Aims not explicit – have to surmise from information	1
	Recruitment of participants and situating the sample	Explains context in terms of UK context and proportion of male homicide offenders. Clear explanation of situation sample and recruitment in terms of groups already running	2

Data collection methods	Explains what data sets consist of and the types of notes taken after sessions, gives specifics of how much data and from what groups	2
Rigorous analysis	Process of analysis is briefly mentioned but not discussed in terms of engagement with data	1
Commitment and grounding in examples	Quotes utilised, integrated into the text rather than set apart – results and discussion integrated – can be difficult to identify SU voice	1
Coherent presentation of findings	As above – themes make sense but presentation is impacted on by choice to combine results and discussion – dilutes SU voice	1
Reflexivity	Not discussed	0
Ethical issues acknowledged/addressed	Not discussed	0
Credibility, quality checking	Acknowledges data is based on clinical material via recall of session content, strengths and limitations discussed	2
Impact and contribution	Does not make recommendations for research or practice	0
Mean Score:		1.0

Appendix A.4: Contribution of studies to themes and their relative mean quality scores

Study	Mean Quality Score using Quality Appraisal (0-2)	Theme 1: Hope	Theme 2: Connecting with others	Theme 3: Meaningful occupation, roles and identity	Theme 4: The powerful environment of the hospital	Theme 5: Coming to terms with the past and diagnosis
McKeown, Jones, Foy, Wright, Paxton & Blackmon, 2016	1.3	✓	✓	✓	✓	✓
Clarke, Sambrook, Lumbard, Kerr & Johnson, 2017	1.9	✓	✓	✓	✓	✓
Chandley & Rouski, 2014	0.8	✓	✓	✓	✓	✓
Nijdam-Jones, Livingston, Verdun-Jones & Brink, 2015	1.5	✗	✓	✓	✓	✗
Olsson, Strand & Kristiansen, 2014	1.6	✓	✓	✓	✓	✗
Skinner, Heasley, Stennett & Braham, 2014	1.6	✓	✓	✓	✓	✓
Madders & George, 2014	0.9	✓	✓	✓	✓	✗
Stuart, Tansey & Quayle, 2017	1.9	✓	✓	✗	✓	✓
Aga, Laenen, Vandeveld, Vermeersch & Vanderplasschen, 2017	1.2	✗	✓	✓	✓	✓
Adshead, Ferrito & Bose, 2015	1.0	✓	✓	✗	✗	✓

Paper 2 –Empirical Research Report

***Narratives of recovery: Capturing recovery stories from
people who have used Forensic Mental Health Services***

Word Count: 7,987

Abstract

This study identified recovery stories of five male participants who had been detained in a low secure forensic service and discharged into the community. Narrative analysis was utilised, using Kirkpatrick's (2008) framework for hearing recovery stories. The personal, community and dominant cultural illness narratives in participants' stories were explored and counterstories identified. Results highlight that hope and understanding individual recovery journeys were important parts of personal narratives. Within a community level narrative, the importance of relationships was identified, as was how participants' identities were shaped by their community context. Dominant cultural narratives included experiencing stigma around mental health, and the power and dominance of the hospital and medical model. Results also highlighted the emerging cultural narratives of increasing openness around experiencing mental illness. This contrasts to the counterstory identified surrounding the continued secrecy and non-acceptance of offending behaviour. An additional counterstory that challenges the dominance of the medical model was the experience of service users as the expert, and challenging whether detainment is effective in promoting recovery. The findings are discussed in terms of clinical implications, particularly the tension between openness around mental health and secrecy around offending. Further research suggestions are given.

Keywords: *forensic mental health, recovery, narrative, secure care*

Introduction

This paper presents the findings from a qualitative study exploring the recovery narratives of men who have used low secure forensic mental health services and were subsequently discharged into the community. The recovery approach provides an alternative perspective to the medical model of mental health based on diagnosis and classification, and represents empowerment of service users in moving away from clinicians as experts (Aga, Vander Laenen, Vandeveld, Vermeersch & Vanderplasschen, 2017). It is widely accepted in mental health services that supporting personal recovery is an essential service goal (Shepherd, Boardman & Slade, 2008). Within service delivery this often involves drawing on ideas from Anthony's (1993) seminal work which defines recovery as a process of achieving quality of life despite the limitations of mental illness.

It has been argued that application of recovery principles in forensic settings presents unique challenges (Cromar-Hayes & Chandley, 2014; Dorkins & Adshead, 2011; Mezey, Kavuma, Turton, Demetriou & Wright, 2010). Drennan and Wooldridge (2014) highlight this is because people in forensic mental health services suffer a double stigmatisation, experiencing contact with both criminal justice and mental health systems. Clarke, Lombard, Sambrook and Kerr (2016) highlight that the nature of the secure environment means opportunities for positive risk taking, developing trust and supporting choice are limited, making recovery tasks challenging. These individuals have restrictions placed on them by the Ministry of Justice because of their risks to the community. Cromar-Hayes and Chandley (2014) note this leads to social exclusion, which is contrary to the recovery agenda.

Dorkins and Adshead (2011, p. 179) summarise how the recovery approach is uniquely challenged by the forensic service user:

- Forensic service users' values and identity
- Community responses, particularly to violent offences, in the form of social exclusion
- Empowerment of those who misuse power
- Hopelessness and the offender identity.

A unique set of tensions can be seen as arising in relation to empowerment, hope and identity in the recovery of the offender patient which go beyond the recovery tasks of those in mental health settings who have not offended.

Turton et al. (2009) emphasize the need for more exploration of the value and applicability of recovery principles within specialist mental health services. There is a growing body of literature dedicated to this, but it is not without limitations and gaps. Researchers have consistently highlighted the importance of seeking out the views of service users (for instance Cromar-Hayes & Chandley, 2014). Several authors have attempted to do this, however within a UK context this has largely been done with service users from high and medium secure services. For example, Madders and George (2014) explored how recovery principles are relevant for patients from a high secure hospital. Mezey et al. (2010) found that those detained within the high security estate face a triple risk of stigma as they have committed a crime, experience mental illness and are detained in high secure care. Adshead, Ferrito and Bose's (2015) research with offenders of homicide at a high secure hospital discussed how the index offence fits into recovery paradigms and concluded that the process of coming to terms with the offence is the most significant recovery process.

The experiences of service users from low secure services are underrepresented in the literature. One published paper uses participants from a low secure service within the UK (Clarke, Sambrook, Lumbard, Kerr & Johnson, 2017). The authors explored recovery experiences of six male patients from a low secure service. Five themes emerged including; recovery being a journey, feeling vulnerable in the environment, loss (particularly of freedom), the importance of relationships with staff, and hope. The findings are generally consistent with the wider forensic recovery literature. However, the authors recommend that further research is needed, particularly in order to explore the efficacy of recovery approaches in terms of reducing recidivism.

Rationale for the Current Research

There is a paucity of research with individuals from low secure services. None of the literature includes discharged service users' perspectives on recovery. Recovery is defined as a process rather than a one off event and, as such, it is important to explore what the recovery journey means for individuals who have experienced services and moved beyond into the community. Considering whether recovery principles can apply effectively, and whether there are unique ways of doing this within forensic services through exploring the perspectives of individuals who have been in low secure services, and furthermore have been discharged, will add a new dimension to this emerging body of literature.

There are a number of reasons why this research is timely. Recovery approaches are supported in England by various Department of Health policies, aiming to promote self-management and choice within healthcare provision. These include for instance, *The Expert Patient* (Department of Health, 2001); *Our Health, Our Care, Our Say* (Department of Health, 2006); and the *Commissioning Framework for Health and Well-being* (Department of Health, 2007). Support has also been given by the British Psychological Society Division of Clinical Psychology (2000). If services within the NHS are to demonstrate the principles of the recovery model, and to integrate expertise through lived experience so that service users can be involved in the shaping of packages of care and service delivery, it is important to seek out their experiences. Arguably, forensic service users should have access to the same opportunities to influence service delivery.

This research utilises a narrative methodology to identify and explore recovery stories from participants. A recent publication from The British Psychological Society (2018) highlighted the importance of taking seriously the meanings and narratives ascribed by patients to their subjective experiences. Clarke et al.'s (2017) research with low secure service users utilised Interpretative Phenomenological Analysis (IPA) in their methodological approach in order to explore the experience of participants. It

is possible that using IPA within this study would have provided valuable insights into the experience of discharged service users. However, IPA's focus on individual experience arguably excludes wider contextual issues and factors. Narrative approaches allow for analysis of wider contextual cultural, social and historical discourses and influences, as well as being able to consider the richness and contradictions within individual stories (Squire, Andrews & Tamboukou, 2008). It is argued that a focus on context in this way is imperative in conducting research with 'offender patients'. This is because the layers of context operating throughout their lives (e.g. mental health diagnosis, treatment pathways, access to services, social disadvantage) are likely to have a significant impact on their stories about recovery.

Research Questions

- What are the recovery stories of people who have used forensic mental health services and have been discharged to the community?
- What does recovery mean for service users?
- What factors influence recovery?

Method

Narrative Method

Narrative research is based on the premise that human beings make sense of and give meaning to their lives through the stories they tell (Andrews, Squire & Tamboukou, 2008). Narrative analysis involves attending to not only the story told, but the ways in which it is told and constructed, by whom, for whom, and the cultural, social and historical contexts it draws upon (Riessman & Speedy, 2007). By re-presenting their personal story to themselves and others, individuals draw on wider stories in the social and cultural context to achieve personal change (Wood, 1991). Narrative

researchers seek different and contradictory meanings from stories to understand individual and social change.

Narrative research is diverse and can be utilised to explore stories in single case designs as well as small and large cohort studies, and the range of materials that can be analysed is wide (Squire, 2008). Unlike other methodologies, there is no recommended sample size, nor is there a specific way to analyse data using a narrative framework. However, Squire (2008) notes the level of analysis should be reflective of the number of participants.

Reflexivity and transparency are necessary to enhance credibility of the research, particularly as there is no specific process of analysis as there is in other qualitative methodologies. There are a unique set of interacting and relative factors existing between the researcher and the research process itself. Therefore, although transparency enhances replicability, the very nature of narrative inquiry means there is a unique dimension to the research. Winkler (2003, p. 399) writes, as a researcher “I, too, lead a storied life and the research relationship is part of my experiential text”. In the pursuit of reflexivity, the factors unique to the researcher-participant relationship are presented below. In addition, the researcher kept a reflective diary throughout the research process (extracts from this are included in Appendix B.1)

The Current Research

The researcher is a Clinical Psychologist in training, who has worked in therapeutic roles in forensic settings within the NHS and HM Prison Service. It has been crucial for the researcher to remain aware of biases throughout the research, particularly relating to the narrative that ‘recovery is possible’ but especially challenging for this patient group. The researcher holds a social constructionist position, which proposes that knowledge perceived to exist is influenced by societal, cultural and historical factors. Knowledge is sustained by social processes, specifically human interaction and social action (Gergen, 1985). From this position, conducting an interview to seek out participants’ stories constructs the narrative.

The narrative analysis in this study draws on Kirkpatrick's (2008) framework for understanding recovery experiences of individuals with mental illness. The framework has two forms of narratives. *Illness narratives* search for meaning within the illness the individual experiences. *Counterstories* stand in opposition or resistance to the dominant narratives; those narratives that Kirkpatrick notes are often communicated as stereotypes.

Kirkpatrick proposes that illness narratives and counterstories are heard by the level of narrative; personal, community, and dominant cultural narratives. *Personal narratives* explore the unique experiences from past, present and future. Individuals tell their own personal stories, but these are composed by adapting and drawing on the culturally available narratives. *Community narratives* are stories that are common amongst a group of individuals which gives an understanding about how individual identity is shaped by community narratives. *Dominant cultural narratives* are 'overlearned' stories communicated in society, often through cultural or social institutions, networks, and the mass media. Counterstories resist oppressive dominant narratives.

Kirkpatrick states it is possible for personal stories, and in particular counterstories, to challenge the dominant narrative and "promote the paradigm shift toward a recovery orientation" (2008, p. 66). This approach to analysis was deemed most appropriate considering the aims of the research.

Research Setting

A low secure forensic service provided access to participants. The service is for men with mental illness, aged 18 and over, detained under the Mental Health Act, who pose a significant clinical risk to others, or are under a legal requirement to be in custody. The service has 32 beds across one acute and one rehabilitation ward. Delivery is via a multidisciplinary staff team. All participants were discharged after risk assessment deemed that they could be safely supported in the community. As part of the follow-up procedure for

discharge, all participants received support from their local community mental health teams, with varying input from community forensic services.

Recruitment

A purposive sampling technique was employed. Patients who met the inclusion criteria were identified as potential participants by the Gatekeepers; a Consultant Clinical Psychologist and a Senior Social Worker at the service.

Inclusion Criteria

- Adult males, 18 or over.
- Had historically been detained in the low secure forensic service and were detained under the Mental Health Act (1983, as amended 2007).
- Participants had, at the time of their admission, a primary diagnosis of mental illness and posed a significant clinical risk to others, or were under a legal requirement to be in custody.

Exclusion Criteria

- Individuals who do not speak English.
- Currently experiencing mental distress or acutely unwell.

33 potential participants were invited to take part in the research. Response rate was low, with three individuals declining to participate and four agreeing to take part in the research. After a second invitation was sent out, a further two declined and one additional participant agreed to take part.

Gate Keepers sent invitation letters to potential participants including a leaflet advertising the research (Appendix B.2), an invitation letter (Appendix B.3), an information sheet (Appendix B.4), and a consent form for a telephone call with the researcher (Appendix B.5). Once participants provided consent to an initial telephone call, Gatekeepers then shared the consent form and contact details of potential participants with the researcher. The researcher then made telephone contact with potential participants explaining the research verbally, answering any questions and requesting consent to an interview.

Interviews were arranged to take place in person or via telephone (Appendix B.6). Prior to the interview informed consent was obtained (Appendix B.7), as well as consent for the Gatekeeper to disclose demographic information (Appendix B.8). The staged process of consent aimed to provide multiple opportunities to achieve fully informed consent.

Participants

Five men took part in the research. Recruitment was from a small population and, given the sensitive nature of the demographic information; details will be kept to a minimum in order to ensure anonymity. Participants were aged between 31 and 65. All had been diagnosed with a psychotic illness. Index offences included acquisitive offences, and offences against the person including violence, weapon possession, attempted murder and manslaughter. The mean duration of total stay in secure forensic services (including high, medium and low secure settings) was 6 years 8 months, with the range between 2 years and below to 10-15 years. Some had been discharged longer than others. Each participant was living independently in the community or in supported accommodation. During their hospitalisation, each participant engaged with medication and undertook various other therapeutic activities including; occupational therapy, group and individual psychology and My Shared Pathway work.

Procedure

Four interviews were completed in person at the service, and one was completed by telephone. Interviews lasted between 12 and 62 minutes, with a mean duration of 36 minutes. In accordance with the narrative approach, interviews were unstructured, with the researcher asking participants to share their recovery story. Questions and prompts were utilised to encourage participants' to tell their story if necessary (Appendix B.9). Ricoeur (1984) describes narratives as jointly told between speaker and hearer, and Mishler (1995) acknowledges the importance of the interpersonal context of the

interview. Therefore, the researcher aimed to limit their participation and influence on the stories told. Nonetheless it is important to acknowledge that these interactions may have shaped the stories told. Interviews were audio-recorded.

Transcription and Analysis

Interviews were transcribed by the researcher within a week of the interview. During transcription the researcher made notes to enhance reflexivity within analysis, noting initial impressions of the stories told. Following Emden's (1998) framework, core stories were created in order to analyse each transcript using Kirkpatrick's (2008) approach. Appendix B.10 presents the steps of the core storying process and provides an example of the core storying process. An iterative process was undertaken involving a continual shifting between raw interview texts, subplots and final core stories to ensure the core story meaning was not lost.

In order to synthesise the data into a narrative, subplots were identified in each participant's core story, as was the level of narrative using Kirkpatrick's framework for each subplot. Appendix B.11 summarises how subplots identified for each participant are framed within Kirkpatrick's levels of narrative analysis. Shared subplots across participants narratives were then developed by examining each core story and identifying the shared aspects of the stories and, importantly, where stories differed or opposed. Once these shared subplots were identified, these were then synthesised and ordered in terms of level of narrative using Kirkpatrick's framework. Particular attention was paid to counterstories. The co-construction of the narrative was an essential element of this as the researcher relied on her reflections of the available dominant cultural narratives.

Ethical Considerations

Ethical approval was obtained from an NHS Research Ethics Committee (Appendix B.12) and was peer reviewed by Staffordshire University

(Appendix B.13). Approval was obtained from the Research and Development Department (Appendix B.14).

In order to manage risks to the researcher or participants, interviews took place at the service so the researcher could follow risk management procedures. Therefore participants were required to access transport. Because participants were discharged, it was acknowledged that this might mean some may have to travel large distances to access participation. As such, the service supporting the research paid for transport costs. Telephone interviews were also offered. One participant faced a number of barriers getting to the service and so opted for a telephone interview.

Findings

Figure 1 presents a summary of the findings, illustrating the shared illness narratives in terms of level of context, and counterstories.

Personal Narratives of Recovery

Understanding my recovery journey

Each of the participants' narratives reflected upon their journey of recovery. Personal narratives within this subplot framed recovery in past, present and future contexts. For three participants, reflecting on the past considered the role of alcohol and substances. For instance, James reflected;

'Alcohol used to be a major part in my life.'

For Kyle, the hospital provided an opportunity to detox;

'I was fond of a drink so it was good to just cut that out of my system from a detox point'.

Most participants discussed the role of medication. The journeys participants took in finding the right medication were challenging, often involving trialling a number of different medications;

'I mean I tried god knows how many different medications' (James)

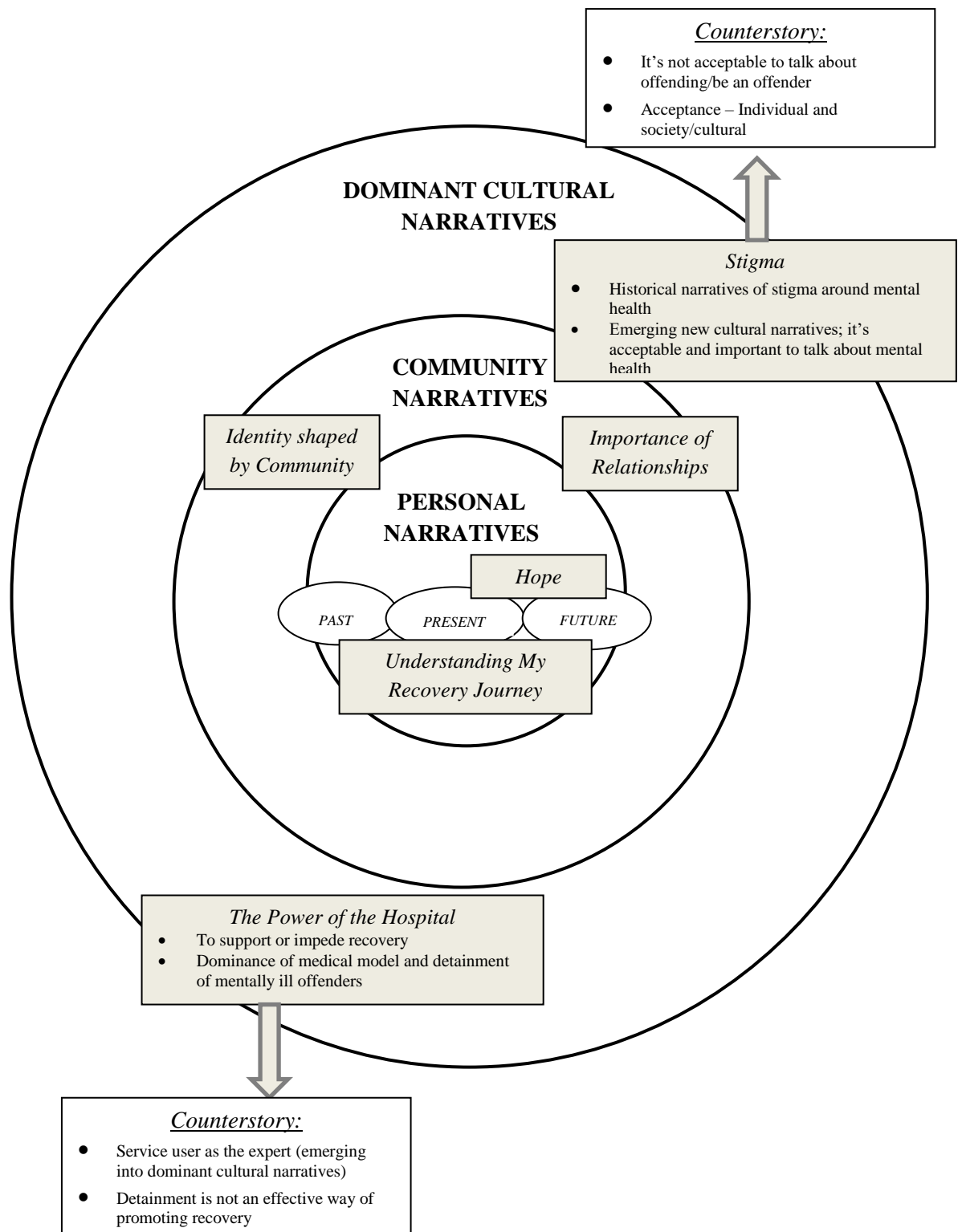


Figure 1. Summary of findings

For John, the medication process left him without autonomy and control over his treatment. John felt medication was a significant factor in the onset of his mental health difficulties;

'I went through being force fed drugs... putting stuff in what cracks you up...when it first all started I didn't have mental illness I was given mental illness'.

Only one participant spoke in depth about his index offence in terms of what happened and the impact upon his personal recovery. Derek reflected;

'I did something which I wouldn't have in a thousand, thousand years thought that could happen to me... that I would do. I did a terrible thing, I took a life of a person and that was the lowest point, the lowest, lowest, lowest point in my existence'.

It is interesting that the index offence, or offending more generally, was not a part of most participants' personal stories.

Participants' personal narratives all included a reflection upon what recovery means to them and where they feel they are presently in their recovery journey. There were conflicting stories within this subplot. James and John felt that they have recovered;

'I'd say I'd recovered yeah' (John)

'I don't think I'll be getting any better than I am doing' (James)

However, for Derek and Burt recovery was not something to be achieved at a particular point but a journey they will continue throughout the rest of their lives;

'Recovery is a journey. You can't look back and [say] that was the start that was the finish' (Burt)

'It's an ongoing thing, it's a journey that will go on till the end of my days' (Derek)

For Derek, this directly linked to him continuing to live with the impact of his index offence;

'You can't erase the memories of what has happened in the past... recovery means overcoming not the pain, not the suffering, but the trauma...or live with the trauma...and not being crushed by it'.

One participant's personal narrative didn't sit within feeling recovered or recovering. Kyle commented;

'Recovery, from what? (Laughs)... there's a part of me that almost says indifference'.

Presently for Kyle, his indifference about whether recovery fits his experience centres on him remaining to feel close to the ideas that he believes brought him into services;

'In some ways it was never a problem that I had these big ideas...I was grounded with [my ideas] I think, that's what I mean by indifference I was actually grounded'.

Kyle's personal narrative is that he is unsure whether recovery is something that he currently has or wants. He suggested that having to let go of some of his ideas as part of recovery is leading him to feel unhappy with parts of his journey thus far:

'I still feel a bit discordant you know, I still feel almost detached from myself at times, which I'm not happy with to be honest'.

Kyle noted:

'Basically my entire life feels like one big blag at the moment'.

Perhaps Kyle feels recovery is 'ticking the boxes'. Letting go of his ideas in order to satisfy hospital, and indeed dominant cultural, ideas of recovery being symptom free conflicts with his own ideas.

All participants described their recovery journey in terms of how they manage potential future risks in the community in order to stay out of hospital. This

includes managing risks around drugs and alcohol, taking medication, avoiding negative peers and actively staying away from risky situations. For example Derek explained;

'It's easy to skip your medication but at the end of the day it's not going to help you... you don't get yourself into situations that you might compromise yourself so you tread carefully'

Hope

Hope was an essential element of participants' present and future reflections on recovery. Looking to the future is important in seeing recovery as possible and being able to envisage a realistic future;

'There's light at the end of the tunnel basically. It might take a while to get there but just keep going sort of thing' (James)

'There's hope...that would be my message to anybody going through what I've been through or going through the system, not to lose hope' (Derek)

For Burt, remaining hopeful for his future was part of his narrative of recovery being a continuing journey;

'You need to be looking at what the future has in store... It's ongoing. I think the next positive step is to at a later date perhaps look at a place where I have a garage'.

Derek's personal narrative around hope centred on having faith in himself and developing self-belief that he is capable of achieving and worthy of more in his life;

'Having faith, believing in myself basically...being in the system and doing the work that I've done restored my belief in myself...led me to believe that there's somebody alive in me, I am capable of a little more'.

Similarly, John's hopeful future centres around feeling appreciative of how far he has come on his journey and how he can hold onto this for the future;

'I'm coming from a position where I've been held down injected with drugs and being locked away... I look at what I've got now and I hold onto and I'm happy'.

Community Narratives

The importance of relationships

Every participant spoke about the central role of relationships to their recovery. Mostly, participants described the significance of genuine, trusting and open relationships with staff supporting their recovery;

'The time the staff are taking with me [has been most helpful]... engaging with the staff helped me realise what is what' (James)

'I think when you've got a doctor and nurses and healthcare that treat you right and respect you right, you can see they do things for you, I think that matters a lot' (John)

Developing relationships with peers within the hospital provides a shared identity based on a mutual understanding and appreciation of experiences as an offender patient.

'We're all in the same boat, we've all been in services so we know where we're coming from with it all' (James)

'I think it's important you got a good relationship with your peers' (John)

Having relationships with peers was narratively linked with a sense of belonging and providing examples of recovery within hospital;

'You can learn so much by talking to other patients' (Burt)

Three participants' narratives included the importance of relationships beyond hospital. Within these stories maintaining, and often overcoming barriers to maintaining, relationships with friends and family aided recovery.

'I think I would have been in the gutter if it hadn't have been for four very, very close friends' (Burt)

'I'm close with my dad and mum... if it was just left I'd be bitterly upset with myself really because my mum and dad are very loving' (John)

These relationships provided ties to the community whilst detained;

'A friend of mine, he was sort of the anchor in the community' (Kyle)

Identity as shaped by community context

The community context shaped participants narratives of their identity. Within a hospital context, identity was defined by the role of being a patient. Burt's identity when in hospital centred around his understanding of staff and patient roles;

'You need to know what the establishment has to offer, what your role within that establishment is, what the boundaries are'.

Many of the stories identified having a sense of purpose and occupation within the hospital;

'I think with being in a restricted place...people need to have things to do, a purpose to have, because if they don't they just switch off which is what it was like when I went to prison you know, I just switched off I became a cabbage basically' (John)

'It's to benefit you in the future, that 25 hours [of purposeful activity] just goes straight away because you're doing activities to promote your recovery' (Burt)

Within Derek's community narrative, his identity was shaped dramatically by the nature of being in a secure forensic environment. He described a specific

situation which led to seeing himself as dangerous. This ultimately led to him beginning to think about recovery;

'I tell you what opened my eyes in a way, a fellow patient punched me one day...it made me come to terms with the situation that I was in. it made me realise that I was in a dangerous place with dangerous people... I realised I was a dangerous man as it would be said and I couldn't continue to be a fool or act a fool'.

Throughout Burt's narrative was a sense that it was important for him to have a shared sense of identity, that he was not alone in his experience of mental health difficulties;

'I think everybody irrespectable [sic] of whether they have mental health issues are still going through a journey of life so you feel a little bit as a normal person if you think about it like that'

Burt reflected upon his journey into services as 'a complete life change'. Holding close the sense of shared identity with others who experience mental health difficulties appears to reduce his feelings of isolation and offer some comfort in his changing sense of identity;

'I speak to so many and they say oh my father, my mother, my cousin, so you're not an isolated person and it can happen to anyone'

For John, the hospital environment deconstructed his identity in some way, and in particular stripped him of his masculinity;

'I was disabled in certain ways...sleep and to be able to ejaculate, and the doctor accepted that these side effects might be a problem so she suggested that I can try another drug, get your manhood back like'

Beyond the hospital, participants' narratives described how the community shaped their identity. This involved taking responsibility or control of their lives;

'Although the support is there at the end of the day Burt has to take that decision because that's what life is all about' (Burt)

This provides a sense of autonomy and independence. For some this involves keeping active within the community;

'You need to be active. I'm active, I go to [the gym] everyday five days a week and I help out where I used to be at [supported housing] and I still see [friends] from there' (John)

Burt recalls a specific event that enabled him to achieve autonomy and independence within the community. He described getting his personal belongings from storage once he was discharged from hospital;

'I thought my next step forward as hard as it's going to be, is to go with a van and a man, to go to this lock up and have [my belongings] back to give me any chance...I don't know what's in the boxes but I know if they're 20 miles away I will never make the next step forward'

For Burt, this was taking control of his recovery;

'I felt I'd really taken the reins...been on a journey but someone else was taking me...so that's been my road to recovery in getting your own belongings back and taking ownership'

Dominant Cultural Narratives

Stigma

Stigma was a salient part of each person's narrative. Participants reflected upon their experience of the cultural stigma and impact of being an offender patient. Narratives included notions that patients within forensic services are dangerous, not 'normal', a 'loony', a 'nutter', a 'dog', and different;

'I got he's becoming poorly again lock him up again... Perhaps you get the odd nutter like me that needs to go into an institute' (Kyle)

'I first noticed I became ill when I was about seventeen and a half, started talking to myself, giggling to myself, it was really

noticeable things you could see but you look at it and think that guy's a loony' (James)

Arguably these narratives are historically part of the dominant cultural narrative; however participants' stories within this research highlight they still experienced the impact of this. For John, the consequences of stigma were significant and prison would have been more socially acceptable;

'I would rather have gone to prison to be honest you know, it'd be a lot easier... [Hospital] is basically like a life sentence'

James highlighted the stigma attached to being in a hospital;

'I was always wanting to get out, get away from the hospital setting, and getting away from the stigma'

Some participants' narratives included an acceptance of their diagnosis and a distancing themselves from their symptoms, perhaps attempting to distance themselves from stigma.

Participants' narratives illustrated the tensions between the historical cultural narratives of stigma around mental health and emerging cultural narratives surrounding openness and acceptance of mental illness. Participants described the importance of asking for help and discussing their experiences of mental health difficulties;

'Talk and listen to people because I think if you do that you'll find their father had a mental health issue or their next door neighbour... ask people for help if you need it...I don't think there's any sort of shame in asking for support' (Burt)

'Knowledge about my symptoms, my mental health and people around you, I can talk to rely on if I need... asking for help and knowing where to go to get what help I can' (James)

Counterstory: I remain who I am for what I've done

In conducting the analysis, it was striking that what was not spoken about within recovery stories was the index offence. Only Derek's story involved a reflection upon his acceptance of offending as part of his narrative. Other participants mentioned their offence, but did not engage in discussion about how this was a part of their story. It could be assumed therefore that offence narratives did not form part of participants' recovery stories. However, it is suggested that the absence of offence narratives sits within a dominant cultural narrative that it is not acceptable to discuss or disclose offending. Derek's story is reflective of a counterstory whereby discussing offending behaviour is a necessary part of recovery.

For Derek, acceptance on a personal level that he has committed the offence facilitates his recovery;

'I won't deny it. I'm not in denial, what happened, happened and there's no getting away from that. So recovery is in a sense coming to terms with what happened'.

Furthermore, he described the impact of not having his offending behaviour acceptable on a societal and cultural level;

'I can't go round saying to everybody that I meet that I spent so many years in a mental hospital, the reason being I took the life of a person...I'm basically incognito in most situations or with most people that I meet. I can't declare or reveal so therefore that always is kind of like a reminder to me that yes I remain who I am for what I've done'.

Derek's counterstory attempts to challenge the dominant cultural narrative, but he faces significant challenges in this. As a result, Derek experiences a continual reminder of his offending as part of his identity. Derek stated 'shame, embarrassment, fear' prevent him from disclosing his offending, illustrating the oppression of the dominant cultural narrative that it may be acceptable to be a mental health patient, however it is not socially acceptable to be an offender.

The power of the hospital

Each illness narrative included a reflection upon the power of the hospital. Narratives conflicted however, portraying the hospital as both helpful in supporting recovery and as impeding recovery. For Burt and Derek the hospital was powerful in creating an opportunity to recover and providing second chances;

'I feel as though I've been given a second chance to live a better life'
(Derek)

James, Kyle and John took positions that the hospital both positively and negatively impacted upon their recovery. For instance John states;

'I think I could have spent a bit shorter time locked up but I think the duration I've had in hospital has got me down the lines of not making any more mistakes'

Within these narratives, the hospital was a powerful environment, one where patients must 'cooperate' and 'play the game' in order to recover;

'You could get over that fence if you so choose to, and the amount of times I looked at it like do I, it's like, actually no I don't need to, I'm gonna play ball here' (Kyle)

'I used to think it was just all a big game or it was a big conspiracy'
(James)

For Kyle, the physical environment itself reflected the power and dominance of the hospital;

'I have to be held behind all these walls and scepticism'

In discussing his experience of taking a drugs test John reflected;

'I thought that was so unjust and so unfair but she was in charge there's nothing I can say or do to her'

For John, the power of the hospital meant that he experienced injustice and felt his voice was unheard in comparison with the power of the staff. This is

extended to his experience of taking medication. John's story reflects his experience of the dominance of the medical model in cultural narratives of treating mental illness;

'One day I had an argument with [a member of staff] and the doctor came and said if you were on Clozaril you wouldn't have had that argument so it's not working, this medication you're on now, we're putting you back on the Clozaril I was gutted, really gutted. So at first I refused to do it, she says you will take your medication John'

Compliance with the medical approach to mental illness was something that all participants discussed, and this was seen as either 'coerced' and 'box-ticking' where the hospital was seen as impeding recovery, or part of the process of recovery if the hospital was seen as supporting recovery:

'Compliance is an essential thing, it's an essential part of the contract you agree with the authorities who are putting you back into society'
(Derek)

'I comply, there's no point in fighting something you're not going to win' (Kyle)

Counterstory: 'Locking people up ain't the way you should do it'

A counterstory to the dominance of the medical approach within forensic mental health appears to be a story where the voice of the patient is most powerful, and detention is not the most useful way to 'treat' the offender patient. Participants highlighted the importance of the service user being the expert;

'What is somebody with schizophrenia, if they're not an expert at that section of the human psyche or if somebody's a radio psychotic or a believer that they're God or the Devil...in their own way they're all experts in their own understanding of who they are and what they have' (Kyle)

Within this counterstory, detainment does not promote and support recovery, and alternatives to detaining the offender patient should be considered;

'I had peace of mind before I went in and they cracked me up basically, they cracked me up and put me back together again being in there' (John)

'Locking people up ain't the way you should do it. I still think that mental health should be completely community based' (Kyle)

Discussion

This study aimed to identify recovery stories of people who have used forensic mental health services and have been discharged into the community, addressing the gap in the current literature. It was hoped the study would explore what recovery means for service users and consider the factors influential in recovery.

The narrative process employed within the research enabled links to be made between individual illness narratives. In doing so hope was highlighted as an important part of personal stories of recovery, supporting other literature in the field (Clarke et al., 2016; Clarke et al., 2017; Shepherd, Doyle, Sanders & Shaw, 2016) and supporting findings from paper one. An interesting finding is the conflicting positions held regarding the meaning of recovery. Some participants felt they had recovered, others felt that recovery was more of an ongoing journey, and one participant did not feel that recovery appropriately described his experience. This is a unique finding and highlights the strengths of narrative approaches in attending to conflicting stories. This raises interesting questions surrounding how to measure and define recovery and how to work with individuals who feel recovery isn't something that fits their personal story. Supporting these individuals, it is arguably imperative to hear the personal truths attached to their journey

through services. It is the role of services to consider how to effectively hear those personal truths, even if that conflicts with service goals and ideals.

Relationships, particularly with staff, facilitated recovery. This supports findings from other research (for instance Adshead, Ferrito & Bose, 2015; Chandley & Rouski, 2014). Open, genuine and trusting relationships with staff enabled participants to feel valued, and provided space to talk about experiences of mental illness as part of recovery. The community level of narrative provided participants with identities that were shaped by hospital detainment, or freedom in the community. Being detained in hospital resulted in a deconstruction and reconstruction of identity in some way. For some the hospital resulted in the construction of a 'dangerous' identity, and for others it resulted in a deconstruction of their masculine identity. Having a clearly defined role and purpose in hospital was important, supporting findings from paper one. Within the community context identity was defined by an achievement of a sense of responsibility and independence.

The analysis explored the dominant cultural narratives shaping participants' recovery stories. Within this, it is possible to see the remnants of a historical narrative centring on the stigma attached to mental illness. The findings highlighted the emergence of a cultural narrative around acceptance of and openness around mental health. It is possible to see this emergence within recent media campaigns, such as Lloyd's Bank's recent 'Get the Inside Out' television campaign and various other social media campaigns. What is interesting is the counterstory, revealing the continued secrecy around offending behaviour. The remarkable absence of offending narratives within the stories highlights the tension between the social acceptance of mental illness stories, but not stories of offending. Cultural narratives on offending behaviour have not caught up with the emerging narratives of acceptance of mental illness in this sense.

It is important to acknowledge potential alternative explanations for participants not including offending as part of their recovery stories. It is possible that participants didn't feel comfortable to discuss their offending with the researcher, impacting upon the stories told. Perhaps offending is

simply not part of participants' recovery. In considering this further; it may be that asking about 'recovery' did not generate stories that were inclusive of offending as this concept is more aligned with mental health and illness, rather than offence rehabilitation. Therefore, participants may have not felt offending was part of their recovery story as the perception is that it is a life choice rather than a part of their illness. If coming to terms with the offence is the 'most significant' recovery process (Adshead, Ferrito & Bose, 2015), services must consider whether talking about recovery is enough. Do services need to engage with recovery *and* rehabilitation stories? An alternative consideration is that participants did not include offending in their narratives as they have dissociated from their past identities. Kohler Riessman (1993) notes that individuals exclude experiences that undermine the current identities they wish to claim. As such, perhaps an offending narrative undermines an identity of recovering or being recovered. Paper 1 highlighted the tension between confronting and forgetting the past, and perhaps for participants in this study, an important part of their recovery was in fact forgetting the past.

Narratives revealed the power and dominance of the hospital to either support or impede recovery. Interestingly, some participants held both these positions simultaneously. This finding sits within the context of a cultural dominance of the medical model in treating mental illness. It is generally accepted within modern NHS care that the service user has an important voice within their care, and participants highlighted that the service user is truly the expert. However, it is evident that service users often feel the power and dominance of the forensic hospital setting renders their voice unheard.

Strengths and Limitations

This study has contributed to the small but growing field of literature on forensic recovery, providing a unique perspective from discharged low secure service users. Using a narrative approach has allowed consideration of the contextual cultural factors that impact on recovery stories, which has been important when considering the findings. Furthermore, the analysis was

able to consider what was not said within the interviews. The stories that were *not* told were important in identifying counterstories.

It is important to acknowledge the limitations of the research. Response rate to invitations to participate in the study was low. Those that responded may not be representative of the population. However, it is important to consider what this might demonstrate about whether individuals continue to engage in recovery beyond an inpatient environment. Gatekeepers identified suitable potential participants based on their own understandings of the aims of the research and their perceptions of potential participants. Furthermore, Gatekeeper bias may have been in turn influenced by the researcher's biases in explaining the research to them. Therefore, a recruitment bias may have meant that those with recovery stories that provide varied and alternative perspectives may have not been invited. The stories of those who have been discharged and have continued to offend or have been recalled are missing within the research and in the literature more generally. This is significant, considering the high rate of recall and reconviction.

Data collection included face to face and telephone interviews. This will have limited the co-constructed nature of the interview, and it is likely to have impacted upon the resulting transcription and analysis. However, had the research not included the opportunity to complete the interviews via telephone, the challenges the participant faced would have meant he would not have been able to tell his story.

Due to the time-limited nature of the research participants did not verify the final core stories, nor the overall illness narratives and counterstories. Therefore, the research only goes some way in re-presenting the stories told. There may be mistakes in the transcription and analysis process, and thus the research has a limited role in empowering and privileging the voice of these service users. Not gaining feedback from participants on the analysed data arguably impacts upon validity, as correspondence with participants across the analysis process would ensure that the findings were fully grounded in participant's stories and enhanced trustworthiness of the researcher's interpretation of the stories.

It is acknowledged the researcher is likely to have felt closest to stories of offending, due to the therapeutic roles the researcher has undertaken within forensic contexts. This may have biased analysis. However, this is balanced with acknowledgement that the researcher has also worked within various mental health settings and is used to hearing stories of recovery from mental health, not just within specialist services and forensic settings.

Conclusion

Offender patients are positioned within a unique intersection of the emerging dominant narrative of acceptance of mental illness, and the counterstory of a lack of acceptance of how offending fits with recovery stories. It appears that culturally dominant attitudes around offending have not caught up with newly dominant ideas around mental illness, which has interesting implications for forensic mental health services. Personal narratives highlight the importance of supporting individuals to feel hopeful about their recovery. Positive, trusting and genuine relationships provide a nurturing environment, demonstrating that recovery is possible. Taking responsibility and developing autonomy are central to identity development within the community. Keeping the service user voice at the heart of services remains a challenge if we are to truly hear the illness narratives within this research.

Clinical Implications

Participants identified the important role of staff in recovery. In particular, having genuine relationships with members of staff who hear their personal stories led to participants feeling that recovery was possible. The findings highlight it is imperative to ensure the service user feels they are the expert in their own care. Current practice within the NHS supports the service user expert agenda, however this research highlights there are specific challenges to achieving this within a forensic setting. Therefore, it is important for forensic services to consider the additional steps necessary to

enable patients to feel they hold some power and control within the constraints of the restrictive environment.

A key part of personal narratives was hopefulness, and within services it is important to identify ways to instil hope in forensic patients. What is especially challenging is how services work with varied definitions of what it means to recover and be recovering. A genuine commitment to hearing personal truths around individual conceptions recovery is necessary. In doing so, services must ask 'whose recovery is important?' This may mean suspending service definitions of recovery in order to come alongside the service user as the expert.

The unique challenge for forensic patients emanates from their position between a cultural acceptance of mental illness, and non-acceptance of offending. How can services promote recovery from mental illness *and* offending in this context? Forensic services have a significant role in modelling attitudes of acceptance of and openness towards stories of offending. Staff should promote the idea that patients are worthy of second chances, but importantly should consider ways to make conversations about offending and violent behaviour less taboo. Staff should initiate and promote discussion of offending so patients feel their offending story can be part of their recovery. Arguably, protecting psychological work as the only context in which patients can discuss their offending further perpetuates the dominant cultural narrative of secrecy around offending.

What remains the biggest challenge is creating change at a societal level. In doing this it is important for society to identify ways to integrate offenders back into communities more effectively, to provide access to positive narratives of offenders being given a second chance in society. Services should work to enhance and nourish links with the community in order to give forensic patients being discharged from services appropriate support.

Future Research

Future research is needed to further explore the stories of forensic service users generally, however specifically with discharged service users. This will enable an exploration of engagement with recovery beyond the hospital, which in turn could provide valuable insights into how the hospital can support recovery. An interesting direction for future research could be to revisit participants' stories some years following this research. This may enrich our understandings of what supports individuals to avoid recall and reoffending. Andrews (2007) has conducted this 'second take' style research often. Furthermore, research with individuals who have reoffended following discharge may bring to light interesting counterstories and useful insights into the further challenges for recovery in forensic services.

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Appendix B.1: Extracts from Researcher's Reflective Diary

Reflective Diary 2/2/17

What is my story/narrative about recovery?

Personal Recovery
- loss of Dad Oct 17

Recovery from the eyes
- of a 'clinician' reading
recovery stories - Prison
NHS

Are they different?

Personally, I feel recovery from the loss of Dad & the grief I have experienced has been significant in how I view recovery & what it means to be recovering. How? Needing others more than I thought I would ever need others - prioritising my resources & where I put my energies...

Does this link to how I view recovery in my role? Has it influenced it? I now feel I understand more about needing to work on recovery goals & priorities & celebrating small wins every day - I think I understood this before as a professional but having personally gone through what I felt was the worst time in my life I feel I truly felt this... Need to consider whether this might impact my analysis.

I wonder if this is the complexity in Fint recovery - What is the priority - mental health & well being / reducing risk / being safe / understanding their offending → are there more tasks making priorities harder? What do we communicate as services? Is this always considered?

22/2/18.

Reflections following Kyle Interview

First interview completed - feeling pleased & encouraged to finally be hearing recovery stories from the men.

What was it like hearing the story?

- Surprising

- Privileged; what can I/we learn

- Mindful of my biases & need to be aware

Qual
Intvs
- Not used to narrative style interview; usually used to more structured role or therapy - this felt unusual to simply ask what his story ~~was~~ was. Unusual but empowering for Kyle perhaps...? I felt tempted to go into 'therapy' but resisted this & towards the end really enjoyed being the listener & feeling comfortable with asking very few questions.

What was it about Kyle's story that surprised me?

⇒ he is unsure whether recovery is something he agrees / feels fits his experience & there felt a sadness when reflecting on letting go of some of his ideas that he believes brought him into services. What was the sadness about I wonder...? Did he let go of his ideas because of other conceptions of what recovery is?? At the expense of his own concepts?

↳ It seemed that he still felt close to his ideas in his story - they were important, he chose to tell me about them - how does he square this with recovery?

Perhaps he doesn't? Perhaps this is why he says he is indifferent?

But - he did have a clear idea about what had helped

Phone Interview

8/3/18.

Reflections following John Interview

John appeared so happy he could finally tell his story to me after not being able to meet in person - at least the phone provided him the chance to do that

BUT how did it impact on the co-constructed nature of the story?

- often had to ask him to repeat - interrupting flow of story & maybe his thinking...
- will be difficult to transcribe in pairs - need to be aware this will impact on data - have I missed an important part of his story

↳ I won't have time to check with him!!
THIS is a shame as it would increase validity.

Recovered vs recovering... John seems to ~~be~~ be clear that he has recovered... this goes against lit review & other interviews (Burt & Derek) - This doesn't really fit with what we know - how do we work with both? As services what do we want/aim for? Recovered or recovering? Is this different for forensic services - is it enough for patients to be recovering or recovered?

I can't help notice again what was not said - consistent feeling to this - people aren't talking about their index offence nor any other offending as part of their story? ... do people feel able to? do they want to? is it something about our relationship...?

narrative

CULTURE

Are there any +ve narratives in society about being a rehabilitated offender??



Would you like to tell your recovery story?

**Might you be interested in
taking part in some research
about recovery?**

I want to speak to men about what **recovery** from mental illness was like for them.

I want to hear and understand their **stories**. It might be that you feel 'recovery' doesn't describe your experiences – that's ok – I want to hear **what you have to say** and how you describe it.

If you might be interested, please read the information enclosed (Although there is a lot – it might help you to decide and think of some questions you may have).



Appendix B.3: Invitation Letter for Research

Forensic Mental Health Services Directorate

Address: [REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

Confidential

Direct Tel: [REDACTED]
Direct Fax: [REDACTED]

Dear [Participant Name],

My name is Sophie Sutherland, I am training to be a Clinical Psychologist and I am carrying out some research as part of my training with Staffordshire and Keele University. I want to find out more about the experiences of men who have used forensic mental health services. I would like to know more about your recovery journey. I would like to interview you and talk about your experiences, because what you say could help make Forensic Services better. I have enclosed an information sheet with much more information on about the research. I know there is quite a lot of information, but you might want to read through it in your own time to help you think about the questions you might want to ask, and what else you might want to know. It might be that you feel the word 'recovery' doesn't best describe your experiences and journey through services – that's ok, I am just interested in the stories people have to tell about their life and their experiences through Forensic services.

If you think this is something that you might be interested in, please fill out the Reply Slip to let me know that you might be interested. If you return the slip back to me to say that you might be interested, I will then contact you by telephone.

During this phone call I would talk about the research and the interview with you. This is so that you can understand more about the research and so that you can ask me any questions. Then, if you would like to take part in the research, I will ask you to fill in a consent form. After this we can arrange an interview time and date. Then we can do the interview. Consenting or agreeing to an initial phone call with the researcher does not mean you automatically consent or agree to take part in the research.

If you decide when we meet that you don't want to or you change your mind after you send your reply slip, that is fine. You can let me know at any time what your decision is. If you do not wish to take part, that is fine too.

I look forward to hearing from you.

Yours sincerely

Sophie Sutherland

Trainee Clinical Psychologist

Phone - [REDACTED]

Email - [REDACTED]

Appendix B.4: Participant Information Sheet

Information Sheet

Study Title: *'Narratives of recovery: Capturing recovery stories from people who have used Forensic Mental Health Services'*

Before you decide whether you would like to take part in this research, I would like you to understand why it is being done and what it will involve for you. If you decide you want to meet with me, we can go through this information sheet together. If you have any questions about the research, or if there is anything that is not clear, please ask me at any time.

Please take time to read the following information carefully and discuss it with relatives, friends, and your GP if you wish. Take time to decide whether you wish to take part.

What is this research about?

I am interested in finding out about men who have been in secure forensic hospitals. I am interested in your recovery. I would like you to tell me your story, in your own words, what things have been important to you. You might feel that the word 'recovery' doesn't fit your experiences – that is ok. You can tell me how it is for you, and how you would describe it.

This research could help us to understand what recovery means for men who go through forensic mental health services. At the moment, there is hardly any research about this. Recovery is very important for the NHS, but I want to know what you think.

Why have I been asked to take part?

You have been asked to take part because Dr [REDACTED] said that you might be interested in the research after you were a Patient at [REDACTED], the Forensic Unit.

Do I have to take part?

You do not have to take part in this research, this is OK. It is up to you to decide whether you want to or not.

If you do want to take part, I will call you to arrange an interview with you, if you fill in the reply slip with your details on. Even if you are not sure whether you would like to take part, and just have some more questions or would like to talk it through with me, that is OK, I can still call you. Doing this won't mean that you have to take part.

If you decide you would like to take part in the interview I will ask you to sign a consent form to say you have agreed to take part in the research. Then we will agree when to meet. Even at the interview, you can stop at any time. If you say no this is OK. You will no longer be involved in the research.

It is up to you to decide to speak with me. I will describe the research and go through this information sheet.

If you agree to take part, I will then ask you to sign a consent form. You are free to withdraw at any time, without giving a reason. This would not affect the standard of care you receive(d).

What does taking part involve?

Taking part involves a meeting or a telephone call where I interview you. I can meet with just you alone, or you can have [REDACTED], who suggested you might be interested in the research, to support you if we meet face to face. The meeting/phone call will last 1 – 2 hours approximately. If you can come to meet with me in person, the meeting will take place at [REDACTED]. You will only need to meet with me once, however, if you would prefer to have two shorter meetings, or would prefer something different, please let me know.

I will ask you some questions about your experiences, but mainly we will talk together about your recovery. I will record our conversation on a Dictaphone, or if we are doing the interview via the telephone, I will use a recording device. This is so that I can be sure about exactly what you have said to me. I will only record our interview together, not the phone call before the interview.

I would also like to gather some information about you (e.g. your age, your diagnosis, how long you spent in hospital, whether you did any psychology, or any other type of therapy in hospital). I will ask you to consent to this, so that when I write up the research, you have agreed whether I can include this information. From this information, you will not be able to identify your name, or anything else that would let people know who you are. If you agree to this, [REDACTED] would fill this information in on a form. Please ask if you would like to see a copy of the form we will use for this.

What information will be included in the research?

Some of what you say will be included in the write up of the research. I will use direct quotes from what people have said to me in the interviews. This research is part of a Professional Doctorate Programme for Staffordshire and Keele University and so the research paper will be submitted as part of my training on the Doctorate Programme.

If you agree to take part I will give you a pseudonym (made up name), so that when the research is written up you will be known by a name that is not yours and is not related to you, for example "Harry" or "Bill". This means your name and other personal details will be kept confidential. You can choose your pseudonym name if you like. Pseudonyms will be used if you mention any members of your family, or members of staff who have worked to support you.

Will my personal details be kept confidential?

Yes. All information about you will be kept confidential. But if I felt there was a risk to you or others I would have to pass this information on to other professionals, your GP, or the police to keep you and everyone else safe. If you agree to take part in the research, I will write to your GP, just to let them know that you will be taking part in the research.

All information about you will be securely locked away, including the tape recorded interview and any written up transcripts from your interview. The pseudonym for you will be separately locked away.

What happens if I decide to withdraw?

You do not have to take part in this research. If you agree to take part, you can still change your mind without giving a reason and withdraw from the research. I will delete or destroy

any information you have given to me. If you wish to not take part at any time, just let me know. You can withdraw even after you have done the interview. Please note that once I have submitted my research paper to the University for marking, I will not be able to take out your interview data. The date of this will be 27th April 2018.

What are the possible benefits of taking part in the research?

The information we get from this research will help us to understand more about what is important for people who go through forensic services. So it might help us to think about how we can best support people to recover. It is your choice whether you choose to share your story.

What are the possible risks to taking part in the research?

You might find it hard to talk about some of the experiences you have had and it might feel emotional to discuss this, especially if some parts of your recovery have been difficult. You will be given details of where you can get support if you feel this way and would like further support. Also, remember you can say stop at any time and you can withdraw from the research if you want to.

If you feel distressed, that you might relapse, or have found the interview especially difficult, you can contact Dr [REDACTED] (who is my supervisor), or if you prefer you can contact [REDACTED]. They can then help you get the support you need, for example getting in contact with your GP. Or you can go straight to your GP. This is why I will write to your GP before you take part in the study, just to let them know you're taking part, in case you need their support afterwards.

There is no inducement, reward or financial payment for participating in the research. Should you decide that you want to take part and want to meet in person, it will be possible to subsidise travel costs up to the cost of public transport.

What if there is a problem?

If you are worried about the research or you want to speak with someone about taking part, you can talk to me when we have our telephone conversation or you can phone [REDACTED], who is part of the research team, on [REDACTED].

If you are unhappy about the research, or the way that you have been treated or dealt with during the interviews or at any time, please let me know when we meet or by phone (number: [REDACTED]) or you can phone [REDACTED] on [REDACTED], or [REDACTED].

If you are still unhappy and want to complain, you can contact The Patient Advice Liaison Service. Their contact details are:

Telephone Number: [REDACTED] or [REDACTED]

Address: Patient Advice & Liaison Service, [REDACTED]
[REDACTED]

Email: pals@sath.nhs.uk

You can visit the PALS Office which is situated [REDACTED]
[REDACTED] if you wish (Opening Hours: Monday to Friday – 9am to 5pm).

If you decide to take part in the interviews and would like some information about who can support you afterwards, if the research impacts on you in any way, you can contact [REDACTED] who can direct you to sources of support. Or you can speak to [REDACTED] on [REDACTED]. They can help you get the support you need and could also liaise with your GP if necessary.

If I feel during the interview that you are very distressed, or I am concerned about your wellbeing, I might ask [REDACTED] or [REDACTED], to call you at a later time and check you are ok. That way we can make sure you are getting the right support.

What will happen to the results of the research?

What you say, along with what other people I interview say, will be written up and sent to a journal for publication. I cannot guarantee whether the research will be published in a journal. If a paper is published, this means that the general public can read it. Please let me know if you would like a copy. My research paper will also be submitted to the university as part of my training on the Doctorate Programme for Keele and Staffordshire University.

It may be that the results of this research are used to think about how forensic services work in the future. Therefore, some of the services within the Staffordshire and Shropshire area may wish to look at the research too.

Who has reviewed the study?

This research has been reviewed and given favourable opinion by Staffordshire University Independent Peer Review Committee, as well as NHS Research Ethics Committee and Research Governance approval.

Who is in the research team?

The research team includes me, Sophie Sutherland, who is a Clinical Psychologist in Training studying at Staffordshire and Keele University. The team also includes [REDACTED], my academic supervisor, and [REDACTED] who is my clinical supervisor.

Where can I get further information?

You can ask for more information when we meet or you can phone me on [REDACTED].

These are my details:

Name: Sophie Sutherland

Job Title: Trainee Clinical Psychologist

Address: [REDACTED]
[REDACTED]

Email: [REDACTED], [REDACTED]

Telephone: [REDACTED], [REDACTED]

These are the details for Dr [REDACTED]:

Address: School of Psychology, [REDACTED]
[REDACTED]

Email: [REDACTED]

Telephone: [REDACTED]

These are the details for Dr [REDACTED]:

Address: [REDACTED]
[REDACTED]

Email: [REDACTED]

Telephone: [REDACTED]

Appendix B.5: Consent to Phone Call

NAME OF PARTICIPANT / ADDRESS

Please tick the box you agree with:

1. I am not interested in the research and would not like to be contacted via telephone about the research.

☐

2. I might be interested in the research and doing the interview, please can the researcher contact me via telephone to talk about this some more.

☐

Please call me. My phone number is:

I agree that the researcher can contact me via telephone.

☐

A good time and day to contact me is:

I know that agreeing to a phone call doesn't mean that I am agreeing to take part in the research

☐

Please sign and date

Signature

Date

Please put the Reply Slip in the envelope and post it using the stamped addressed envelope. This will go to Dr [REDACTED]. If you agree to a phone call, this form will then be passed on to the researcher. Thank you.

Appendix B.6: Interview Confirmation Letter

DATE

Dear [Participant Name],

Thank you for letting me know that you would like to take part in the research by meeting for an interview with me/having a telephone interview.

As we discussed on the phone, I would like to confirm this meeting on:

DATE at TIME

at LOCATION

If you would like to change the time or date of the interview please ring [REDACTED]
[REDACTED], or [REDACTED].

I look forward to meeting you.

Yours sincerely

Sophie Sutherland

Trainee Clinical Psychologist

Appendix B.7: Consent Form

Consent Form

Project Title: '*Narratives of recovery: Capturing recovery stories from people who have used Forensic Mental Health Services*'

Name of researcher: Sophie Sutherland

Please initial the box if you agree

I have read the information sheet dated October 2017
(Version II) and I have had time to consider the information

☐

I agree to take part in the research

☐

I agree to be directly quoted when the study is written up,
and I understand a pseudonym (made up name) will be used

☐

I agree to be tape-recorded

☐

I am free to withdraw at any time

☐

I have had an opportunity to ask any questions I might have
and have had these answered satisfactorily

☐

I agree for [REDACTED] to share some
information (examples on the information sheet) about me.

☐

I agree to my General Practitioner being informed of my
participation in the study

☐

Please Sign:

_____	_____	_____
Name of participant	Date	Signature

_____	_____	_____
Name of researcher	Date	Signature

Consent Form Prompts

1. Check that the Participant has read the information sheet ☐
2. Check whether the participant has any questions and ensure the answers are clear. Do I need to provide further information? ☐
3. Check the participant understands their rights to withdraw at any time, without giving a reason ☐
4. Does the participant understand that after the interview, what he/she says will be written up and how the results will be disseminated? ☐
5. Does the participant understand confidentiality and the limits of this? Would they like to choose their pseudonym(s)? ☐
6. Sign consent form: one copy for researcher, one for participant ☐

_____	_____	_____
Name of researcher	Date	Signature

Appendix B.8: Demographic Checklist

Demographic Checklist

[Participant Name] has given consent for you to complete the following checklist about them as part of the research process.

I thank you for your time in completing this.

Yours Sincerely,

Sophie Sutherland

Age

☐

18 – 24

☐

25 – 30

☐

31 – 35

☐

36 – 40

☐

41-45

☐

46 – 50

☐

51 – 55

☐

56 – 60

☐

61 – 65

☐

65+

Reason for participant's accessing of Services:

Mental health Diagnosis (e.g. paranoid schizophrenia):

Offence (e.g. sexual offence, fire setting, acquisitive):

Brief summary of interventions (e.g. Occupation Therapy, Psychology Group Work):

Length of stay in Secure Services:

Appendix B.9: Interview Prompts

Interview Prompts

1. INTRODUCTION:

I am interested in people who have been in secure forensic hospitals. I am especially interested in your recovery journey. Today I would like to listen to you and hear your story. What you say could help to make services better.

2. CONFIRM CONSENT/SIGN CONSENT FORM

Have you any further questions about anything we've talked about? Remember, if you want to stop at any time, just let me know, that is ok. If you would like a break too, just ask and we can.

3. PROMPTS:

- How did you get involved with forensic services?
- Tell me your story
- Tell me about your recovery
- What helped you to recovery?
- What does recovery mean for you?
- Can you tell me more about that...
- That sounds interesting/challenging...
- What did you feel about that...
- Was that helpful/unhelpful...

4. CLOSE OF INTERVIEW:

Thank you for your time in speaking with me. Have you any questions that you would like to ask me? If you have any questions at a later date, or you would like to speak to someone other than me, please contact [REDACTED].

Appendix B.10: Core Storying Process and Example of Core Storying Process (Derek)

Table 1. Core storying process followed for each interview

Stage 1	Reading full raw interview text several times
Stage 2	Deletion of interviewer words/questions
Stage 3	Delete words that detract from the key idea of each sentence/group of sentences and repeat until all extraneous content is removed
Stage 4	Identify subplots (constituent themes)
Stage 5	Move fragments of subplots together to create one core story

Stage 1: Full raw interview text transcription

INT: so I'm interested in people that have been in secure forensic hospitals like you have um and I'm especially interested in your recovery journey so um (.) this is just about me listening and hearing your, your story really (.) um (.)

D: starting from the beginning

INT: wherever you would like to start

D: right, I would say that in [DATE] I was convicted of manslaughter (.) of a woman (.) and I (.) was sectioned under the Mental Health Act (.) 37/42 and was sent to, first of all I was sent to (.) [***] prison where I was held about 3 months for assessment (INT: right) and then I was moved to [***] hospital where I spend the next (.) probably 10 years (.) (INT: right) yeah (.) and from there I was moved to, no I didn't spend 10 years that wrong sorry, I spent about 4 or 5 years (INT: mm) my dates are incorrect (.) (INT: that's ok) and then I went to [*** hospital name] where I spent about 8 years and then from [there] I was moved to [*** hospital name] (INT: right) (.) where I met [name] Psychologist who (.) who did a lot of work with me really (.) (INT: mm) um (.) and he allowed me to explore my own self (INT: mm) um (.) in written a form I was able to (.) to document my own journey (.) (INT: mm) which in the end was (.) was the most useful bit of work, the most useful thing, the best thing to happen to me (.) the whole time that I, I've been in services (.) 'cause it kind of like (.) allowed me to gain some insight into where I was coming from, where I was at, the reasons why I ended up committing this offence and, and, and (.) in the end (.) recovering or being on the road to recovery (INT: right) so that piece of work I did with [Psychologist] was very, very

helpful indeed (INT: mm) but also I, I, I managed to meet some other interesting and helpful people in the services who (.) who were very helpful to me in, in, in bringing about my (.) state of recovery that I'm at at this moment in time (INT: yeah) so it's been a long journey (INT: mm) a difficult journey but (.) I think that I'm in a better place now than I was for a long, long time in my life (.) (INT: right) you know (...)

INT: can you tell me a bit more about, you said you met some really interesting people that have helped (D: yeah, yeah) in your recovery, can you tell me a bit more about that

D: um (.) when I first went into the services I (.) I didn't know what to expect, I (.) I, I, I (.) I think I was like a bit of a closed book I didn't (.) feel I could trust anybody (INT: mm) open up to people, I was kind of like (.) you know (.) I was ticking the boxes as it were kind of a thing, and then I met people like, some people who (.) who kind of like (.) I was able to speak to um (.) on a (.) particular (.) on a I was gonna say a particular level but (INT: mm) erm (.) a (.) meaningful basis, on a meaningful basis and um (.) they kind of like got me to (.) to (.) open up to and, and be myself you know (.) (INT: mm, mm) I could name a few names like (laughs) but I won't name a few you know but, but they were very, very helpful in, in helping me to kind of like (.) recover to the position, to the state, to the position that I'm at right now (INT: yeah) yeah, yeah (...)

INT: and are they kind of staff or fellow patients or

D: staff mainly staff (INT: mm) (.) I must not say I felt the patients didn't help me because they make my journey that much more easier by (.) being friendly towards me and being kind and so I did meet some very helpful members, I mean patients as well as, as well as the staff as well but I think (.) in the, in the end I think it was the staff who (.) who put me back on, put me on the road to recovery (INT: mm) yes I have to admit that yes (INT: mm) (...) It's been a long journey but like I said, like I said before but yeah, the staff, mainly the staff (.) (INT: mm, mm) (...)

INT: and (.) what does recovery mean for you

D: recovery means kind of like (.) involves (.) to recover is to, is to kind of like (.) get back on track basically isn't it (INT: mm) it's, it's kind of like losing your way and then regaining or finding your way sort of a thing and (.) I, in doing what I did back in the day coming to my index offence (.) I, to use a cliché or whatever it might be fell off the rails, I went off the rails (INT: mm) I did something which (.) I wouldn't have in a thousand, thousand years thought that could happen to me (.) that I would do (.) you know, I did a terrible thing, I took a life of a person (.) and that was (.) that was (.) the lowest point (.) the lowest, lowest, lowest point in my existence it was like being in the

basement of a lift that went up 25 or 30 storeys (.) and (.) for a long time I kind of like (.) I couldn't (.) I couldn't quite come to terms with that (INT: mm) (.) and for a couple of years I (.) I did very little (.) you know I (.) in a way I kind of like (.) I, I really do-, I (.) I was numb (.) in meltdown (.) not really wanting to do much just existing basically (INT: mm) and here the staff, this is where the staff (.) come to my, particular staff come to my room, because I'd spend all my day in bed just getting up for dinner and medicine and going back to bed that was my existence, and a member of staff came in one day and sat on the end of the bed and says Derek get up (.) and from there things started to (.) you know (.) I, I began to (.) to, um (.) want to (.) to do things or get involved in things and to (.) to get my life back on track (INT: mm) well that's sounds a bit like really, but you know that's what (.) basically where it started from the little trickle that becomes where it was, kind of it was the help of the staff that kind of (.) um (.) that got me back on the road to recovery (INT: mm) (...) that was in high security when (.) when my journey began but (.) I think (.) what happened before that (.) was that I (.) what was the question again (laughs) what does recovery mean to me (laughs) I'm waffling (laughs) I'm rambling

INT: (laughs) no you're not waffling no, you're doing exactly, exactly what I hoped you're telling me your story (D: yeah, yeah) continue

D: I tell you what opened my eyes in a way in hospital was an eye opener (.) A fellow patient I said they're all good to me this that and the other one of them punched me one day when I was in hospital (.) and that woke me up really in a way you know (.) it meant (.) it kind of like says (.) it (.) kind like you know it says to me um (.) it made me (.) come to terms with the situation that I was in (.) (INT: right) I think come to terms with, it made me realise that I was in a (.) dangerous place with dangerous people and therefore I've got to learn to kind of like (.) adapt (...)

INT: and (.) did you

D: I had to, I had to (.) it brought blood to my nose and I laughed and after I said Christ no one's ever done that to me before (.) and it was an awakening it woke me up in a way (INT: mm) that was I think (.) that was when I was in high secure that was (INT: yeah) the first, the first (.) spark (INT: right) that kind of like (.) um (.) became my, my (.) my journey of recovery you know it was the first thing you know I realised that um (.) I had to adapt (.) to change to (.) kind of like (.) live (.) like I was gonna say within my means but I realised I was a dangerous man as it were (.) as it would be said living with dangerous people in high security (INT: mm) and I couldn't (.) be (.) continue to be a fool or act a fool or whatever it was (.) it was serious times (INT: right) I had to think seriously about myself, the journey I was on, the journey I was coming from, and where I wanted to be (.) out of the system (.) I don't know

how long that journey was going to be but o had to get my head down and get on with things that was it, the beginning of things basically for me (INT: mm) (.) and then (.) ok (.) I was tried on a number of different medications (INT: right) uh (.) and it took a while for them to (.) find one that suited me (.) (INT: mm) I tried a few you know and this one had that effect and another one had another effect until (.) they hit on one that, that (.) that kind of like um (.) it kind of like (.) it agreed with my metabolism as it were (INT: mm) kind of thing, and I've been with that one for 10 years or so but (INT: right) but that, that's something else, an aside but what recovery means to me basically is regaining some, some kind of (.) resemblance of yourself, getting back to yourself basically (INT: mm) you don't get back, you can't get back, you can't um erase the memories of what has happened in the past but you can come to terms with it and you learn to live with it (INT: right) and recovery means overcoming the um (.) not the pain, not the suffering, but the trauma (.) or live with the trauma and living with it and (.) you can't say it's not instead of because that doesn't mean nothing but living coming to terms with it and (.) and (.) not being crushed by it (INT: right) (...)

INT: and is that the trauma (.) of (.)

D: the index offence

INT: what you did, right, right

D: What I did (.) yes (.) it's living coming to terms with it and (.) and (.) not being crushed by it (.) you know (...)

INT: and are you still (.) on the path to recovery would you consider

D: I am, I think I am, it's an ongoing thing (INT: right ok) it's a journey that will go on (.) till the end of my day (.) cause every now and again you get a flashback or (.) or you wake up and you think (.) it's a constant (INT: right) it's a constant because I mean I'm back in the community now (INT: mm) but I still have to communicate with people (.) and (.) in doing so do I tell them who I am (.) who do I reveal myself to, who do I tell (INT: right) who you know so (.) I can't go round saying to everybody that I meet that oh so I spent so many years in a mental hospital, a mental hospital oh for the reason being I took the life of a person, I can't declare to any people, who do I declare it to (.) so I have to live (.) I have to live (.) I'm basically incognito in most, in most situations or with most people that I meet (INT: mm) I can't declare or reveal so therefore that always is kind of like a reminder to me that yes I remain who I am for what I've done, cause I can't, I can't openly go about telling people who I am, what I've done (INT: right) for more reason than one so (.)

INT: why is that

D: shame (.) shame is one (.) that's an old fashioned word (.) shame (.) um embarrassment (.) um (.) fear (...) all of those kind of things kind of like you know mean that I, if I have to declare (.) I will declare, I will and I do (INT: right) but it's got to trust, that's a trusted person (.) but if I um (.) if somebody prompts me to (INT: mm) I won't deny it (INT: mm) (.) cause I'm not in denial (.) what happened happened and there's no getting away from that (.) so recovery is in a sense coming to terms with what happened (.) and (.) I say, I'd say moving on but you don't move on you live with it (INT: right) you learn to live with it (.) and (.) and, and basically live with it and get on with it as well (.) (INT: right) you know (INT: mm) that's basically recovery (.) off the top of my head basically I haven't really you know what I'm saying (.) it's changing things you know bringing about some kind of change in your life (INT: mm) (.) moving from one situation to another one , hopefully a better one than the one that you're coming from (INT: right) that's what recovery is (...)

INT: and can you tell me more about that kind of changing situation (.) for you

D: changing situation (.) it's (.) well when you're in hospital you have to like I said, in a sense you have to adapt to a particular way of (.) acting, thinking, behaving and everything (.) when you're out of hospital you're back in society it's different so you have to kind of like (.) again you have to (.) change (INT: mm) mm (.) there's change upon ch- I don't know I'm not making sense (laughs)

INT: no you are

D: but (.) tell me the question again

INT: I was wondering about (.) you were talking about changing situations and I wondered what that means for you

D: changing situations well it means (.) well you've got to be compliant (.) compliance is an essential thing, it's an essential part of your (.) the contract you (.) agree with the authorities who are (.) putting you back into society (.) so you got to comply, you got to comply with what is expected of you (.) like medication (.) you have to take your medication, it's easy to skip you medication but at the end of the day it's not going to help you is it (INT: right) it's not going to help me the person, so you take your medication (.) you don't get yourself into situations that you think kind of like might (.) you might compromise yourself (.) (INT: right) so you kind of like, you tread carefully in a way, you have to tread carefully (INT: mm) (.) you know you have, you have, you have to (.) mm (...)

INT: mm (.) and that's what's (.) kept you (.) on the path to recovery in the community is that right

D: I would think so yeah (.) complying with the (.) not contract but what is expected of you (...) (INT: yeah) (.) not getting myself into (.) situations where (.) things might get out of hand (.) trying to kind of like (.) control (.) trying to bring a certain amount of control into my daily existence, you know, kind of like (.) mm (.) it's (.) it's lifestyle (.) it's lifestyle, it's making a certain number of lifestyle changes which you hope will keep you on the right track (INT: mm) which is the track to recovery (INT: yeah) it's making the right choices (.) or trying to make the right choices (.) in terms of (.) what you do, where you go, who you associate with, and (.) all those kind of things, doing what's expected of you basically (INT: mm, mm, yeah) (...)

INT: is there anything else you think has helped you recover

D: anything else that's helped me recover (draws breath) (.) I've said a few people in the system helped me recover (.) mm (.) anything else that's basically helped me recover (.) faith (.)

INT: mm, can you tell me more about that

D: faith (.) mm (.) faith, having faith (.) believing in myself basically that's a bit selfish really (.) mm (.) my journey like I said before it's been a long journey you know it's (.) I think (.) in my opinion that is I've had more downs than ups in my life (INT: mm) and (.) being in the system, it's one of those funny things to say, but being in the system (.) kind of like gave me (.) a second chance (.) I feel as though I've been given a second chance (.) to (.) to live a better life really , or a chance to live a better life (.) to (.) you know (.) make some improvements in my own existence (.) so I think (.) self-belief was one of the things that I (.) got (INT: mm) from (.) I gleamed it from the work (.) and the interaction I had with people within the system (INT: right) because on street level I (.) I didn't have much confidence I didn't have people to (.) who kind of like, to act as role models to me or (.) or kind of like help me (.) gave me any reason to believe why I should believe in myself I didn't have that (.) that kind of input from people (INT: right) round me you know (INT: mm) if I'm making sense (INT: yeah) so you know being in the system and doing the work that I've done and (.) meeting these people who I've said have been influential in my existence um (.) kind of like (.) um (.) restored my belief in myself (.) (INT: right) mm (.) they kind of like led me to believe that I (.) there's somebody alive in me somebody realises there's somebody alive in me, I am capable of a little more , I'm not saying I'm capable of becoming a doctor or a psychologist but I'm a little bit more and I can do a little bit more than I believe I can (INT: right) in terms of (.) um (.) being able to (.) a little more competent that I ever thought I was (.) and it's building on that competence that (.) I have kind of like set out to do basically (.) (INT: mm) you know like (.) getting a laptop and seeing how it works (laughs) who told me to do that (laughs)

INT: (laughs) is that a recent thing or

D: no I've been dabbling with laptops for a while but (laughs) (.) but it's, it's kind of like I've discovered a liking for knowledge (.) (INT: mm) mm and I'm on that journey kind of like you know trying to (.) enlighten myself (INT: mm) which in a way is, I'm not saying it's a full time thing but (.) it's, it's (.) an ongoing thing in the hope that in that way I'm able to better myself (INT: right) and helps, helps keep me out of trouble as well you know (laughs) so it's, it's all good really, basically (...)

INT: that's really interesting (.) is there anything else you think you would want to tell me (.) about your recovery

D: erm about my recovery, there's so much I can't really, off the top of my head, you know, but (.) I would say (.) that I would use myself as an example of somebody who's (.) been to the depths and been to the level where I'm on right now (.) there's hope (.) (INT: right) that's my message, that would be my message to anybody going through what I've been through or going through the system, not to lose hope (.) basically (.) and this is what those people did for me they restored my hope I would say that they led me to believe I was a better person but what they did essentially was to restore my hope for myself (INT: right) and that I think is the main thing (.) having hope that tomorrow will be a better day (.) and (.) doing what you can within it to make it a better tomorrow (.) hope (.) my hope, belief, hope (.) those I think are key (...) mm (INT: mm) that's what I think anyway (.) belief, hope (...)

INT: that's really helpful (.) thank you (.)

D: yeah (...) that it

INT: unless there's anything else you want to tell me about your recovery

D: anything else about my recovery (.) you ask

INT: I'm just open to hearing your story whatever you want to tell me about whatever you think about your recovery (.) I think you've explained yourself really, really clearly (.) so unless there's anything else you want to add

D: mm (.) have I missed anything out [directed to CPN]

CPN: is it ok for me to speak

INT: yeah course

CPN: I think um (.) the biggest thing you say, is the fact you've (.) the fact Derek takes personal responsibility for (.) his own life (.) especially his health (.) he doesn't do anything that would jeopardise his mental health and he does everything in his power to make sure the troubles he's gone through in

life they never repeat themselves (.) he takes full responsibility for that (INT: mm) so (.) Derek's the sort of chap that will phone me the day before I'm supposed to drop off his medication and make sure I'm coming

D: yeah, yeah

CPN: he takes full responsibility for his own health (.)

D: yeah

INT: you agree with that

D: I agree with that yeah (laughs) I agree with that fully yeah (.) it's (.) it's been a journey (.) full of serious things you know (...) I can't add no more cause if I start I'll just waffle on (laughs)

INT: (laughs) it's been really, really helpful, no really helpful

D: I hope it's been helpful to you

INT: it has thank you for speaking to me and I appreciate you coming this way I know you've come a way to take part so thank you

D: not a problem anything to help (.) psychology has brought me this far so anything to help

Stage 2: Deletion of interviewer words/questions

1

~~INT: so I'm interested in people that have been in secure forensic hospitals like you have um and I'm especially interested in your recovery journey so um (.) this is just about me listening and hearing your, your story really (.) um (.)~~

D: starting from the beginning

~~INT: wherever you would like to start~~

D: right, I would say that in 1998 I was convicted of manslaughter (.) of a Asian woman (.) and I (.) was sectioned under the Mental Health Act (.) 37/42 and was sent to, first of all I was sent to (.) [***] prison where I was held about 3 months for assessment ~~(INT: right)~~ and then I was moved to [***] hospital where I spend the next (.) probably 10 years (.) ~~(INT: right)~~ yeah (.) and from there I was moved to, no I didn't spend 10 years that wrong sorry, I spent about 4 or 5 years ~~(INT: mm)~~ my dates are incorrect (.) ~~(INT: that's ok)~~ and then I went to [*** hospital name] where I spent about 8 years and then from [there] I was moved to [*** hospital name] ~~(INT: right)~~ (.) where I met [name] Psychologist who (.) who did a lot of work with me really (.) ~~(INT: mm)~~ um (.) and he allowed me to explore my own self ~~(INT: mm)~~ um (.) in written a form I was able to (.) to document my own journey (.) ~~(INT: mm)~~ which in the end was (.) was the most useful bit of work, the most useful thing, the best thing to happen to me (.) the whole time that I, I've been in services (.) 'cause it kind of like (.) allowed me to gain some insight into where I was coming from, where I was at, the reasons why I ended up committing this offence and, and, and (.) in the end (.) recovering or being on the road to recovery ~~(INT: right)~~ so that piece of work I did with [Psychologist] was very, very helpful indeed ~~(INT: mm)~~ but also I, I, I managed to meet some other interesting and helpful people in the services who (.) who were very helpful to me in, in, in bringing about my (.) state of recovery that I'm at at this moment in time ~~(INT: yeah)~~ so it's been a long journey ~~(INT: mm)~~ a difficult journey but (.) I think that I'm in a better place now than I was for a long, long time in my life (.) ~~(INT: right)~~ you know (...)

~~INT: can you tell me a bit more about, you said you met some really interesting people that have helped (D: yeah, yeah) in your recovery, can you tell me a bit more about that~~

D: um (.) when I first went into the services I (.) I didn't know what to expect, I (.) I, I, I (.) I think I was like a bit of a closed book I didn't (.) feel I could trust anybody ~~(INT: mm)~~ open up to people, I was kind of like (.) you know (.) I was ticking the boxes as it were kind of a thing, and then I met people like, some people who (.) who kind of like (.) I was able to speak to um (.) on a (.) particular (.) on a I was gonna say a particular level but ~~(INT: mm)~~ erm (.) a (.) meaningful basis, on a meaningful basis and um (.) they kind of like got me to (.) to (.) open up to and, and be myself you know (.) ~~(INT: mm, mm)~~ I could name a few names like (laughs) but I won't name a few you know but, but they were very, very helpful in, in helping me to kind of like (.) recover to the position, to the state, to the position that I'm at right now ~~(INT: yeah)~~ yeah, yeah (...)

~~INT: and are they kind of staff or fellow patients or~~

D: staff mainly staff ~~(INT: mm)~~ (.) I must not say I felt the patients didn't help me because they make my journey that much more easier by (.) being friendly towards me and being kind and so I did meet some very helpful members, I mean patients as well as, as well as the staff as well but I think (.) in the, in the end I think it was the staff who (.) who put me back on, put me on the road to recovery

(INT:mm)-yes I have to admit that yes (INT:mm)(...) It's been a long journey but like I said, like I said before but yeah, the staff, mainly the staff (INT:mm,mm)(...)

INT-and(.) what does recovery mean for you

D: recovery means kind of like (.) involves (.) to recover is to, is to kind of like (.) get back on track basically isn't it (INT:mm) it's, it's kind of like losing your way and then regaining or finding your way sort of a thing and (.) I, in doing what I did back in the day coming to my index offence (.) I, to use a cliché or whatever it might be fell off the rails, I went off the rails (INT:mm) I did something which (.) I wouldn't have in a thousand, thousand years thought that could happen to me (.) that I would do (.) you know, I did a terrible thing, I took a life of a person (.) and that was (.) that was (.) the lowest point (.) the lowest, lowest, lowest point in my existence it was like being in the basement of a lift that went up 25 or 30 storeys (.) and (.) for a long time I kind of like (.) I couldn't (.) I couldn't quite come to terms with that (INT:mm) (.) and for a couple of years I (.) I did very little (.) you know I (.) in a way I kind of like (.) I, I really do-, I (.) I was numb (.) in meltdown (.) not really wanting to do much just existing basically (INT:mm) and here the staff, this is where the staff (.) come to my, particular staff come to my room, because I'd spend all my day in bed just getting up for dinner and medicine and going back to bed that was my existence, and a member of staff came in one day and sat on the end of the bed and says Derek get up (.) and from there things started to (.) you know (.) I, I began to (.) to, um (.) want to (.) to do things or get involved in things and to (.) to get my life back on track (INT:mm) well that's sounds a bit like really, but you know that's what (.) basically where it started from the little trickle that becomes where it was, kind of it was the help of the staff that kind of (.) um (.) that got me back on the road to recovery (INT:mm) (...) that was in high security when (.) when my journey began but (.) I think (.) what happened before that (.) was that I (.) what was the question again (laughs) what does recovery mean to me (laughs) I'm waffling (laughs) I'm rambling

INT-(laughs) no you're not waffling no, you're doing exactly, exactly what I hoped you're telling me your story (D: yeah, yeah) continue

D: I tell you what opened my eyes in a way in hospital was an eye opener (.) A fellow patient I said they're all good to me this that and the other one of them punched me one day when I was in hospital (.) and that woke me up really in a way you know (.) it meant (.) it kind of like says (.) it (.) kind like you know it says to me um (.) it made me (.) come to terms with the situation that I was in (.) (INT:right) I think come to terms with, it made me realise that I was in a (.) dangerous place with dangerous people and therefore I've got to learn to kind of like (.) adapt (...)

INT-and(.) did you

D: I had to, I had to (.) it brought blood to my nose and I laughed and after I said Christ no one's ever done that to me before (.) and it was an awakening it woke me up in a way (INT:mm) that was I think (.) that was when I was in high secure that was (INT:yeah) the first, the first (.) spark (INT:right) that kind of like (.) um (.) became my, my (.) my journey of recovery you know it was the first thing you know I realised that um (.) I had to adapt (.) to change to (.) kind of like (.) live (.) like I was gonna say within my means but I realised I was a dangerous man as it were (.) as it would be said living with dangerous people in high security (INT:mm) and I couldn't (.) be (.) continue to be a fool or act a fool or whatever it was (.) it was serious times (INT:right) I had to think seriously about myself, the journey I was on, the journey I was coming from, and where I wanted to be (.) out of the

system (.) I don't know how long that journey was going to be but o had to get my head down and get on with things that was it, the beginning of things basically for me (INT: mm) (.) and then (.) ok (.) I was tried on a number of different medications (INT: right) uh (.) and it took a while for them to (.) find one that suited me (.) (INT: mm) I tried a few you know and this one had that effect and another one had another effect until (.) they hit on one that, that (.) that kind of like um (.) it kind of like (.) it agreed with my metabolism as it were (INT: mm) kind of thing, and I've been with that one for 10 years or so but (INT: right) but that, that's something else, an aside but what recovery means to me basically is regaining some, some kind of (.) resemblance of yourself, getting back to yourself basically (INT: mm) you don't get back, you can't get back, you can't um erase the memories of what has happened in the past but you can come to terms with it and you learn to live with it (INT: right) and recovery means overcoming the um (.) not the pain, not the suffering, but the trauma (.) or live with the trauma and living with it and (.) you can't say it's not instead of because that doesn't mean nothing but living coming to terms with it and (.) and (.) not being crushed by it (INT: right) (...)

INT: and is that the trauma (.) of (.)

D: the index offence

INT: what you did, right, right

D: What I did (.) yes (.) it's living coming to terms with it and (.) and (.) not being crushed by it (.) you know (...)

INT: and are you still (.) on the path to recovery would you consider

D: I am, I think I am, it's an ongoing thing (INT: right ok) it's a journey that will go on (.) till the end of my day (.) cause every now and again you get a flashback or (.) or you wake up and you think (.) it's a constant (INT: right) it's a constant because I mean I'm back in the community now (INT: mm) but I still have to communicate with people (.) and (.) in doing so do I tell them who I am (.) who do I reveal myself to, who do I tell (INT: right) who you know so (.) I can't go round saying to everybody that I meet that oh so I spent so many years in a mental hospital, a mental hospital oh for the reason being I took the life of a person, I can't declare to any people, who do I declare it to (.) so I have to live (.) I have to live (.) I'm basically incognito in most, in most situations or with most people that I meet (INT: mm) I can't declare or reveal so therefore that always is kind of like a reminder to me that yes I remain who I am for what I've done, cause I can't, I can't openly go about telling people who I am, what I've done (INT: right) for more reason than one so (.)

INT: why is that

D: shame (.) shame is one (.) that's an old fashioned word (.) shame (.) um embarrassment (.) um (.) fear (...) all of those kind of things kind of like you know mean that I, if I have to declare (.) I will declare, I will and I do (INT: right) but it's got to trust, that's a trusted person (.) but if I um (.) if somebody prompts me to (INT: mm) I won't deny it (INT: mm) (.) cause I'm not in denial (.) what happened happened and there's no getting away from that (.) so recovery is in a sense coming to terms with what happened (.) and (.) I say, I'd say moving on but you don't move on you live with it (INT: right) you learn to live with it (.) and (.) and, and basically live with it and get on with it as well (.) (INT: right) you know (INT: mm) that's basically recovery (.) off the top of my head basically I haven't really you know what I'm saying (.) it's changing things you know bringing about some kind

of change in your life ~~(INT: mm)~~ (.) moving from one situation to another one, hopefully a better one than the one that you're coming from ~~(INT: right)~~ that's what recovery is (...)

~~INT: and can you tell me more about that kind of changing situation (.) for you~~

D: changing situation (.) it's (.) well when you're in hospital you have to like I said, in a sense you have to adapt to a particular way of (.) acting, thinking, behaving and everything (.) when you're out of hospital you're back in society it's different so you have to kind of like (.) again you have to (.) change ~~(INT: mm)~~ mm (.) there's change upon ch- I don't know I'm not making sense (laughs)

~~INT: no you are~~

D: but (.) tell me the question again

~~INT: I was wondering about (.) you were talking about changing situations and I wondered what that means for you~~

D: changing situations well it means (.) well you've got to be compliant (.) compliance is an essential thing, it's an essential part of your (.) the contract you (.) agree with the authorities who are (.) putting you back into society (.) so you got to comply, you got to comply with what is expected of you (.) like medication (.) you have to take your medication, it's easy to skip you medication but at the end of the day it's not going to help you is it ~~(INT: right)~~ it's not going to help me the person, so you take your medication (.) you don't get yourself into situations that you think kind of like might (.) you might compromise yourself (.) ~~(INT: right)~~ so you kind of like, you tread carefully in a way, you have to tread carefully ~~(INT: mm)~~ (.) you know you have, you have, you have to (.) mm (...)

~~INT: mm (.) and that's what's (.) kept you (.) on the path to recovery in the community is that right~~

D: I would think so yeah (.) complying with the (.) not contract but what is expected of you (...) ~~(INT: yeah)~~ (.) not getting myself into (.) situations where (.) things might get out of hand (.) trying to kind of like (.) control (.) trying to bring a certain amount of control into my daily existence, you know, kind of like (.) mm (.) it's (.) it's lifestyle (.) it's lifestyle, it's making a certain number of lifestyle changes which you hope will keep you on the right track ~~(INT: mm)~~ which is the track to recovery ~~(INT: yeah)~~ it's making the right choices (.) or trying to make the right choices (.) in terms of (.) what you do, where you go, who you associate with, and (.) all those kind of things, doing what's expected of you basically ~~(INT: mm, mm, yeah)~~ (...)

~~INT: is there anything else you think has helped you recover~~

D: anything else that's helped me recover (draws breath) (.) I've said a few people in the system helped me recover (.) mm (.) anything else that's basically helped me recover (.) faith (.)

~~INT: mm, can you tell me more about that~~

D: faith (.) mm (.) faith, having faith (.) believing in myself basically that's a bit selfish really (.) mm (.) my journey like I said before it's been a long journey you know it's (.) I think (.) in my opinion that is I've had more downs than ups in my life ~~(INT: mm)~~ and (.) being in the system, it's one of those funny things to say, but being in the system (.) kind of like gave me (.) a second chance (.) I feel as though I've been given a second chance (.) to (.) to live a better life really, or a chance to live a better

life (.) to (.) you know (.) make some improvements in my own existence (.) so I think (.) self-belief was one of the things that I (.) got ~~(INT: mm)~~ from (.) I gleamed it from the work (.) and the interaction I had with people within the system ~~(INT: right)~~ because on street level I (.) I didn't have much confidence I didn't have people to (.) who kind of like, to act as role models to me or (.) or kind of like help me (.) gave me any reason to believe why I should believe in myself I didn't have that (.) that kind of input from people ~~(INT: right)~~ round me you know (INT: mm) if I'm making sense ~~(INT: yeah)~~ so you know being in the system and doing the work that I've done and (.) meeting these people who I've said have been influential in my existence um (.) kind of like (.) um (.) restored my belief in myself (.) ~~(INT: right)~~ mm (.) they kind of like led me to believe that I (.) there's somebody alive in me somebody realises there's somebody alive in me, I am capable of a little more, I'm not saying I'm capable of becoming a doctor or a psychologist but I'm a little bit more and I can do a little bit more than I believe I can ~~(INT: right)~~ in terms of (.) um (.) being able to (.) a little more competent than I ever thought I was (.) and it's building on that competence that (.) I have kind of like set out to do basically (.) ~~(INT: mm)~~ you know like (.) getting a laptop and seeing how it works (laughs) who told me to do that (laughs)

~~INT: (laughs) is that a recent thing or~~

D: no I've been dabbling with laptops for a while but (laughs) (.) but it's, it's kind of like I've discovered a liking for knowledge (.) ~~(INT: mm)~~ mm and I'm on that journey kind of like you know trying to (.) enlighten myself ~~(INT: mm)~~ which in a way is, I'm not saying it's a full time thing but (.) it's, it's (.) an ongoing thing in the hope that in that way I'm able to better myself ~~(INT: right)~~ and helps, helps keep me out of trouble as well you know (laughs) so it's, it's all good really, basically (...)

~~INT: that's really interesting (.) is there anything else you think you would want to tell me (.) about your recovery~~

D: erm about my recovery, there's so much I can't really, off the top of my head, you know, but (.) I would say (.) that I would use myself as an example of somebody who's (.) been to the depths and been to the level where I'm on right now (.) there's hope (.) ~~(INT: right)~~ that's my message, that would be my message to anybody going through what I've been through or going through the system, not to lose hope (.) basically (.) and this is what those people did for me they restored my hope I would say that they led me to believe I was a better person but what they did essentially was to restore my hope for myself ~~(INT: right)~~ and that I think is the main thing (.) having hope that tomorrow will be a better day (.) and (.) doing what you can within it to make it a better tomorrow (.) hope (.) my hope, belief, hope (.) those I think are key (...) mm ~~(INT: mm)~~ that's what I think anyway (.) belief, hope (...)

~~INT: that's really helpful (.) thank you (.)~~

D: yeah (...) that it

~~INT: unless there's anything else you want to tell me about your recovery~~

D: anything else about my recovery (.) you ask

~~INT: I'm just open to hearing your story whatever you want to tell me about whatever you think about your recovery (.) I think you've explained yourself really, really clearly (.) so unless there's anything else you want to add~~

D: mm (.) have I missed anything out [directed to CPN]

CPN: is it ok for me to speak

~~INT: yeah course~~

CPN: I think um (.) the biggest thing you say, is the fact you've (.) the fact Derek takes personal responsibility for (.) his own life (.) especially his health (.) he doesn't do anything that would jeopardise his mental health and he does everything in his power to make sure the troubles he's gone through in life they never repeat themselves (.) he takes full responsibility for that ~~(INT: mm)~~ so (.) Derek's the sort of chap that will phone me the day before I'm supposed to drop off his medication and make sure I'm coming

D: yeah, yeah

CPN: he takes full responsibility for his own health (.)

D: yeah

~~INT: you agree with that~~

D: I agree with that yeah (laughs) I agree with that fully yeah (.) it's (.) it's been a journey (.) full of serious things you know (...) I can't add no more cause if I start I'll just waffle on (laughs)

~~INT: (laughs) it's been really, really helpful, no really helpful~~

D: I hope it's been helpful to you

~~INT: it has thank you for speaking to me and I appreciate you coming this way I know you've come a way to take part so thank you~~

D: not a problem anything to help (.) psychology has brought me this far so anything to help

Stage 3: Deletion of words that detract from the key idea of each sentence/group of sentences and repeat until all extraneous content is removed

1

D: starting from the beginning

D: right, I would say that in 1998 I was convicted of manslaughter (.) of a Asian woman (.) and I (.) was sectioned under the Mental Health Act (.) 37/42 and was sent to, first of all I was sent to (.) [***] prison where I was held about 3 months for assessment and then I was moved to [***] hospital where I ~~spend the next (.) probably 10 years (.) yeah (.) and from there I was moved to, no I didn't spend 10 years that wrong sorry,~~ I spent about 4 or 5 years ~~my dates are incorrect (.)~~ and then I went to [*** hospital name] where I spent about 8 years and then from [there] I was moved to [*** hospital name] (.) where I met [name] Psychologist ~~who (.)~~ who did a lot of work with me really ~~(.) um (.)~~ and he allowed me to explore my own self ~~um (.)~~ in written a form I was able to ~~(.) to~~ document my own journey (.) which in the end ~~was (.)~~ was the most useful bit of work, the most useful thing, the best thing to happen to me ~~(.)~~ the whole time that ~~I,~~ I've been in services (.) 'cause it kind of like ~~(.)~~ allowed me to gain some insight into where I was coming from, where I was at, the reasons why I ended up committing this offence ~~end, end, and (.)~~ in the end ~~(.)~~ recovering or being on the road to recovery so that piece of work I did with [Psychologist] was very, very helpful indeed but also ~~I,~~ I managed to meet some other interesting and helpful people in the services ~~who (.)~~ who were very helpful to me ~~in, in,~~ in bringing about my (.) state of recovery that I'm at at this moment in time so it's been a long journey a difficult journey but (.) I think that I'm in a better place now than I was for a long, long time in my life ~~(.) you know (...)~~

D: um (.) when I first went into the services ~~I (.)~~ I didn't know what to expect ~~I (.) I (.) I (.) I (.)~~ I think I was like a bit of a closed book I didn't ~~(.)~~ feel I could trust anybody open up to people, ~~I was kind of like (.) you know (.)~~ I was ticking the boxes ~~as it were kind of a thing,~~ and then I met people like, some people who ~~(.) who kind of like (.)~~ I was able to speak ~~to um (.)~~ on a ~~(.) particular (.) on a I was gonna say a particular level but erm (.) a (.)~~ meaningful basis, ~~on a meaningful basis and um (.)~~ they kind of like got me to ~~(.) to (.)~~ open up to and, and be myself ~~you know (.) I could name a few names like (laughs) but I won't name a few you know but, but they were very, very helpful in, in helping me to kind of like (.) recover to the position, to the state, to the position that I'm at right now yeah, yeah (...)~~

D: staff mainly staff (.) I must not say I felt the patients didn't help me because they make my journey that much more easier by ~~(.)~~ being friendly towards me and being kind and so I did meet some very helpful ~~members, I mean patients as well as,~~ as well as the staff ~~as well but I think (.) in the,~~ in the end I think it was the staff who ~~(.) who put me back on,~~ put me on the road to recovery ~~yes I have to admit that yes (...)~~ It's been a long journey but ~~like I said, like I said before but yeah, the staff, mainly the staff (...)~~

D: recovery means kind of like (.) involves (.) to recover is to ~~, is to kind of like (.)~~ get back on track basically isn't it it's, it's kind of like losing your way and then regaining or finding your way ~~sort of a thing and (.)~~ I, in doing what I did ~~back in the day~~ coming to my index offence (.) I, to use a cliché or whatever it might be fell off the rails, ~~I went off the rails~~ I did something which (.) I wouldn't have in a thousand, thousand years thought that could happen to me (.) that I would do (.) you know, I did a terrible thing, I took a life of a person (.) and that was ~~(.) that was (.)~~ the lowest point (.) the lowest, lowest, lowest point in my existence it was like being in the basement of a lift that went up 25 or 30 storeys (.) and ~~(.)~~ for a long time ~~I kind of like (.) I couldn't (.)~~ I couldn't quite come to terms with that (.) and for a couple of years ~~I (.)~~ I did very little ~~(.) you know I (.) in a way I kind of like (.) I, I really do,~~

H(.) I was numb (.) in meltdown (.) not really wanting to do much just existing basically and here the staff, this is where the staff (.) ~~come to my~~, particular staff come to my room, because I'd spend all my day in bed just getting up for dinner and medicine and going back to bed that was my existence, and a member of staff came in one day and sat on the end of the bed and says Derek get up (.) and from there ~~things started to (.) you know (.)~~, I began ~~to (.) to, um (.)~~ want to ~~(.) to do~~ things or get involved in things and to (.) to get my life back on ~~track well that's sounds a bit like really, but you know that's what (.)~~ basically where it started from the little trickle that becomes where it was, kind of it was the help of the staff that ~~kind of (.) um (.)~~ that got me back on the road to recovery (...) ~~that was in high security when (.) when my journey began but (.) I think (.) what happened before that (.) was that I (.) what was the question again (laughs) what does recovery mean to me (laughs) I'm waffling (laughs) I'm rambling~~

D: I tell you what opened my eyes in a way ~~in hospital was an eye opener (.)~~ A fellow patient ~~I said they're all good to me this that and the other one of them~~ punched me one day when I was in hospital (.) and that woke me up really in a way you know ~~(.) it meant (.) it kind of like says (.) it (.) kind like you know it says to me um (.)~~ it made me (.) come to terms with the situation that I was in (.) ~~I think come to terms with~~, it made me realise that I was in a (.) dangerous place with dangerous people and therefore I've got to learn to kind of like ~~(.) adapt (.)~~

D: I had to, I had to (.) it brought blood to my nose and I laughed and after I said Christ no one's ever ~~done that to me before (.)~~ and it was an awakening it woke me up in a way ~~that was I think (.) that was when I was in high secure that was the first (.) spark that kind of like (.) um (.) became my, my (.)~~ my journey of recovery you know it was the first thing you know I realised that ~~um (.)~~ I had to adapt (.) to change ~~to (.) kind of like (.) live (.) like I was gonna say within my means but I realised I was a dangerous man as it were (.) as it would be said living with dangerous people in high security and I couldn't (.) be (.) continue to be a fool or act a fool or whatever it was (.) it was serious times I had to think seriously about myself, the journey I was on, the journey I was coming from, and where I wanted to be (.) out of the system (.) I don't know how long that journey was going to be but I had to get my head down and get on with things that was it, the beginning of things basically for me (.) ~~and then (.) ok (.)~~ I was tried on a number of different medications ~~uh (.)~~ and it took a while for them to ~~(.) find one that suited me (.) I tried a few you know and this one had that effect and another one had another effect until (.) they hit on one that, that (.) that kind of like um (.) it kind of like (.) it agreed with my metabolism as it were kind of thing, and I've been with that one for 10 years or so but but that, that's something else, an aside~~ but what recovery means to me basically is regaining ~~some, some kind of (.)~~ resemblance of yourself, getting back to yourself ~~basically you don't get back, you can't get back, you can't um~~ erase the memories of what has happened in the past but you can come to terms with it and you learn to live with it and recovery means overcoming the ~~um (.)~~ not the pain, not the suffering, but the trauma (.) or live with the trauma and living with it and (.) ~~you can't say it's not instead of because that doesn't mean nothing but living~~ coming to terms with it and ~~(.) and (.)~~ not being crushed by it (...)~~

D: the index offence

D: What I did (.) yes (.) it's living coming to terms with it and (.) and (.) not being crushed by it (.) you know (.)

D: I am, I think I am, it's an ongoing thing it's a journey that will go on ~~(.)~~ till the end of my day ~~(.)~~ cause every now and again you get a flashback ~~or (.) or you wake up and you think (.) it's a constant~~ it's a constant because I mean I'm back in the community now but I still have to communicate with people ~~(.)~~ and ~~(.)~~ in doing so do I tell them who I am ~~(.)~~ -who do I reveal myself to, who do I tell ~~who you know co (.)~~ I can't go round saying to everybody that I meet that oh so I spent so many years in a mental hospital, a mental hospital oh for the reason being I took the life of a person, I can't declare to any people, who do I declare it to ~~(.)~~ ~~so I have to live (.) I have to live (.)~~ I'm basically incognito ~~in most~~ in most situations or with most people that I meet I can't declare or reveal so therefore that always is kind of like a reminder to me that yes I remain who I am for what I've done, cause I can't, I can't openly go about telling people who I am, what I've done for more reason than one so ~~(.)~~

D: shame ~~(.) shame is one (.) that's an old fashioned word (.) shame (.) um, embarrassment (.) um (.)~~ fear (...) all of those kind of things ~~so kind of like you know mean that I, if I have to declare (.) I will~~ declare, I will and I do but it's got to trust, that's a trusted person ~~(.) but if I um (.)~~ if somebody prompts me to I won't deny it ~~(.)~~ cause I'm not in denial ~~(.)~~ what happened happened and there's no getting away from that ~~(.)~~ so recovery is in a sense coming to terms with what happened ~~(.)~~ and ~~(.)~~ ~~say, I'd say moving on but you don't move on you live with it you learn to live with it (.) and (.) and, and basically live with it and get on with it as well (.) you know that's basically recovery (.) off the top of my head basically I haven't really you know what I'm saying (.)~~ it's changing things you know bringing about some kind of change in your life ~~(.)~~ moving from one situation to another one, hopefully a better one than the one that you're coming from that's what recovery is (...) ~~(.)~~

D: changing situation ~~(.) it's (.)~~ well when you're in hospital you have to ~~like I said, in a sense you~~ have to adapt to a particular way of ~~(.)~~ acting, thinking, behaving and everything ~~(.)~~ when you're out of hospital you're back in society it's different so ~~you have to kind of like (.)~~ again you have to ~~(.)~~ change ~~mm (.) there's change upon ch - I don't know I'm not making sense (laughs)~~

D: but ~~(.)~~ tell me the question again

D: changing situations well it means ~~(.)~~ well you've got to be compliant ~~(.)~~ compliance is an essential thing, it's an essential part of ~~your (.)~~ the contract you ~~(.)~~ agree with the authorities who are ~~(.)~~ putting you back into society ~~(.)~~ so you got to comply, you got to comply with what is expected of you ~~(.)~~ like medication ~~(.)~~ you have to take your medication, it's easy to skip you medication but at the end of the day it's not going to help you is it it's not going to help me the person, so you take your medication ~~(.)~~ you don't get yourself into situations that ~~you think kind of like might (.)~~ you might compromise yourself ~~(.)~~ so ~~you kind of like, you tread carefully in a way, you have to tread carefully (.) you know you have, you have, you have to (.) mm (.)~~

D: I would think so yeah ~~(.)~~ complying with the ~~(.)~~ not contract but what is expected of you ~~(...)~~ ~~(.)~~ not getting myself into ~~(.)~~ situations where ~~(.)~~ things might get out of hand ~~(.)~~ ~~trying to kind of like (.)~~ control ~~(.)~~ trying to bring a certain amount of control into my daily existence, ~~you know, kind of like (.)~~ ~~mm (.) it's (.) it's lifestyle (.)~~ it's lifestyle, ~~it's~~ making a certain number of lifestyle changes which you hope will keep you on the right track which is the track to recovery it's making the right choices ~~(.)~~ or trying to make the right choices ~~(.)~~ in terms of ~~(.)~~ what you do, where you go, who you associate with, and ~~(.)~~ all those kind of things, doing what's expected of you basically (...) ~~(.)~~

D: anything else that's helped me recover (draws breath) (.) I've said a few people in the system helped me recover (.) mm (.) anything else that's basically helped me recover (.) faith (.)

D: faith (.) mm (.) faith, having faith (.) believing in myself basically ~~that's a bit selfish really~~ (.) mm (.) my journey like I said before it's been a long journey you know it's (.) I think (.) in my opinion that is I've had more downs than ups in my life and (.) being in the system, it's one of those funny things to say, ~~but being in the system~~ (.) kind of like gave me (.) a second chance (.) I feel as though I've been given a second chance (.) to (.) to live a better life really, or a chance to live a better life (.) to (.) you know (.) make some improvements in my own existence (.) so I think (.) self-belief was one of the things that I (.) got from (.) I gleaned it from the work (.) and the interaction I had with people within the system because on street level I (.) I didn't have much confidence I didn't have people ~~to~~ (.) who kind of like, to act as role models to me or (.) or kind of like help me (.) gave me any reason to believe why I should believe in myself I didn't have ~~that~~ (.) ~~that kind of input from people around me~~ you know (INT: mm) if I'm making sense so you know being in the system and doing the work that I've done and (.) meeting these people who I've said have been influential in my existence um (.) kind of like (.) um (.) restored my belief in myself (.) mm (.) they kind of like led me to believe that ~~++~~ there's somebody alive in me somebody realises there's somebody alive in me, I am capable of a little more, I'm not saying I'm capable of becoming a doctor or a psychologist but I'm a little bit more and I can do a little bit more than I believe I can in terms of (.) um (.) being able to (.) a little more competent than I ever thought I was (.) and it's building on that competence that (.) I have kind of like set out to do basically (.) you know like (.) getting a laptop and seeing how it works (laughs) who told me to do that (laughs)

D: no I've been dabbling with laptops for a while but (laughs) (.) but it's, it's kind of like I've discovered a liking for knowledge (.) mm and I'm on that journey kind of like you know trying to (.) enlighten myself which in a way is ~~I'm not saying it's a full time thing but~~ (.) it's, it's (.) an ongoing thing in the hope that in that way I'm able to better myself and helps, helps keep me out of trouble as well you know (laughs) so it's, it's all good really, basically (.)

D: erm about my recovery, there's so much I can't really, off the top of my head, you know, but (.) I would say (.) that I would use myself as an example of somebody who's (.) been to the depths and been to the level where I'm on right now (.) there's hope (.) that's my message, that would be my message to anybody going through what I've been through or going through the system, not to lose hope ~~(.) basically~~ (.) and this is what those people did for me they restored my hope I would say that they led me to believe I was a better person but what they did essentially was to restore my hope for myself and that I think is the main thing (.) having hope that tomorrow will be a better day (.) and (.) doing what you can within it to make it a better tomorrow (.) hope (.) my hope, belief, hope (.) those I think are key (.) mm that's what I think anyway (.) belief, hope (.)

D: yeah (.) that it

D: anything else about my recovery (.) you ask

D: mm (.) have I missed anything out {directed to CPN}

CPN: is it ok for me to speak

CPN: ~~I think um (.) the biggest thing you say, is the fact you've (.)~~ the fact Derek takes personal responsibility for (.) his own life (.) especially his health (.) he doesn't do anything that would jeopardise his mental health and he does everything in his power to make sure the troubles he's gone through in life they never repeat themselves (.) he takes full responsibility for that ~~so (.) Derek's the sort of chap that will phone me the day before I'm supposed to drop off his medication and make sure I'm coming~~

D: ~~yeah, yeah~~

CPN: ~~he takes full responsibility for his own health (.)~~

D: ~~yeah~~

D: ~~I agree with that yeah (laughs) I agree with that fully yeah (.) it's (.) it's been a journey (.) full of serious things you know (.) I can't add no more cause if I start I'll just waffle on (laughs)~~

D: ~~I hope it's been helpful to you~~

D: ~~not a problem anything to help (.) psychology has brought me this far so anything to help~~

Stage 4: Identify subplots

1

Derek

Interview date: 08.03.2018, 12:30pm

Interview duration: 27 minutes 8 seconds

In 1998 I was convicted of manslaughter (.) of a Asian woman (.) and I (.) was sectioned under the Mental Health Act (.) 37/42 and first of all I was sent to (.) [***] prison where I was held about 3 months for assessment and then I was moved to [***] hospital where I spent about 4 or 5 years (.) and then I went to [*** hospital name] where I spent about 8 years and then from [there] I was moved to [*** hospital name] (.) where I met [name] Psychologist who did a lot of work with me really (.) and he allowed me to explore my own self (.) in written a form I was able to document my own journey (.) which in the end was the most useful bit of work, the best thing to happen to me the whole time that I've been in services (.) 'cause it kind of like allowed me to gain some insight into where I was coming from, where I was at, the reasons why I ended up committing this offence and in the end recovering or being on the road to recovery but also I managed to meet some other interesting and helpful people in the services who were very helpful to me in bringing about my (.) state of recovery that I'm at at this moment in time so it's been a long journey a difficult journey but (.) I think that I'm in a better place now than I was for a long, long time in my life (...)

Comment [SS(51)]: SUBPLOT: Hospital as providing opportunity and a second chance

Comment [SS(52)]: SUBPLOT: gaining insight into and taking responsibility for the index offence

Comment [SS(53)]: SUBPLOT: my recovery journey

When I first went into the services I didn't know what to expect (.) I think I was like a bit of a closed book I didn't feel I could trust anybody open up to people, I was ticking the boxes, and then I met some people who I was able to speak on a meaningful basis (.) they got me to open up to and be myself (...) staff mainly (.) I must not say I felt the patients didn't help me because they make my journey that much more easier by being friendly towards me and being kind and so I did meet some very helpful patients as well as the staff but I think in the end I think it was the staff who put me on the road to recovery (...)

Comment [SS(54)]: SUBPLOT: Importance of (trusting) relationships

To recover is to get back on track basically isn't it it's, it's kind of like losing your way and then regaining or finding your way (.) I, in doing what I did coming to my index offence (.) I, to use a cliché or whatever it might be fell off the rails, I did something which (.) I wouldn't have in a thousand, thousand years thought that could happen to me (.) that I would do (.) you know, I did a terrible thing, I took a life of a person (.) and that was the lowest point (.) the lowest, lowest, lowest point in my existence it was like being in the basement of a lift that went up 25 or 30 storeys (.) and for a long time I couldn't quite come to terms with that (.) and for a couple of years (.) I did very little (.) I was numb (.) in meltdown (.) not really wanting to do much just existing basically (.) particular staff come to my room, because I'd spend all my day in bed just getting up for dinner and medicine and going back to bed that was my existence, and a member of staff came in one day and sat on the end of the bed and says Derek get up (.) and from there I began want to do things or get involved in things and to get my life back it was the help of the staff that got me back on the road to recovery (...)

Comment [SS(55)]: SUBPLOT: what recovery means for me

Comment [SS(56)]: SUBPLOT: gaining insight into and taking responsibility for the index offence

Comment [SS(57)]: SUBPLOT: my recovery journey

Comment [SS(58)]: SUBPLOT: Importance of (trusting) relationships

I tell you what opened my eyes in a way (.) A fellow patient punched me one day when I was in hospital (.) and that woke me up really in a way you know (.) it made me (.) come to terms with the situation that I was in (.) it made me realise that I was in a (.) dangerous place with dangerous people and therefore I've got to learn to kind of like adapt (.) that was the first spark (.) I realised that (.) I had to adapt (.) to change (.) realised I was a dangerous man as it would be said living with

Comment [SS(59)]: SUBPLOT: Realisation that being in a dangerous place meant I was dangerous

dangerous people in high security and I couldn't continue to be a fool or act a fool (.) it was serious times I had to think seriously about myself, the journey I was on, the journey I was coming from, and where I wanted to be (.) out of the system (.) I don't know how long that journey was going to be but had to get my head down and get on with (.)

Comment [SS(510): SUBPLOT: Realisation that being in a dangerous place meant I was dangerous

I was tried on a number of different medications and it took a while for them to find one that suited me (.) I've been with that one for 10 years or so but what recovery means to me basically is regaining some kind of resemblance of yourself, getting back to yourself (.) you can't erase the memories of what has happened in the past but you can come to terms with it and you learn to live with it and recovery means overcoming the (.) not the pain, not the suffering, but the trauma (.) or live with the trauma and living with it and (.) coming to terms with it and not being crushed by it (.) the index offence, it's an ongoing thing it's a journey that will go on till the end of my day (.) cause every now and again you get a flashback (.) it's a constant because I mean I'm back in the community now but I still have to communicate with people (.) and (.) in doing so do I tell them who I am (.) who do I reveal myself to, who do I tell (.) I can't go round saying to everybody that I meet that oh so I spent so many years in a mental hospital, a mental hospital oh for the reason being I took the life of a person (.) I'm basically incognito in most situations or with most people that I meet I can't declare or reveal so therefore that always is kind of like a reminder to me that yes I remain who I am for what I've done (.)

Comment [SS(511): SUBPLOT: taking medication

Comment [SS(512): SUBPLOT: what recovery means for me

Comment [SS(513): SUBPLOT: gaining insight into and taking responsibility for the index offence

Comment [SS(514): SUBPLOT: continued stigma of being an offender patient

Comment [SS(515): SUBPLOT: continued stigma of being an offender patient

Comment [SS(516): SUBPLOT: continued stigma of being an offender patient

Comment [SS(517): SUBPLOT: continued stigma of being an offender patient

Comment [SS(518): What recovery means to me

Shame (.) embarrassment (.) fear (.) all of those kind of things (.) if I have to declare (.) I will declare, and I do but that's a trusted person (.) if somebody prompts me to I won't deny it (.) cause I'm not in denial (.) what happened, happened and there's no getting away from that (.) so recovery is in a sense coming to terms with what happened and I'd say moving on but you don't move on you live with it you learn to live with it and get on with it as well (.) you know that's basically recovery (.) it's changing things you know bringing about some kind of change in your life (.) moving from one situation to another one, hopefully a better one than the one that you're coming from that's what recovery is (.)

When you're in hospital you have to adapt to a particular way of acting, thinking, behaving and everything (.) when you're out of hospital you're back in society it's different so again you have to change (.)

Comment [SS(519): SUBPLOT: having to adapt

You've got to be compliant (.) compliance is an essential thing, it's an essential part of the contract you agree with the authorities who are (.) putting you back into society (.) you got to comply with what is expected of you (.) like medication (.) you have to take your medication (.) it's easy to skip you medication but at the end of the day it's not going to help you (.) you don't get yourself into situations that you might compromise yourself (.) so you tread carefully (.) not getting myself into (.) situations where (.) things might get out of hand (.) trying to bring a certain amount of control into my daily existence (.) it's lifestyle, making a certain number of lifestyle changes which you hope will keep you on the right track which is the track to recovery it's making the right choices (.) or trying to make the right choices (.) in terms of (.) what you do, where you go, who you associate with (.)

Comment [SS(520): SUBPLOT: compliance

Comment [SS(521): SUBPLOT: compliance

Comment [SS(522): SUBPLOT: controlling risks in the community

Comment [SS(523): SUBPLOT: controlling risks in the community

Comment [SS(524): SUBPLOT: controlling risks in the community

Comment [SS(525): SUBPLOT: having faith in myself

Faith, having faith (.) believing in myself basically (.) I've had more downs than ups in my life and being in the system, it's one of those funny things to say, gave me a second chance (.) I feel as though I've been given a second chance to live a better life (.) to make some improvements in my own existence (.) self-belief was one of the things that I got from the work (.) and the interaction I

Comment [SS(526): SUBPLOT: Hospital as providing opportunity and a second chance

Comment [SS(527): SUBPLOT: having faith in myself

had with people within the system because on street level I (.) I didn't have much confidence I didn't have people to act as role models to me or help me (.) gave me any reason to believe why I should believe in myself I didn't have (.) being in the system and doing the work that I've done kind of like (.) restored my belief in myself (.) they kind of like led me to believe that there's somebody alive in me, I am capable of a little more, I'm not saying I'm capable of becoming a doctor or a psychologist but I can do a little bit more than I believe I can in terms of being able to (.) be a little more competent than I ever thought I was (.) and it's building on that competence that (.) I have kind of like set out to do basically (.) (.) I've discovered a liking for knowledge (.) I'm on that journey trying to enlighten myself which in a way is an ongoing thing in the hope that in that way I'm able to better myself and helps keep me out of trouble as well

I would use myself as an example of somebody who's (.) been to the depths and been to the level where I'm on right now (.) there's hope (.) that would be my message to anybody going through what I've been through or going through the system, not to lose hope (.) and this is what those people did for me they restored my hope I would say that they led me to believe I was a better person but what they did essentially was to restore my hope for myself (.) having hope that tomorrow will be a better day (.) and (.) doing what you can within it to make it a better tomorrow (.)

CPN: (.) the fact Derek takes personal responsibility for (.) his own life (.) especially his health (.) he doesn't do anything that would jeopardise his mental health and he does everything in his power to make sure the troubles he's gone through in life they never repeat themselves (.) he takes full responsibility for that

Stage 5: Move fragments of subplots together to create one core story

1

In 1998 I was convicted of manslaughter (.) of a Asian woman (.) and I (.) was sectioned under the Mental Health Act (.) 37/42 and first of all I was sent to (.) [***] prison where I was held about 3 months for assessment and then I was moved to [***] hospital where I spent about 4 or 5 years (.) and then I went to [*** hospital name] where I spent about 8 years and then from [there] I was moved to [*** hospital name] (.) where I met [name] Psychologist who did a lot of work with me really (.) and he allowed me to explore my own self (.) in written a form I was able to document my own journey (.) which in the end was the most useful bit of work, the best thing to happen to me the whole time that I've been in services (.) 'cause it kind of like allowed me to gain some insight into where I was coming from, where I was at, the reasons why I ended up committing this offence and in the end recovering or being on the road to recovery but also I managed to meet some other interesting and helpful people in the services who were very helpful to me in bringing about my (.) state of recovery that I'm at at this moment in time so it's been a long journey a difficult journey but (.) I think that I'm in a better place now than I was for a long, long time in my life (...)

To recover is to get back on track basically isn't it it's, it's kind of like losing your way and then regaining or finding your way (.) I, in doing what I did coming to my index offence (.) I, to use a cliché or whatever it might be fell off the rails, I did something which (.) I wouldn't have in a thousand, thousand years thought that could happen to me (.) that I would do (.) you know, I did a terrible thing, I took a life of a person (.) and that was the lowest point (.) the lowest, lowest, lowest point in my existence it was like being in the basement of a lift that went up 25 or 30 storeys (.) and for a long time I couldn't quite come to terms with that (.) and for a couple of years (.) I did very little (.) I was numb (.) in meltdown (.) not really wanting to do much just existing basically (.) particular staff come to my room, because I'd spend all my day in bed just getting up for dinner and medicine and going back to bed that was my existence, and a member of staff came in one day and sat on the end of the bed and says Derek get up (.) and from there I began want to do things or get involved in things and to get my life back it was the help of the staff that got me back on the road to recovery (...)

When I first went into the services I didn't know what to expect (.) I think I was like a bit of a closed book I didn't feel I could trust anybody open up to people, I was ticking the boxes, and then I met some people who I was able to speak on a meaningful basis (.) they got me to open up to and be myself (...) staff mainly (.) I must not say I felt the patients didn't help me because they make my journey that much more easier by being friendly towards me and being kind and so I did meet some very helpful patients as well as the staff but I think in the end I think it was the staff who put me on the road to recovery (...)

What recovery means to me basically is regaining some kind of resemblance of yourself, getting back to yourself (.) you can't erase the memories of what has happened in the past but you can come to terms with it and you learn to live with it and recovery means overcoming the (.) not the pain, not the suffering, but the trauma (.) or live with the trauma and living with it and (.) coming to terms with it and not being crushed by it (...) the index offence, it's an ongoing thing it's a journey that will go on till the end of my day (.) cause every now and again you get a flashback (.) it's a constant because I mean I'm back in the community now but I still have to communicate with people (.) and (.) in doing so do I tell them who I am (.) who do I reveal myself to, who do I tell (.) can't go round saying to everybody that I meet that oh so I spent so many years in a mental hospital, a mental hospital oh for the reason being I took the life of a person (.) I'm basically incognito in most

Comment [SS(51)]: SUBPLOT: Hospital as providing opportunity and a second chance

Comment [SS(52)]: SUBPLOT: gaining insight into and taking responsibility for the index offence

Comment [SS(53)]: SUBPLOT: my recovery journey

Comment [SS(54)]: SUBPLOT: what recovery means for me

Comment [SS(55)]: SUBPLOT: gaining insight into and taking responsibility for the index offence

Comment [SS(56)]: SUBPLOT: my recovery journey

Comment [SS(57)]: SUBPLOT: Importance of (trusting) relationships

Comment [SS(58)]: SUBPLOT: Importance of (trusting) relationships

Comment [SS(59)]: SUBPLOT: what recovery means for me

Comment [SS(510)]: SUBPLOT: gaining insight into and taking responsibility for the index offence

Comment [SS(511)]: SUBPLOT: continued stigma of being an offender patient

situations or with most people that I meet I can't declare or reveal so therefore that always is kind of like a reminder to me that yes I remain who I am for what I've done (.)

Comment [SS(512)]: SUBPLOT: continued stigma of being an offender patient

Shame (.) embarrassment (.) fear (.) all of those kind of things, if I have to declare (.) I will declare, and I do but that's a trusted person (.) if somebody prompts me to I won't deny it (.) cause I'm not in denial (.) what happened, happened and there's no getting away from that (.) so recovery is in a sense coming to terms with what happened and I'd say moving on but you don't move on you live with it you learn to live with it and get on with it as well (.) you know that's basically recovery (.) it's changing things you know bringing about some kind of change in your life (.) moving from one situation to another one, hopefully a better one than the one that you're coming from that's what recovery is (.)

Comment [SS(513)]: SUBPLOT: continued stigma of being an offender patient

Comment [SS(514)]: SUBPLOT: continued stigma of being an offender patient

Comment [SS(515)]: What recovery means to me

When you're in hospital you have to adapt to a particular way of acting, thinking, behaving and everything (.) when you're out of hospital you're back in society it's different so again you have to change (.)

Comment [SS(516)]: SUBPLOT: having to adapt

I tell you what opened my eyes in a way (.) A fellow patient punched me one day when I was in hospital (.) and that woke me up really in a way you know (.) it made me (.) come to terms with the situation that I was in (.) it made me realise that I was in a (.) dangerous place with dangerous people and therefore I've got to learn to kind of like adapt (.) that was the first spark (.) I realised that (.) I had to adapt (.) to change (.) I realised I was a dangerous man as it would be said living with dangerous people in high security and I couldn't continue to be a fool or act a fool (.) it was serious times I had to think seriously about myself, the journey I was on, the journey I was coming from, and where I wanted to be (.) out of the system (.) I don't know how long that journey was going to be but had to get my head down and get on with (.)

Comment [SS(517)]: SUBPLOT: Realisation that being in a dangerous place meant I was dangerous

Comment [SS(518)]: SUBPLOT: Realisation that being in a dangerous place meant I was dangerous

I was tried on a number of different medications and it took a while for them to find one that suited me (.) I've been with that one for 10 years or so

Comment [SS(519)]: SUBPLOT: taking medication

You've got to be compliant (.) compliance is an essential thing, it's an essential part of the contract you agree with the authorities who are (.) putting you back into society (.) you got to comply with what is expected of you (.) like medication (.) you have to take your medication, it's easy to skip you medication but at the end of the day it's not going to help you (.) you don't get yourself into situations that you might compromise yourself (.) so you tread carefully (.) not getting myself into (.) situations where (.) things might get out of hand (.) trying to bring a certain amount of control into my daily existence (.) it's lifestyle, making a certain number of lifestyle changes which you hope will keep you on the right track which is the track to recovery it's making the right choices (.) or trying to make the right choices (.) in terms of (.) what you do, where you go, who you associate with (.)

Comment [SS(520)]: SUBPLOT: compliance

Comment [SS(521)]: SUBPLOT: compliance

Comment [SS(522)]: SUBPLOT: controlling risks in the community

Comment [SS(523)]: SUBPLOT: controlling risks in the community

Comment [SS(524)]: SUBPLOT: controlling risks in the community

CPN: (.) the fact Derek takes personal responsibility for (.) his own life (.) especially his health (.) he doesn't do anything that would jeopardise his mental health and he does everything in his power to make sure the troubles he's gone through in life they never repeat themselves (.) he takes full responsibility for that

Comment [SS(525)]: SUBPLOT: controlling risks in the community

Faith, having faith (.) believing in myself basically (.) I've had more downs than ups in my life and being in the system, it's one of those funny things to say, gave me a second chance (.) I feel as though I've been given a second chance to live a better life (.) to make some improvements in my

Comment [SS(526)]: SUBPLOT: having faith in myself

Comment [SS(527)]: SUBPLOT: Hospital as providing opportunity and a second chance

own existence (.) self-belief was one of the things that I got from the work (.) and the interaction I had with people within the system because on street level I (.) I didn't have much confidence I didn't have people to act as role models to me or help me (.) gave me any reason to believe why I should believe in myself I didn't have (.) being in the system and doing the work that I've done kind of like (.) restored my belief in myself (.) they kind of like led me to believe that there's somebody alive in me, I am capable of a little more, I'm not saying I'm capable of becoming a doctor or a psychologist but I can do a little bit more than I believe I can in terms of being able to (.) be a little more competent that I ever thought I was (.) and it's building on that competence that (.) I have kind of like set out to do basically (.) (.) I've discovered a liking for knowledge (.) I'm on that journey trying to enlighten myself which in a way is an ongoing thing in the hope that in that way I'm able to better myself and helps keep me out of trouble as well

Comment [SS(528): SUBPLOT: having faith in myself

Comment [SS(529): SUBPLOT: Having faith in myself

I would use myself as an example of somebody who's (.) been to the depths and been to the level where I'm on right now (.) there's hope (.) that would be my message to anybody going through what I've been through or going through the system, not to lose hope (.) and this is what those people did for me they restored my hope I would say that they led me to believe I was a better person but what they did essentially was to restore my hope for myself (.) having hope that tomorrow will be a better day (.) and (.) doing what you can within it to make it a better tomorrow (.)

Comment [SS(530): SUBPLOT: my recovery journey

Comment [SS(531): SUBPLOT: hope

Appendix B.11: Table of Subplots and Level of Narrative

Participant	Subplot	Level of Narrative	Example
James	mental illness creating difference to 'the norm' – judgement of self and others	<i>Personal</i> ; what I noticed when I became unwell <i>Cultural</i> ; people with MI as the 'loony' and 'visibility' of MI creating difference to the 'norm'	<i>I first noticed I became ill when I was about seventeen and a half, started talking to myself, giggling to myself, it was like really noticeable things you could see but you know you look at it and think oh that guy's a loony</i>
	finding the right medication	<i>Personal</i> ; past experiences of medication	<i>The medication it was really, really horrible when I first started medication I'd get injections and I'd get really bad side effects, I mean I tried god knows how many different medications</i>
	what recovery means to me	<i>Personal</i> ; defining recovery <i>Cultural</i> ; Behaviours associated with MI seen as odd, finding comfort in having a label (?)	<i>Being the best person that you can be without any symptoms or odd behaviours (.) schizoaffective disorder</i>
	where I was then and where I am now	<i>Personal</i> ; I am recovered <i>Cultural</i> ; not experiencing symptoms as having recovered – driven by dominant stories in mental healthcare	<i>I don't think I'll be getting any better than I am doing (.) I used to talk to myself a lot, giggle, pace up and down, get angry</i>
	Hospital as game players	<i>Community</i> ; us and them <i>Cultural</i> ; power of the hospital over patient	<i>at first I used to think it was just all a big game or it was a big conspiracy</i>
	importance of relationships in recovery	<i>Community</i> ; sense of belonging and identifying with others <i>Cultural</i> ; if you have MI you are seen as not normal	<i>Engaging with the staff, just being around likeminded people as well's helped me realise what is what basically (.)I suppose being treated like a normal person</i>
	Hope	<i>Personal</i> ; Counterstory - possibility that recovery is possible and realistic	<i>just showing me there's light at the end of the tunnel basically</i>
	being in a hospital as stigmatising	<i>Cultural</i> ; stigma of being an offender patient <i>Personal</i> ; past –wanting to get away from the stigma	<i>I was always jumping the gun, wanting to get out, get away from the hospital setting, and getting away from the stigma</i>
	Asking for help	<i>Personal</i> ; being able to ask for support <i>Cultural</i> ; Counterstory- it is ok to ask for help	<i>asking for help and knowing where to go to get what help I can</i>
	the role of drugs and alcohol	<i>Personal</i> ; impact of substances in past and event that made him realise how others experience him	<i>alcohol used to be a major part in in my life and couple of years back I was walking through the town centre at night time with my friend and I saw a guy walking down the street he was</i>

		<i>Cultural</i> ; night life scene and excessive/binge drinking, getting 'hammered'	<i>absolutely hammered (.) and I thought that's how I looked every day</i>
John	experiencing mental illness and being judged and/or stigmatised	<i>Personal</i> ; past present and future experience of having the label <i>Cultural</i> ; stigma from experiencing mental health difficulties and being in hospital, negative judgements "you're dangerous"	<i>I think what's important to me is (.) I'm not looked at in a bad way like for being in hospitals (.) I knew if I hit him back I, I knew I'd end up being the person taken away again and there's no such thing as self-defence with mental health (.) you're back into hospital for a long time again</i>
	Powerful hospital leading to injustice	<i>Cultural</i> ; Hospital as holding the power, patient with no voice <i>Cultural</i> ; Counterstory – hospitals create, rather than 'cure' mental illness	<i>I went through being force fed drugs (.) putting stuff in what cracks you up (.) so I thought that was so unjust and so unfair but she was in charge there's nothing I can say or do to her so (.) it was a cruel thing to do really</i>
	Masculinity	<i>Personal</i> ; impact of medication on masculinity <i>Cultural/Community</i> ; power of hospital to deconstruct parts of identity including masculinity	<i>I was disabled in certain ways (.) sleep and to be able to ejaculate (.) and the doctor accepted that these side effects might be a problem in the future (.) so she suggested that I can try another drug (.) get your manhood back like</i>
	enjoyment from activities and occupation/purpose on the ward	<i>Personal</i> ; Having a purpose prevented me from disengaging and 'switching off' <i>Community</i> ; purposeful activity as helpful within the environment	<i>I think as well with being in a restricted place because you barely go out (.) I think people need to have things to do a purpose to have because if they don't they just switch off which is what it was like when I went to prison you know, I just switched off I became a cabbage basically</i>
	Appreciation of where I am now	<i>Personal</i> ; I've recovered; self-efficacy and achievement	<i>I've got a car now and I've got my own place (.) nice place (.) I look at what I've got now and I hold onto and I'm happy really (.) I'd say I'd recovered yeah</i>
	poor treatment leading to disengagement	<i>Community</i> ; treat us right and we'll engage/cooperate <i>Cultural</i> ; people with MI treated badly, dehumanised – like a dog	<i>treat someone like a dog they're going to act like a dog aren't they</i>
	management of risks in the community	<i>Personal</i> ; staying away from risks	<i>I'm strong minded to stay away from them and stay away from drugs (.) it's put me in a psychological place where I'm less likely now to conduct myself in any illegal activity or conduct myself into take drugs</i>
	the impact of the index offence	<i>Personal</i> ; past; I was violent and it affected	<i>I attacked my mother my mum was a victim of my (.) because my</i>

		my family <i>Cultural</i> ; mentally unwell people are dangerous	<i>psychological (.) whatever you call it (.) psychological (...) my illness really (.) I attacked her</i>
	importance of (genuine) relationships	<i>Personal</i> ; genuine relationships matter <i>Community</i> ; relationships with peers; having a shared sense of identity	<i>I think when you've got a doctor and nurses and healthcare that treat you right and respect you right you can see they do things for you I think that matters a lot I think it's important you got a good relationship with your peers</i>
	hospital as playing a game	<i>Community</i> ; us and them <i>Cultural</i> ; power of the hospital over patient	<i>but I said I'm not bothered I'm not playing this game</i>
	I'd rather have gone to prison	<i>Cultural</i> ; more socially acceptable to go to prison??? Counterstory - power of hospitals as wanting to lock people up unnecessarily	<i>if I was put into prison instead of going to a hospital location in 2009 I would have been out within about two to three years (.) but I went into hospital and I was kept in for like nine years (.) it's basically like a life sentence</i>
	the hospital cracked me up	<i>Personal</i> ; my MI was created by hospital <i>Cultural</i> ; Counterstory – hospitals create, rather than 'cure' mental illness	<i>when it first all started I didn't have mental illness I was given mental illness by what happened to me</i>
	hospital as harsh and protective at the same time	<i>Personal</i> ; past treatment as harsh but it's been positive for the present	<i>I would say the way I've been treated might be a bit harsh but it's put me in a position where I think more closely now at heart about things</i>
Burt	recovery as a continuing journey	<i>Personal</i> ; I am still recovering, hope for the future	<i>I think the next positive step is to think would I always be want to be living in my little flat (.) perhaps at a later date perhaps look at a place where I have a garage</i>
	look to the future and don't ruminate on the past	<i>Personal</i> ; impact of staying in past and not thinking positively about future	<i>issues if you're remembering what has gone in the past that remembering becomes ruminating it becomes a vicious circle and it doesn't give you a break in that so you ruminate and you're regurgitating your negatives rather than positives of what can be in the future</i>
	recovery is unique to you as an individual	<i>Personal</i> ; treat me as an individual <i>Cultural</i> ; Counterstory – no one size fits all recovery approach, healthcare must adopt this	<i>Your recovery is unique to you I don't think there is an off the shelf package</i>
	I'm just like everybody else and I'm not alone in my experience of mental health	<i>Personal</i> ; finding comfort in not feeling alone <i>Cultural</i> ; it is more acceptable to talk about mental health BUT still hidden/a need to talk more about mental health (NB. Recent media	<i>I speak to so many and they say oh my father, my mother, my cousin, so you're not an isolated person by any means and it can happen to anyone</i>

	campaigns)	
life is never going to be the same	<i>Personal</i> ; impact of my past on my present and future <i>Cultural</i> ; offenders not having a second chance – labels following and access to opportunities always affected by offending and MH	<i>life is never going to be the same (.) you can't turn the clock back</i>
Knowing the role of the hospital and knowing your role as a patient	<i>Personal</i> ; I want to know what is expected of me <i>Community</i> ; knowing the roles and boundaries – what is your identity/role as staff and what is mine as patient	<i>you need to know what the (.) establishment has to offer (.) what your role within that establishment is (.) what the boundaries are</i>
relationships with others as important	<i>Personal</i> ; impact of others on my journey <i>Community</i> ; sharing and learning from others	<i>you can learn so much by talking to other patients (.) members of staff (.) and that opens so many avenues</i>
circumstances and shame of index offence	<i>Personal</i> ; regret, remorse, shame <i>Cultural</i> ; a need to express remorse to be recovered	<i>this was the result of my own actions which I deeply regret and a number of life changing events taking place in a short period of time</i>
ultimately you're responsible	<i>Personal</i> ; taking responsibility as being 'make or break' <i>Cultural</i> ; dominant western ideas of taking responsibility for self, standing on own two feet	<i>you realise that whatever comes through the letterbox has got your name on it (.) the buck stops with you (.) when you close the door it's your flat (.) whatever comes you're responsible (.) and I think that could have been either the make or break</i>
Setting up and adjusting to a new life	<i>Personal</i> ; adjustment to transitions in recovery journey	<i>so there's another set of routines that you need to put in place (.) if you've not been doing it or 50 per cent (.) that other 50 per cent can be enough to take you down (.) or bring you up</i>
hospital as providing opportunity	<i>Community</i> ; hospital environment as a place to practice skills for community – shared narrative of empowering <i>Personal</i> ; that was helpful to me	<i>if it's taking place at the [hospital] you can see how it takes place back in your home or your wherever you finally decide to live (.) and I think that that's a classic example a superb example of seeing what takes place and what takes place in the real world when you're responsible for it</i>
taking control of my recovery	<i>Personal</i> ; specific experience that was significant in recovery	<i>that definitely is April the 11th when I felt I'd really taken the reigns (.) been on a journey but someone else was taking me but that was the date (.) so that's been my road to recovery in sort of getting your own belongings back and taking ownership</i>
importance of physical health	<i>Personal</i> ; looking after physical health as an	<i>you must always if you can focus on your good points of your</i>

		aspect of continuing recovery	<i>general health (.) listen to your body</i>
Derek	Hospital as providing opportunity and a second chance	<i>Personal</i> ; hospital as giving a second chance, supporting recovery <i>Cultural</i> ; Counterstory - recovery is possible, you can get a second chance	<i>I feel as though I've been given a second chance to live a better life (.) to make some improvements in my own existence</i>
	gaining insight into and taking responsibility for index offence	<i>Personal</i> ; importance of gaining insight	<i>it kind of like allowed me to gain some insight into where I was coming from, where I was at, the reasons why I ended up committing this offence</i>
	My recovery journey	<i>Personal</i> ; recovery is a journey, appreciating how far I've come	<i>It's been a long journey a difficult journey but (.) I think that I'm in a better place now than I was for a long, long time in my life</i>
	importance of (trusting) relationships	<i>Personal</i> ; trusting relationships leading to meaningful engagement with recovery <i>Community</i> ; staff as there to support	<i>I think I was like a bit of a closed book I didn't feel I could trust anybody open up to people, I was ticking the boxes, and then I met some people who I was able to speak on a meaningful basis (.) they got me to open up to and be myself (...) staff mainly</i>
	what recovery means for me	<i>Personal</i> ; recovery as regaining your identity	<i>to get back on track basically isn't it it's, it's kind of like losing your way and then regaining or finding your way</i>
	Realisation that being in a dangerous place meant I was dangerous	<i>Community</i> ; shared identity of being dangerous in a dangerous environment <i>Cultural</i> ; offenders with MI as dangerous	<i>I realised I was a dangerous man as it would be said living with dangerous people in high security and I couldn't continue to be a fool or act a fool</i>
	taking medication	<i>Personal</i> ; role of medication <i>Cultural/Community</i> ; medication as a cure or treatment for MI – medical model dominance	<i>I was tried on a number of different medications and it took a while for them to find one that suited me</i>
	continued stigma of being an offender patient	<i>Cultural</i> ; stigma and shame around being an offender patient – need to hide <i>Personal</i> ; continued impact of past on future	<i>I'm basically incognito in most situations or with most people that I meet I can't declare or reveal so therefore that always is kind of like a reminder to me that yes I remain who I am for what I've done</i>
	Having to adapt	<i>Community</i> ; identity as shaped by the environment (either hospital or community) <i>Personal</i> ; impact of change and continual adapting	<i>When you're in hospital you have to adapt to a particular way of acting, thinking, behaving and everything (.) when you're out of hospital you're back in society it's different so again you have to change</i>
	Compliance	<i>Cultural</i> ; hospital as holding the power and contracting patients into complying	<i>compliance is an essential thing, it's an essential part of the contract you agree with the authorities who are putting you back into society</i>
	controlling risks in the community	<i>Personal</i> ; managing future risks	<i>you don't get yourself into situations that you might compromise yourself (.) so you tread carefully</i>

	Having faith in myself	<i>Personal</i> ; restored faith and self belief <i>Cultural</i> ; Counterstory – I am worth more, I am worthy of a second chance	<i>Being in the system and doing the work that I've done kind of like (.) restored my belief in myself (.) they kind of like led me to believe that there's somebody alive in me, I am capable of a little more</i>
	Hope	<i>Community</i> ; shared ideas of hope and possibility of recovery <i>Cultural</i> ; Counterstory – change and recovery is possible	<i>There's hope (.) that would be my message to anybody going through what I've been through or going through the system, not to lose hope</i>
Kyle	Seriousness of my mental illness	<i>Personal</i> ; my experience of MI was serious <i>Community</i> ; levels and different 'types' of suffering for those with MI <i>Cultural</i> ; labels and stigma i.e. 'nutter'	<i>When I was first brought into the mental health system to say that I was psychotic is a bit of an underestimation (.) Perhaps you get the odd nutter like me that needs to go into an institute but not your bog standard Joe with schizophrenia</i>
	Understanding why I did it	<i>Cultural</i> ; Counterstory – seeing involvement in offence and experience of MI as challenging and trying to change the world <i>Personal</i> ; the reasons for his offence	<i>It made no sense so I thought, I know what I'm going to do, I'm gonna be a difference here (...) you get people that are like (.) I can't do anything, I can't change anything the world will do what the world does and that's it but, if you don't that's somebody else that wins (.) that's somebody else that gets unchallenged (.) so yeah, that was one of the reasons</i>
	My ideas got me in trouble but they also grounded me	<i>Cultural</i> ; Ideas that don't fit the 'norm' or accepted dominant narrative will get me in trouble/get me locked up <i>Personal</i> ; I find comfort and grounding in these ideas	<i>In some ways it was never a problem that (.) I had these big ideas I'm a lot more careful in how I put things across (.) It just feels like everything I've fought for it's just (.) been wasted away</i>
	feeling indifferent about recovery	<i>Personal</i> ; present feelings about recovery; identity <i>Cultural</i> ; Counterstory – do I want to recover? (link to still feeling grounded by ideas that brought him into services)	<i>Basically my entire life feels like one big blag at the moment (.) There's a part of me that almost says indifference (.) take everything with a pinch of salt</i>
	psychology helped me recover	<i>Personal</i> ; Interventions as successful in recovery <i>Community</i> ; psychological work as supportive of recovery	<i>the psychology (...) it was profound</i>
	Locking people up as both helpful and unhelpful	<i>Personal</i> ; It helped me but didn't at the same time <i>Cultural</i> ; Counterstory – we shouldn't detain	<i>I definitely think put on a ward just simply from the access side of it, but at the same time, locking people up ain't the way you should do it</i>

		offender patients	
	cooperation with and acceptance of diagnosis	<i>Personal</i> ; past, acceptance as part of cooperating <i>Community/Cultural</i> ; if you cooperate/accept diagnosis you can recover	<i>I'm gonna play ball here , when I've come into hospital I've always tried to be as cooperative as I can because I do appreciate the fact I do have a mental health diagnosis</i>
	importance of keeping active	<i>Personal</i> ; physical health	<i>I used to go training three times a week, if I wasn't doing that I was rowing (.)I've always been a very physical sort of person</i>
	boundaries within the environment	<i>Community</i> ; us and them; staff as strict and patients as untrustworthy leading to scepticism <i>Cultural</i> ; hospital as powerful and patient as judged	<i>not being strict but being strict, if you know what I mean and it's like why don't you just say it you know what are you looking for out of me here (.) no I have to be held behind all these walls and scepticism and all the rest of it</i>
	you're the expert in your own diagnosis	<i>Personal</i> ; Counterstory - I am the expert in my MH <i>Cultural</i> ; Counterstory - service user voice as taking precedence over professionals as experts	<i>If somebody's a radio psychotic or a, a believer that they're God or the Devil, or you know what I mean (.)they're all in their own way they're all experts in their own understanding of who they are and what they have</i>
	Stigma and community response	<i>Cultural</i> ; medicalisation and fear of MI – people with MI as 'unsafe'/risky	<i>I got he's becoming poorly again lock him up again</i>
	avoidance of drugs and alcohol as important	<i>Personal</i> ; importance of not using substances for my recovery <i>Cultural</i> ; power of system to give ultimatum	<i>Definitely sticking clear of the drugs simply because I was given the ultimatum you take drugs we will lock you up again (...) the lack of being able to go for a beer</i>
	importance of relationships	<i>Personal</i> ; importance of good relationships <i>Community</i> ; seeking relationships with people who he can identify with	<i>having some really decent people around me you know, some people that I actually sort of recognise with</i>

Appendix B.12: NHS Research Ethics Committee Approval



Health Research Authority

Mrs Sophie Sutherland
Trainee Clinical Psychologist
South Staffordshire and Shropshire NHS Foundation Trust
Trust HQ, St. Georges Hospital
Corporation Street
Stafford
ST16 3SR

Email: hra.approval@nhs.net

11 January 2018

Dear Mrs Sutherland

Letter of HRA Approval

Study title:	Narratives of recovery: Capturing recovery stories from people who have used Forensic Mental Health Services
IRAS project ID:	229859
REC reference:	17/WA/0269
Sponsor	Staffordshire University

I am pleased to confirm that HRA Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

Page 1 of 7

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from the [HRA website](#).

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The document *"After Ethical Review – guidance for sponsors and investigators"*, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

In addition to the guidance in the above, please note the following:

- HRA Approval applies for the duration of your REC favourable opinion, unless otherwise notified in writing by the HRA.
- Substantial amendments should be submitted directly to the Research Ethics Committee, as detailed in the *After Ethical Review* document. Non-substantial amendments should be submitted for review by the HRA using the form provided on the [HRA website](#), and emailed to hra.amendments@nhs.net.
- The HRA will categorise amendments (substantial and non-substantial) and issue confirmation of continued HRA Approval. Further details can be found on the [HRA website](#).

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found through [IRAS](#).

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application

IRAS project ID	229859
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procedure. If you wish to make your views known please use the feedback form available on the [HRA website](#).

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details on the [HRA website](#).

Your IRAS project ID is **229859**. Please quote this on all correspondence.

Yours sincerely

Juliana Araujo

Assessor

Email: hra.approval@nhs.net

*Copy to: Sponsor Representative: Professor Nachiappan Chockalingam, Staffordshire University
Lead NHS R&D Office Representative: Mrs Audrey Bright, South Staffordshire and Shropshire NHS Foundation Trust*

Appendix A - List of Documents

The final document set assessed and approved by HRA Approval is listed below.

Document	Version	Date
Copies of advertisement materials for research participants [Leaflet for research]	1	03 July 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Professional Negligence Insurance]	1	03 July 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [4. Employers Liability Staffordshire University 2017 - 18]		
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [5. Public Liability Staffordshire University 2017 - 18]		15 July 2017
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [6. Professional Indemnity Staffordshire University 2017 - 18]		14 July 2017
GP/consultant information sheets or letters [GP Notification Letter]	1	12 October 2017
HRA Schedule of Events [HRA Schedule of Events (Reviewed)]	1.0	11 October 2017
HRA Statement of Activities [HRA Statement of Activities (Reviewed)]	1.0	11 October 2017
Interview schedules or topic guides for participants [Interview prompts]	1	03 July 2017
IRAS Application Form [IRAS_Form_25082017]		25 August 2017
Letter from sponsor [Letter from sponsor]	1	12 April 2017
Letters of invitation to participant [Invitation letter]	1	03 July 2017
Other [Sponsor letter]	1	13 April 2017
Other [Employers Liability]	1	03 July 2017
Other [Public Liability]	1	03 July 2017
Other [Demographic checklist]	1	03 July 2017
Other [GCP Training Certificate]	1	21 October 2015
Other [GCP Updated training certificate]	1	05 October 2017
Participant consent form [Consent form]	Version 2	12 October 2017
Participant consent form [Consent to phone call]	1	03 July 2017
Participant information sheet (PIS) [Participant information sheet]	Version 2	12 October 2017
Research protocol or project proposal [Project proposal]	2	03 July 2017
Summary CV for Chief Investigator (CI) [CV for CI]	1	03 July 2017
Summary CV for supervisor (student research) [Clinical Supervisor CV]	1	03 July 2017
229859 17WA0269 further information fav opinion letter 16-10-17.pdf		16 October 2017
229859 17WA0269 PROVISIONAL OPINION LETTER 22-9-17.pdf		22 September 2017
229859 17WA0269 VALIDATION LETTER 25-8-17.pdf		25 August 2017

Appendix B - Summary of HRA Assessment

This appendix provides assurance to you, the sponsor and the NHS in England that the study, as reviewed for HRA Approval, is compliant with relevant standards. It also provides information and clarification, where appropriate, to participating NHS organisations in England to assist in assessing and arranging capacity and capability.

For information on how the sponsor should be working with participating NHS organisations in England, please refer to the *participating NHS organisations, capacity and capability and Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* sections in this appendix.

The following person is the sponsor contact for the purpose of addressing participating organisation questions relating to the study:

Name: Professor Nachiappan Chockalingam

Tel: 01782295853

Email: n.chockalingam@staffs.ac.uk

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	The Statement of Activities will form the agreement between the sponsor and the site. The Schedule of Events was submitted.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the activities expected of them for this

Section	HRA Assessment Criteria	Compliant with Standards	Comments
			research study
4.3	Financial arrangements assessed	Yes	No funding application was made for the study.
5.1	Compliance with the Data Protection Act and data security issues assessed	Yes	No comments
5.2	CTIMPS – Arrangements for compliance with the Clinical Trials Regulations assessed	Not Applicable	No comments
5.3	Compliance with any applicable laws or regulations	Yes	No comments
6.1	NHS Research Ethics Committee favourable opinion received for applicable studies	Yes	NHS Research Ethics Committee favourable opinion was confirmed by the Wales Research Ethics Committee 6 on 16 October 2017.
6.2	CTIMPS – Clinical Trials Authorisation (CTA) letter received	Not Applicable	No comments
6.3	Devices – MHRA notice of no objection received	Not Applicable	No comments
6.4	Other regulatory approvals and authorisations received	Not Applicable	No comments

Participating NHS Organisations in England

<i>This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.</i>
<p>There is one NHS participating organisation; therefore there is one site type.</p> <p>The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.</p>

If chief investigators, sponsors or principal investigators are asked to complete site level forms for participating NHS organisations in England which are not provided in IRAS or on the HRA website, the chief investigator, sponsor or principal investigator should notify the HRA immediately at hra.approval@nhs.net. The HRA will work with these organisations to achieve a consistent approach to information provision.

Confirmation of Capacity and Capability

This describes whether formal confirmation of capacity and capability is expected from participating NHS organisations in England.

Participating NHS organisations in England **will be expected to formally confirm their capacity and capability to host this research.**

- Following issue of this letter, participating NHS organisations in England may now confirm to the sponsor their capacity and capability to host this research, when ready to do so. How capacity and capability will be confirmed is detailed in the *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* section of this appendix.
- The [Assessing, Arranging, and Confirming](#) document on the HRA website provides further information for the sponsor and NHS organisations on assessing, arranging and confirming capacity and capability.

Principal Investigator Suitability

This confirms whether the sponsor position on whether a PI, LC or neither should be in place is correct for each type of participating NHS organisation in England and the minimum expectations for education, training and experience that PIs should meet (where applicable).

The Chief Investigator will be responsible for all research activities at the NHS organisations. No local Principal Investigator is expected.

GCP training is not a generic training expectation, in line with the [HRA/MHRA statement on training expectations](#).

HR Good Practice Resource Pack Expectations

This confirms the HR Good Practice Resource Pack expectations for the study and the pre-engagement checks that should and should not be undertaken

The researcher has contractual arrangements in place with the site.

Other Information to Aid Study Set-up

This details any other information that may be helpful to sponsors and participating NHS organisations in England to aid study set-up.

The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix B.13: Peer Review Approval



INDEPENDENT PEER REVIEW APPROVAL FEEDBACK

Researcher Name Sophie Sutherland
Title of Study Narratives of recovery: Capturing recovery stories from people who have used Forensic Mental Health Services
Award Pathway Doctorate in Clinical Psychology
Status of approval: Approved

Thank you for forwarding the amendments requested by the Independent Peer Review Panel (IPR)

Action now needed:

You must now apply to the Local NHS Research Ethics Committee (LREC) for approval to conduct your study. You must not commence the study without this second approval.

Please forward a copy of the letter you receive from the LREC by email to HealthScienceEthics@staffs.ac.uk as soon as possible after you have received approval.

Once you have received LREC approval you can commence your study. You should be sure to do so in consultation with your supervisor.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

When your study is complete, please send the Ethics Committee an end of study report. A template can be found on the ethics BlackBoard site.

Comments for your consideration:

E. M. Boath

Signed: Dr Elizabeth Boath

Date: 12/04/2017

Health Sciences Ethics Panel

Appendix B.14: Research and Development Approval from the Local Authority

South Staffordshire and Shropshire Healthcare **NHS**

NHS Foundation Trust

Our Ref: AB/R389

20 April 2018

Research and Development
Block 7
St George's Hospital
Corporation Street
STAFFORD
ST16 3AG

Tel: (01785) 783170
Email: audrey.bright@ssst.nhs.uk

Mrs Sophie Sutherland
Trainee Clinical Psychologist
South Staffordshire and Shropshire Healthcare
NHS Foundation Trust
Corporation Street
Stafford
ST16 3SR

Dear Sophie

Study title: Narratives of Recovery

We have considered your continued access to service users and staff from within this Trust in connection with the above study.

On behalf of the Trust, the Lead Officer for Research Governance (Ruth Lambley-Burke), is satisfied that the requirements for Research Governance, both Nationally and Locally, have been met and is willing to give retrospective authorisation for the study from **11 January 2018** with the following provisos:

- That you conform to the requirements laid out in the letters from the HRA dated **11 January 2018** which prohibits any changes to the agreed protocol
- That you keep the Trust informed about the progress of the project at 6 monthly intervals
- If at any time details relating to the research project or researcher change, the R&D department must be informed.

Your research has been entered into the Trust database and will appear on the Trust website.

As part of the Research Governance framework it is important that the Trust are notified as to the outcome of your research and as such we will request feedback once the research has finished along with details of dissemination of your findings. To aid dissemination of findings, copies of final reports are placed on our Trust Website.

If I can help in any other way please do not hesitate to contact me.

Yours sincerely



Ruth Lambley-Burke
Head of Research and Innovation

Paper 3 –Executive Summary

Narratives of Recovery: Capturing recovery stories from people who have used Forensic Mental Health Services – An Executive Summary

Word Count: 2,300

Contents

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Introduction

This summary provides an overview of a research study which interviewed men who have been in low secure forensic mental health services and are now living in the community. The research wanted to hear what people said about their recovery.

This summary is for forensic mental health service users, and anyone who might be interested in recovery. It may be useful for forensic mental health services to use this executive summary in preparing patients for their discharge into the community.

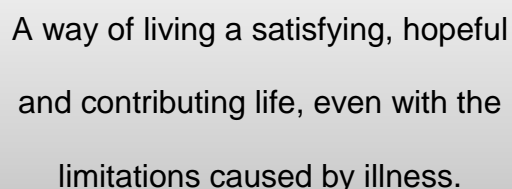
Forensic mental health services are provided for:

- (A.) People with a mental disorder who;
- (B.) pose, or have posed, risks to others, and;
- (C.) that risk is usually related to their mental disorder.

(Joint Commissioning Panel for Mental Health, 2013)

People in forensic services are held in high, medium or low secure settings, depending on their level of risk. Those considered most at risk are detained within high secure settings.

Recovery is an important concept in mental health. There are many definitions of recovery, however it is generally accepted that recovery is:



A way of living a satisfying, hopeful
and contributing life, even with the
limitations caused by illness.

What the Literature Says

Using recovery approaches in mental health care has gained momentum over recent years. Recovery principles have been applied across numerous mental health settings. Researchers have explored service users' accounts of recovery in general mental health settings. Other research has looked at recovery from schizophrenia. There has also been research to consider the links between recovery and service users' relationships with professionals. The literature on recovery is dominated by studies describing recovery from mental health settings that exclude specialist mental health services, such as forensic services.

Several researchers have questioned whether recovery principles can apply to forensic settings. There are issues unique to forensic settings that make applying recovery principles challenging, including:

- Being 'doubly stigmatised' for having a mental illness and being an offender
- The physical environment of a secure forensic hospital limiting opportunities to engage in activities that promote recovery
- Social exclusion due to being detained in hospital means that keeping positive relationships with people outside the hospital, and developing new relationships, is challenging. This is a problem as relationships are an important part of recovery according to the literature.
- Having an offender identity may lead to feeling hopeless. The research states that feeling hopeful is important in mental health recovery.

(Cromar-Hayes & Chandley, 2014; Dorkins & Adshead, 2011; Drennan & Wooldridge, 2014; Mezey et al., 2010).

The research that has been conducted in forensic settings focuses on professionals' opinions about what recovery is and the factors believed to be important for recovery. However, it has been highlighted that it is important to find out what is important to service users themselves, if healthcare is to be

meaningful (Department of Health, 2001). Some research has been conducted with patients in high and medium secure services. The research often highlights that the following are important for recovery:

- Hope
- Connecting with other people
- Having meaningful occupation and purpose
- The specific roles and identity of an offender patient
- The powerful environment of the hospital
- Coming to terms with the past and diagnosis

Some of these factors appear to support recovery, and some appear to make recovery more challenging.

There are significant gaps in the literature. Only one study within the UK explores the views of patients within a low secure setting (Clarke, Sambrook, Lumbard, Kerr, & Johnson, 2017) and there is no available research with individuals who have been discharged into the community. This research aimed to address the gap. It was hoped that this research would be able to consider whether recovery principles can apply effectively in forensic settings.

Aims of the Study

The aims of the study were to explore the recovery stories of people who have used forensic mental health services and find out:

- What are the recovery stories of people who have used forensic mental health services and now live in the community?
- What does recovery mean for service users?
- What factors influence recovery?

Methodology

People who had been discharged from a low secure forensic service were invited to take part in the research. A Consultant Clinical Psychologist and a Social Worker at the service identified potential participants, who were sent an information pack including an invitation letter and an information sheet. Participants who agreed to take part were offered either a face to face interview or an interview over the phone. 33 participants were invited to take part and 5 participants took part in the research. Interviews were audio-recorded and written up word for word by the researcher. There were no set interview questions, instead participants were asked to simply tell their recovery story. The researcher used prompts when necessary (such as 'can you tell me more about that'). Once the participants' stories were written up, they were analysed using a narrative approach.

Narrative research is based on the idea that people make sense of their lives through the stories they tell. In telling stories, people give meaning to their lives. From this perspective narratives are not just a way of seeing the world; our world is created by the stories people tell.

Narrative research is useful when exploring personal identity and social factors including the influence of culture, on the stories people tell. However, it is especially useful to consider the interaction between the two. For instance, when people talk about their experience of illness and tell their personal story through existing cultural narratives.

Narrative researchers are concerned with:

- the way the stories are told
- what the stories say
- what the stories mean

The narrative approach in this study used Kirkpatrick's (2008) framework for understanding recovery experiences of individuals with mental illness. The framework suggests that *illness narratives* are stories people tell about their experience of their illness. *Counterstories* are stories which resist cultural

stereotypes (a stereotype for instance could be that mentally ill people are dangerous).

People tell their story, which includes illness narratives and counterstories, and it can be understood on three different levels:

- Personal
- Community (stories shared by a group of people)
- Dominant cultural narratives (stereotypes communicated in our social world)

This research aimed to analyse the recovery stories told by the participants through the different levels.

Main Findings

Participants' stories about recovery shared a number of factors. Figure 1 illustrates the shared illness narratives and counterstories.

- Being able to feel hopeful about recovery was important in participants' personal stories. If they felt that recovery was realistic and possible for them, participants could feel hopeful about their future.
- Participants understood their journey of recovery in very different ways. For some participants recovery was a journey rather than an event with a start or an end. For these participants recovery was something that would continue for the rest of their lives. Other participants felt they had recovered and were not still in the process of recovery. One participant felt unsure about whether the word recovery was something that fitted his experience.
- All of the participants' stories included the important relationships that participants felt had supported their recovery. Every participant said that open, trusting and genuine relationships with staff whilst they were in hospital helped them to know that recovery was possible.

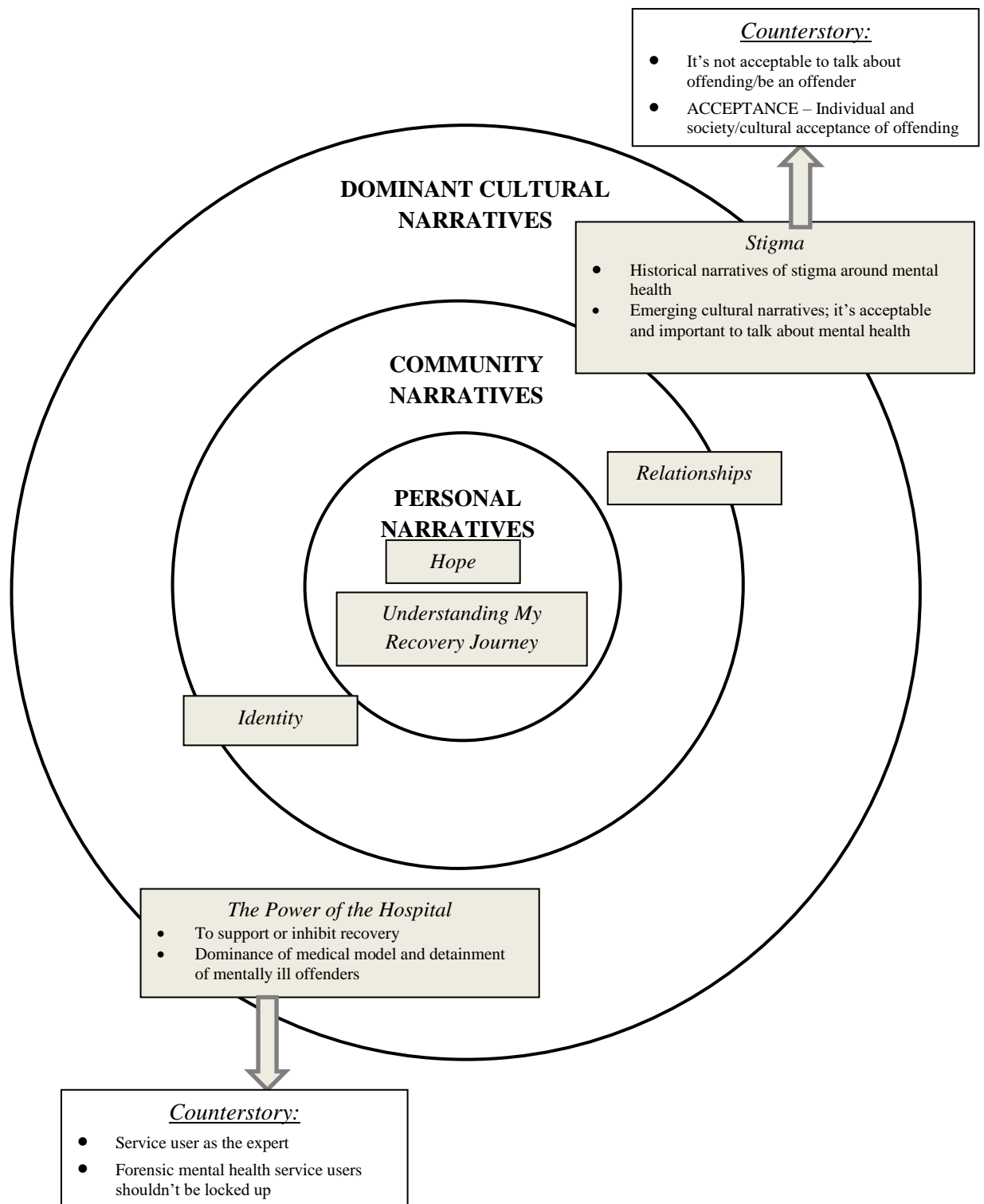


Figure 1. Visual Summary of Findings

- Relationships with peers in the hospital are also important in providing a sense of belonging for the participants. Relationships beyond the hospital provide important links to the community, which participants said was important in recovery.
- When participants were in hospital, it was important to have a role and a purpose. For some participants being in hospital led to seeing themselves as dangerous. For others, it meant finding comfort in not feeling alone in their experience of mental illness.
- When participants were in the community, having a sense of responsibility and independence, and taking control for managing their recovery provided them with a positive identity.
- Participants experienced stigma from both within and beyond the hospital for having a mental illness. For example, being seen as a 'loony' or a 'nutter'. It is suggested that these stereotypes are part of society's historical stories of mental illness. However, recently there has been an increased awareness of and openness about mental illness. This can be seen in a number of high profile media campaigns encouraging people to talk about mental illness. Participants in this research spoke about the importance of not feeling shameful about asking for help and opening up about their mental health.
- In contrast however, participants generally did not speak about their offending. It is suggested that although society is now more accepting of mental illness, it is still not accepting of offending behaviour. This places people who have mental illness and have offended in an interesting position –where recovery can openly include stories about mental illness, but not about offending.
- Participants spoke about how powerful the hospital was. For some, this was positive as the hospital was powerful in providing a second chance or an opportunity to recover. For others, the power of the

hospital meant that they had to 'tick the boxes' in order to recover, and 'play the game' the way the hospital wanted. Interestingly, three of the participants took both positions that the hospital was supportive of and detrimental for their recovery. Compliance with the medical model (where psychological problems are treated the same as physical problems) was seen as important, including for instance taking medication.

- Participants did not always feel that they had a say in their care, despite feeling that they were the expert on their experience. A counterstory to the medical approach of treating these patients was that detaining offenders with mental illness is not the most appropriate way to support recovery.

Conclusions

Forensic mental health patients have two recovery tasks; to recover from their mental health difficulties and to recover from their offending. Culturally, it is more acceptable to talk about and recover from mental health difficulties, than it is to be a recovered and rehabilitated offender. This means that people in forensic mental health services face unique challenges in recovery.

Limitations

The number of people in the research was small, hearing the stories of 5 men. This means that applying the findings beyond these individual stories may be difficult. The participants invited to take part in the research might not be entirely representative of everyone who uses forensic services. Furthermore, the researcher was not able to verify the results of the research with the participants in order to check for accuracy and quality control for misunderstandings in the stories told. The researcher has a background of working therapeutically within forensic settings. This may mean that the researcher was biased in hearing and looking for stories of offending within the stories told.

Clinical Implications and Recommendations

- Staff in forensic services have an important role in enabling patients to feel hopeful about their futures. Development of open and genuine relationships gives patients hope.
- Forensic services must acknowledge that the nature of the forensic setting means that service users feel less powerful in having a voice in their care. Services must consider the extra steps required for forensic settings so that service users can truly feel the expert. This will bring forensic services in line with policies on choice and self-management of care within the NHS.
- In considering how to measure the achievement of recovery within forensic services, it is important to acknowledge the individual differences in how service users define and understand their recovery journey. Specifically, it is important to consider how to work with service users whose perception of recovery does not fit with NHS or service understandings.
- Forensic services must model acceptance of offending behaviour as part of recovery. In doing this, staff should engage in open discussion around violence and offending. This will provide individuals the chance to consider how they can recover from offending. Having psychological work as the only place where offending is discussed means that the secrecy around stories of offending continues.
- On a societal level, much further consideration needs to be given to identify ways in which offenders can be reintegrated into society so that they can feel accepted. This is the only way that forensic mental health patients can truly recover. Services therefore have a role in creating and maintaining effective links with the community, in order to support successful reintegration into the community.

Sharing the Research

This executive summary will be disseminated to the low secure service used for the study, and more widely will be disseminated within that local Forensic Directorate. Participants who took part in the study and request a copy of the research will also receive a copy. This executive summary is also available as a short information sheet (see Appendix C.1)

Future Research

It is important that there is more research exploring the perspectives of forensic service users in order to fully understand recovery and the unique challenges in forensic settings. In particular, it would be helpful to conduct more research with discharged service users who are in the community. A longitudinal study, following participants over a number of years may help to further highlight recovery processes in the community. An interesting area for future research would be to explore the perspectives of those who have been recalled or have reoffended.

References

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Research Executive Summary

Narratives of Recovery: Capturing recovery stories from people who have used Forensic Mental Health Services

Introduction and Background

Recovery is an important concept in mental health. Recovery is living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Several researchers have questioned whether recovery principles can apply to Forensic Mental Health settings. There is hardly any research that asks what recovery means for those who use Forensic services. It is unclear how offending fits with what we know about recovery more generally.

Aims of the study

The aims of the study were to explore the recovery stories of people who have used forensic mental health services and find out:

1. What are the recovery stories of people who have used forensic mental health services and now live in the community?
2. What does recovery mean for service users?
3. What factors influence recovery?

Limitations

- ◆ Small sample size
- ◆ Researcher didn't check the results with participants to check accuracy
- ◆ Potential participants were identified based on others perceptions of them—maybe this led to a bias in recruitment and not selecting those with different or more challenging recovery stories

Methodology

5 Male participants who had been discharged from a Low Secure Forensic Mental Health Service were asked to tell their recovery story.

The recovery stories were analysed using a Narrative Methodology.

Narrative research is interested in:

- “ the way the stories are told
- “ what the stories say
- “ what the stories mean

The personal, community, and cultural shared stories of recovery were identified.

Findings

Personal stories of recovery:

- ◆ Being hopeful about the future
- ◆ Understanding my own recovery journey

Community stories of recovery:

- ◆ Relationships are really important for recovery, especially open and trusting relationships with staff
- ◆ My identity (sense of who I am) is shaped by my environment and is different when I am in hospital and when I am in the community

Cultural stories of recovery:

- ◆ It's ok to talk about mental health vs. it's not ok to talk about being an offender
- ◆ The hospital is powerful and both helps and doesn't help my recovery, BUT locking people up isn't the only way

Conclusion and Recommendations

Patients can feel stuck between talking about their mental health, but not about their offending. Services need to work with people's personal truths about what recovery means to them.