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RECOVERY EXPERIENCES OF FORENSIC MENTAL HEALTH SERVICE USERS.

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I would like to dedicate this to my mum, who was so proud of me for getting on the doctorate, and whom I miss dearly.

Summary of the Major Research Project

Section A: Emerging research into service users' recovery experiences suggests there are different aspects, aids and barriers to recovery for forensic mental health service users compared to general mental health populations. However, literature also suggests subgroups within forensic mental health populations may have additional needs/challenges to recovery. A systematic review was conducted exploring similarities and differences in recovery experiences between subgroups of forensic mental health service users. Thematic synthesis of 15 studies revealed common themes across subgroups, including: autonomy, relating to others, self-identity and hope. Differences between subgroups were found regarding diagnosis, age and offence. The implications of the findings are discussed.

Section B: Despite being over-represented in services, research into recovery experiences of forensic mental health service users of ethnic backgrounds is lacking. Semi-structured interviews were held with 10 forensic mental health service users of ethnic background to develop an understanding of their recovery experiences using a Grounded Theory approach. A model of understanding was developed in relation to the existing literature, with core categories of self, network, institution, recovery and individual context emerging. The model is discussed in relation to the existing research, with considerations unique to this subgroup of forensic mental health service users highlighted. Implications of the findings are explored.

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Section A:

Laura McKenzie-Smith BSc (Hons), MSc

Title: Recovery Experiences of Forensic Mental Health Subgroups

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Abstract

Background: Service users' recovery experiences have been used to the develop models of recovery for forensic mental health service users. However, literature suggests subgroups within this population may have additional needs/challenges to recovery.

Aim: This review aimed to explore similarities and differences in recovery experiences between subgroups of forensic mental health service users.

Methods: A systematic review was conducted of four electronic databases; PsycINFO, CINAHL, BNI and ASSIA. Manual searches of relevant journals were also conducted. In total 15 studies were identified. Quality appraisal was conducted using the CASP for qualitative research, and thematic synthesis undertaken to identify themes across the studies.

Findings: Common themes across subgroups included: recovery as a process, autonomy, relating to others, self-identity, stigma, health and intervention, activities, security and hope. Differences between subgroups were found regarding diagnosis, age and offence in terms of aids and barriers to recovery.

Implications: Subgroups of forensic mental health service users experience additional factors as aids/barriers to recovery. Therefore, service development should consider specific needs of different subgroups in developing recovery-oriented services. The lack of research into ethnic minorities' experiences is a particular omission given the over-representation of this subgroup in forensic mental health.

Keywords: forensic, recovery, experience, service-user, subgroup

Introduction

Recovery in Mental Health

The concept of recovery in mental health has its origins in the move from institutionalisation to community based care (Anthony, 1993). In a paper outlining the history and development of recovery-oriented mental health services, Anthony (1993) discussed that this move resulted in consideration of what was required to rehabilitate service users into the community, prompting holistic consideration of how mental illness impacted on different areas of service users' lives, rather than limiting focus to illness alone. From here, Anthony (1993) discussed that mental health services began to apply understandings of recovery as not limited to, or even requiring, clinical recovery. The recovery literature has since explored different understandings of recovery[1]. Lloyd, Waghorn, and Williams (2008), for example, referred to the literature on service user, carer and community perspectives on mental health in order to develop a conceptual framework of recovery which incorporated four domains; clinical recovery, functional recovery, social recovery and personal recovery. This framework has since been widely referred to in the recovery literature (e.g. Drennan & Alred, 2012). The different domains of recovery will be discussed below.

In their discussion of the recovery literature, Drennan and Alred (2012) describe clinical recovery as the traditional medical model view of recovery from symptoms of disease and illness, and has been discussed as the model upon which mental health services have traditionally been developed in Slade's (2009) guide on personal recovery for mental health

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[1] The concept of recovery has been criticised by some service user groups, such as the recovery in the bin (RITB) collective, who state the meaning of recovery has transformed from living a meaningful life to instead returning to being without difficulties. RITB argue that this definition places an emphasis on work ability whilst ignoring the social and political context that makes this difficult to actualise, resulting in oppression and stigmatisation of service users (Recovery In The Bin [RITB], 2017).

professionals. Functional recovery refers to the recovery of abilities necessary for activities of daily living, working and maintaining relationships (Drennan & Alred, 2012). This may involve working with occupational therapists and other professionals to develop skills to live independently and to return to employment. However, it is emphasised that ultimately functional recovery depends on the individual's own goals for rehabilitation (Lloyd et al., 2008).

Social recovery is understood to be the process of overcoming social exclusion and subsequent stigma and discrimination experienced by those with mental health difficulties (Drennan & Alred, 2012). Personal recovery refers to a person's ability to live a meaningful and satisfying life in spite of illness, and is described as a process and a journey, in which personal growth is core (Anthony, 1993). Slade (2009) identified four stages to personal recovery: hope, self-identity, meaning and responsibility, and outlines tasks which can support individuals in these stages; development of a positive identity separate to the person's diagnostic label, developing a personal meaning of the experience of illness which is understood as only part of the person, self-management of illness in which a person takes personal responsibility for seeking support, and the development of social roles which supports the development of self-identity.

Empirical evidence supports numerous interventions aimed at improving recovery, and are thus recommended for recovery-oriented services. These include the use of peer support workers, with randomised controlled trials (RCTs) noting improved engagement, hope, control and agency (Repper & Carter, 2011). RCTs also demonstrate benefits in terms of hope and quality of life in response to wellness recovery action planning (Cook et al., 2011) which involves defining wellness and goals at the individual level. The strengths model, supporting people to achieve self-set goals (Rapp & Goscha, 2006) also demonstrates improved psychosocial outcomes in RCTs (Modrcin, Rapp & Poertner, 1988; Macias, Kinney, Farley, Jackson & Vos, 1994).

However, these understandings of, and evidence for, recovery were developed with the

general mental health population in mind; the concept of recovery and recovery-oriented practices may be more difficult to apply to forensic mental health settings (Clarke, Lumbard, Sambrook, & Kerr, 2016).

Context of Forensic Mental Health Services

The Joint Commissioning Panel for Mental Health (JCP-MH) provides information for commissioners regarding the structure and remit of forensic mental health services, which may be provided in hospital, prison or community settings to people who have been assessed by the mental health and criminal justice system as experiencing a mental health disorder and who pose a risk to others due to their mental health difficulties (JCP-MH, 2013).

Services are organised according to various levels of risk, with high, medium and low secure services available depending on the level of risk the person is assessed as posing to others. High secure services are prisons and hospitals which house those deemed to require high secure conditions due to violent and dangerous behaviour. Medium secure services are a step down from high secure services and are provided for those with varying degrees of risk from those who are not permitted any leave due to their level of risk, down to those who have escorted or unescorted community leave in preparation for discharge into the community or low secure services. Low secure services are provided for those who do not require the level of security provided by medium secure services, and again focus on rehabilitation into the community. Community forensic mental health services are then available for those discharged from secure environments who often go on to community placements with varying degrees of support. Prison health services are also provided at varying levels of security and encompass specialist mental health teams.

Recovery in Forensic Mental Health

Recovery is a particular priority for forensic mental health services given that commissioning guidelines for services state that forensic mental health services should be person centred and recovery focused (JCP-MH, 2013), and recommend that recovery outcomes are used to evaluate progress to this end. This is further reflected in the standards

for forensic mental health services published by the forensic quality network for forensic mental health services (Royal College of Psychiatrists [RCN], 2019), and in the *'Five Year Forward View for Mental Health'* (Mental Health Taskforce, 2016), who recommend ongoing support for recovery in the least restrictive environment.

However, there are additional challenges to recovery for forensic mental health service users. One challenge is that service users may present with specific needs within different sections of the forensic mental health pathway, and recovery may hold different meanings at different points along the pathway. For example, recovery at the high secure point of the pathway may predominantly involve reducing risk and coming to terms with having an offender identity (McKeown, Jones, Foy, Wright & Blackmon, 2015), whereas medium and low secure services may focus more on rehabilitation into the community (JCP-MH, 2013).

A challenge for forensic mental health services is in supporting independence, responsibility and recovery, whilst containing risk and ensuring public protection in a restrictive environment. In their clinical experience, Mann, Matias and Allen (2014) discuss that this is a difficult balance to maintain, and suggest that practice tends to prioritise risk needs over therapeutic needs, at times leading to restrictive practice in order to manage staff anxiety around the consequences of a risk behaviour occurring. However, they discuss that such practice can hinder autonomy and choice, central components to the recovery concept. This is consistent with findings of the Centre for Mental Health's report *'Pathways to Unlocking Secure Mental Health Care'* (2011) who report risk-averse attitudes in Ministry of Justice (MoJ) staff as well as clinicians.

Another challenge to treating forensic mental health services in restrictive settings such as prison or secure hospitals poses is that perceptions of clinical recovery is judged by clinical teams. This process has been criticised by the Pathways to Unlocking Secure Mental Health Care report (Durcan, Hoare, & Cumming, 2011) for a lack of transparency in decisions regarding treatments, outcomes and discharge. Such criticisms have led to suggestions that the decisions regarding progression are fairly arbitrary, and highlights challenges of addressing

power differentials in recovery for forensic service users (Durcan, Hoare, & Cumming, 2011). Forensic mental health service users face the two-fold discrimination of having both a mental health diagnosis and an offence history (social factors), which can impact on their functional and social recovery, particularly in their ability to gain employment (Mezey & Eastman, 2009). Forensic mental health service users also have additional difficulties in accessing appropriate housing, occupying social roles and community and social inclusion (Mezey & Eastman, 2009). Drennan and Alred (2012) suggest that forensic service users also have the challenge of accepting the views of family members, victims' families and wider society, and may face restrictions as to where they may live, or be subject to monitoring of their personal relationships. As a result, they may fear discharge and rejection from the community.

Stigma has also been discussed as a barrier to personal recovery. Mezey, Kavuma, Turton, Demetriou, and Wright (2010), for example, used qualitative research to explore the views and experiences of recovery in forensic mental health service users and found stigma to be a barrier to the development of self-identity and hope, with service users expressing the view that those labels would stay with them, and may prolong their detention. Further, responsibility, as identified by Slade (2009) as a feature of personal recovery from mental ill-health, is more challenging when detained under the Mental Health Act (O'Hagan, 2004). O'Hagan (2004) discusses that limiting impact of detention on service users' ability to make choices and exert control in their lives. This research indicates additional challenges to forensic mental health service users' recovery beyond those experienced by the general mental health population.

These additional challenges to forensic mental health service users' recovery prompted Drennan and Alred (2012) to propose a fifth facet of recovery 'offender recovery'. This refers to the challenge that service users face in accepting that they have offended and recognising the need to learn from their mistakes and make changes to ensure that they do not offend in the future. This meaning of recovery also involves accepting the consequences of their offence, and is supported by forensic mental health service users accounts of awareness of the

impact of their offence on their victims and the desire to make amends (e.g. Ferrito, Vetere, Adshead, & Moore, 2012). These factors impacting on recovery have been discussed as applicable to the whole forensic mental health population, yet the population consists of service users with different demographics that may further influence their recovery experience.

The Role of Demographic Factors

There is an emerging evidence base, both from the general and forensic mental health literature, suggesting that different demographic subgroups may face unique challenges to recovery in forensic mental health service users. For example, Drennan and Alred (2012) discuss that clinical recovery may be perceived as more difficult for people with a diagnosis of personality disorder, as this diagnosis is characterised as being pervasive and persistent. In terms of clinical recovery, there is evidence from qualitative interviews of the experiences of forensic mental health service users with a diagnosis of personality disorder having been excluded from services (Shepherd, Sanders, & Shaw, 2017). Shepherd et al. (2017) further found that the diagnosis of personality disorder also impacted on personal recovery in terms of development of self-identity.

In another example, although all secure service users are vulnerable to stigmatising labels such as “aggressive” and “violent”, those detained within high secure services have been suggested to be even more stigmatised in this regard (Cromar-Hayes & Chandley, 2015). Further evidence of differences in recovery experiences come from lesbians, gay men and bisexuals (LGBs). LGBs have evidenced a higher prevalence of mental ill-health compared to heterosexuals (Meyer, 2003), suggested to be caused by “minority stress” – the impact of living in a stigmatising and discriminating social setting (Meyer, 2003). This research suggests that social recovery may be more challenging for these subgroups.

Implications for Services

Utilising recovery-oriented approaches in forensic mental health services has been found to improve engagement and outcomes (Gudjonsson, Savona, Green, & Terry, 2011), which has subsequent economic implications. Anthony (1993) notes that the key to understanding recovery needs of service users (crucial for service development) are the experiences of recovery from mental health service users.

Two recent reviews explored the literature looking at forensic mental health service users' experiences of recovery. Clarke et al. (2016) identified six superordinate themes from a total of 11 studies. These were: self-identity, connectedness, accepting the past, freedom, hope and health intervention. Shepherd, Doyle, Sanders and Shaw (2016) conducted a review and meta-synthesis of the literature with the aim of developing a model of the personal recovery processes for forensic mental health service users. Through reviewing five studies, they identified safety and security, hope and social networks, and self-identity as central themes to recovery.

By reviewing the existing literature into the recovery experiences of forensic mental health service users these reviews have developed an over-arching understanding of the needs and experiences of this population necessary for the development of recovery-oriented services. However, despite an emerging evidence base for the unique challenges faced by subgroups of forensic mental health service users in their recovery process, there is currently no review that explores the literature in terms of similarities and differences in recovery experiences across different subgroups.

Rationale

In summary, recovery within forensic mental health settings is multi-faceted. There are a range of factors that help or hinder recovery, such as hope, self-identity and restrictions. Many of these are seemingly consistent across the literature, as evidenced by previous reviews. However, there is emerging evidence suggesting differences in the recovery experiences across different subgroups of forensic mental health service users. Despite this,

there is currently no review that serves to develop an over-arching understanding of the literature in terms of similarities and differences in the recovery experiences of different subgroups of forensic mental health services users.

Aim

This paper reviews the literature available regarding forensic mental health service users' experiences of recovery, with the aim of identifying similarities and differences across different subgroups in order to answer the following questions:

1. What themes can be identified that apply across the recovery experiences of forensic mental health service users?
2. How do the subgroups of forensic mental health service users that have been explored by the literature differ in their experiences of recovery?

Methodology

Search Process

Databases ASSIA, British Nursing Index (BNI), CINAHL and PsycInfo were selected for their relevance to the field and were searched using the terms "Forensic" OR "Secure" AND "Recovery". These terms were searched for within abstracts to ensure relevance and were kept broad to ensure relevant material was not missed. "The Journal of Forensic Psychiatry and Psychology" and "Criminal Behaviour and Mental Health" were also searched using the above terms as relevant journals to the search query. The search was conducted in November 2018.

The inclusion and exclusion criteria (Table 1) was used to inform the search process.

Quantitative papers relying on measures of recovery were excluded as these were developed for non-forensic populations (e.g. the Mental Health Recovery Star; Burns, Onyemaechi, Okonkwo, & MacKeith, 2011). As recovery for forensic mental health service users differs from the general mental health population (e.g. Mezey et al., 2010), these studies may as a result lack forensic specific considerations. Focus groups were excluded as

they have the potential for conformity, thus reducing the validity of the individual's account of their experience (Smithson, 2000). Articles referring to staff experience as well as service user experience were included, with service user experiences extracted for the search query.

Table 1. Inclusion and Exclusion Criteria

Inclusion	Exclusion
Forensic population	Non-forensic population
Service user experience of recovery	Quantitative papers relying on measures of recovery
English language	Service user experience of an intervention or activity
Peer reviewed	Focus group
	Non-peer reviewed
	Non service user perception (e.g. staff or family)

The PRISMA diagram in Figure 1 outlines the search process. Titles of search results were selected based on relevance to forensic mental health service users' experiences of recovery. If unclear, the article was selected to be reviewed at the abstract level. Abstracts were reviewed according to the inclusion and exclusion criteria and duplicates and non-peer reviewed articles were removed. The full-texts of the remaining articles was then accessed and assessed for eligibility.

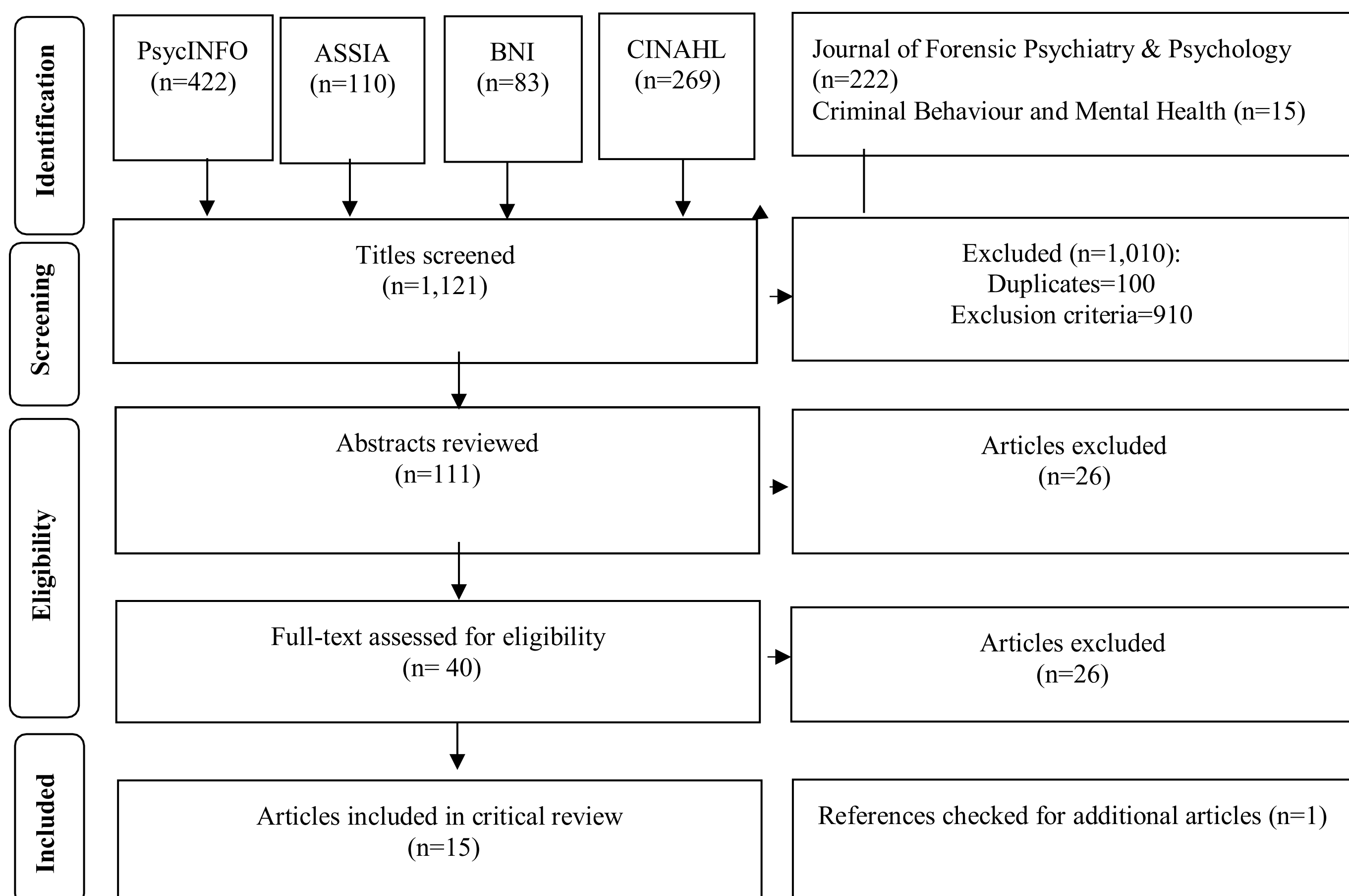

Figure 1. PRISMA diagram outlining search process

Quality Assessment

Quality of the identified studies was assessed using the Critical Appraising Skills Programme (CASP) criteria for evaluating qualitative research (CASP, 2006), and a summary of this assessment can be found in Appendix A. It must also be noted that appraisal tools are argued themselves to be controversial and subjective (e.g. Barbour & Barbour, 2003; Thomas & Harden, 2008), as what is considered as good research changes over time (Barbour & Barbour, 2003). As such, it has been argued that influential research that would previously have been considered may be neglected despite still potentially contributing theoretical understandings (Barbour & Barbour, 2003). In addition, there is a lack of evidence to justify exclusion based on quality assessment (Thomas & Harden, 2008). Therefore, consistent with the previous reviews into forensic mental health service users' experiences of recovery, the quality assessment was not used as a means to exclude studies from the review, but rather to consider the limitations of the literature and implications for further research.

Data Synthesis

Data were synthesised through thematic analysis, also known as thematic data synthesis (Thomas & Harden, 2008). This was achieved in a number of steps. First, initial codes were identified. There are different methods for identifying initial codes in qualitative data synthesis, and for the purposes of this analysis each article was scanned for key concepts (Campbell et al., 2003) described by service users as involved in recovery, as this was the focus of the review. These were not limited to the main themes that each article generated, but also sub-themes and initial codes. These initial codes were then developed into descriptive themes followed by the application of analysis to develop analytical themes, combining codes where appropriate in relation to the wider recovery literature (see Appendix B for a table outlining theme progression). Where studies included staff or non-forensic mental health service user views, only forensic mental health service user views were included.

The purpose of synthesising qualitative data is to develop an over-arching understanding of concepts across a range of studies (Thomas & Harden, 2008), important for summarising

themes consistently across qualitative literature that may have applied different qualitative and interpretive methods, and which may have also described the same concepts using different terms.

Findings

Overview of Identified Studies

Reviewed papers (n=15) were qualitative, conducted in three countries including the UK (n=13), Canada (n=1) and Sweden (n=1). Participants were recruited from a range of settings including high (n=5), medium (n=4), and low (n=1), secure hospitals as well as a specialist learning disability low secure service (n=1), and prison (n=1). Two studies also recruited participants from all levels of security (high/medium/low) and one study did not specify the setting. Sample sizes varied in range (1-30) depending on type of methodology used, methods included case report (n=1), content analysis (n=1), IPA (n=3), Grounded Theory (n=1), Thematic Analysis (n=6), Grounded Theory using a social constructionist approach (n=1) and Thematic Analysis combined with Narrative Analysis (n=1). One study did not specify the methodology. A summary of included articles can be found in Appendix C.

Participant demographics for each study are provided in Appendix C. Only one study reported full demographic information. Although some studies' participant demographics are representative in terms of gender and ethnicity, no articles focus on these population-specific experiences of recovery. Table 2. outlines which subgroups of demographics were explored in the studies identified.

Table 2. Breakdown of studies according to demographic and subgroup focus

Demographic	Subgroup	Number of studies
Setting and security (n=8)	Low secure	1
	Medium secure	3
	High secure	2
	Other countries	2
Diagnosis (n=5)	Psychosis	1
	Asperger syndrome	1
	Dual diagnosis & recall	2
	Personality disorder	1
Age (n=1)	Older adult	1
Offence (n=1)	Homicide	1

Quality Assessment

There was variability in the quality of the studies identified. For example, the study by Shepherd, Sanders, and Shaw (2017) had clear and relevant aims and appropriate, justified methodological design. The study had a clear and in-depth description of their data analysis as well as the findings and a discussion of reflexivity and co-construction of phenomena. Clarke, Sambrook, Lumbard, Kerr, and Johnson (2017), Di Lorito, Völlm, and Dening (2018), Laithwaite and Gumley (2007), Mezey et al. (2010), and O'Sullivan, Boulter, and Black (2013) also demonstrated clear and relevant aims, justifiable methodological design, appropriate recruitment and clear findings.

Other studies, such as McKeown, Jones, Foy, Wright, Paxton, and Blackmon (2016), lacked justification of the relevance of the study or the methodological design and recruitment, and failed to explain the data analysis in depth or discuss the credibility of the findings. The study by Chiringa, Robinson, and Clancy (2014) also provided limited justification for the research and its methodological approach, and further did not discuss ethical issues. Barsky and West (2007) lacked explanation of how participants were recruited, how ethical issues were considered and the credibility of their findings. Kelbrick and Radley (2013) conducted a case study of forensic rehabilitation in Asperger syndrome. As this review seeks to review literature reporting service users' experiences of recovery, this study met the inclusion criteria as some views of the service user, although limited in number, were included. The limited inclusion of the service user's views may reflect communication difficulties experiences by those with Asperger syndrome. As a case study, many of the quality assessment criteria were not applicable; however; the study still did not discuss ethical issues or the potential biases of the authors, and further did not explain how the participant described in the case study was selected. The implications of the lack of ethical consideration, reflection of researcher bias, and consideration of validity of the findings found in many of the included studies is discussed below.

The use of reflexivity in qualitative research is particularly important as qualitative data

analysis is based on the assumptions and the meaning the researcher attributes to the data (Mauthner & Doucet, 2003), which may differ to the meanings held by participants and other researchers, which may subsequently impact on the validity of the interpretations. Researchers may attempt to control for this bias by demonstrating how their interpretations were reached through the use of reflection (Mauthner & Doucet, 2003) and by providing adequate contextual examples of service user views. Most of the studies rated as high in quality demonstrated the use of reflexivity in some form, such as the use of a reflexive journal (e.g. Clarke et al., 2017). However, most studies lacked consideration of researcher biases due to the omission of transparency of the analysis process and lack of consideration of personal biases. This means that validity of the findings cannot be assumed by the reader.

This apparent lack of reflexivity in much of the literature is problematic in that researchers' assumptions and experiences may bias their interpretations of their data, and may lead researchers to pay more attention to data they assume to be important. This has implications for forensic mental health service users in particular who are a marginalised and stigmatised population. This has implications when using such research to inform service development, as this may be argued to reflect service users' views when due to the lack of reflexivity, findings assumed to reflect the views of service users actually reflect researchers' biases.

Additionally, whilst most studies confirmed ethical approval, they did not all discuss specific ethical issues that may arise from interviewing forensic mental health service users. This is a crucial omission, given that forensic settings give rise to particular ethical challenges; such as capacity to consent, which is compounded by issues of power and control, and the inevitable coercive nature of services (Coffey, 2006). Such issues may lead forensic mental health service users feeling that they are unable to decline to participate in research for fear of this reflecting badly on their progress, and may have consequences for how much service users feel able to share within an interview with an unequal power balance.

Conflict of interest is also an issue which may result in biased interpretation of results where results may lead to profit, publication or funding (American Psychological Association [APA], 2019). In such cases, it may be in researchers' interests to interpret data in a certain way, for example, in a way that presents their service in a favourable light. Many studies did not state whether there were any conflicts of interest from the researchers (e.g. Barsky & West, 2007; Nijdam-Jones, Livingston, Verdun-Jones, & Brink, 2015; Turton et al., 2011), which further impacts on the degree to which the findings within these studies may be considered valid, as potential conflicts of interests may have influenced the interpretation of the data. Those that did make a statement regarding conflict of interest declared no conflicts (e.g. Clarke et al., 2017; Di Lorito et al., 2018; Olsson, Strand, & Kristiansen, 2014), strengthening the validity of their findings.

Reflexivity of the Reviewer

As this review includes qualitative methodology in synthesising the data, it is important to consider potential biases of the reviewer. The reviewer has no conflicts of interest to declare; however, biases in the analyses of the included studies may be understood in the context of the reviewer's familiarity with the literature and previous experience of working within a forensic mental health setting. This is important to consider as the reviewer heard service users' experiences that may have influenced the reviewer's understanding of recovery in this population. Attempts were made to control for potential biases on the part of the reviewer by the use of a reflective journal and research supervision.

Themes

Themes emerging from the recovery experiences of service users included the following: Recovery as a process, autonomy, relating to others, self-identity, hope, intervention and health, activities, security and stigma. An overview of studies supporting each theme can be found in Table 3. The development of these themes will be discussed in relation to the literature.

Table 3. Themes generated and percentage of studies that support each theme.

Study	Theme								
	Process	**Autonomy**	**Relating to others**	**Self-identity**	**Hope**	**Intervention & Health**	**Activities**	**Security**	**Stigma**
Barsky & West (2007)	x	✓	✓	✓	✓	✓	✓	✓	✓
Chiringa et al. (2013)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Clarke et al. (2017)	✓	✓	✓	✓	✓	✓	x	X	✓
Di Lorito et al. (2018)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Ferrito et al. (2012)	x	✓	✓	✓	✓	✓	x	X	✓
Kelbrick & Radley (2018)	x	x	✓	✓	X	x	x	✓	x
Laithwaite & Gumley (2007)	✓	x	✓	✓	✓	✓	✓	✓	x
McKeown et al. (2016)	x	✓	✓	✓	✓	✓	✓	X	X
Mezey et al. (2010)	✓	x	✓	✓	✓	✓	X	✓	✓
Nijdam-Jones et al. (2015)	✓	✓	✓	✓	✓	✓	✓	✓	✓
O'Sullivan et al. (2013)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Olsson et al. (2014)	✓	✓	✓	✓	✓	✓	✓	✓	x
Shepherd et al. (2017)	X	X	✓	X	X	✓	X	X	X
Turton et al. (2011)	✓	✓	✓	✓	✓	✓	x	x	✓
Percentage	64%	71%	100%	93%	86%	93%	57%	64%	64%

Process. Approximately two thirds of the literature discussed recovery as a process (e.g. McKeown et al., 2016; Turton et al., 2011), and spoke about moving from a place of experiencing mental ill- health and rejecting the need to change, to accepting the need to change and working towards goals. This view of recovery as a process is consistent with literature into recovery in general mental health, in which Shepherd, Boardman, and Slade (2008) propose stages of recovery from feeling hopeless to becoming aware of possibilities and working on goals and developing a self-identity, until the person is living a meaningful life. Uncertainty regarding the length of detention (Clarke et al., 2017; Nijdam-Jones et al., 2015; Olsson et al., 2014), was discussed as a difficulty in relation to the process of recovery, drawing contrasts to the experiences of forensic mental health services compared to prisoners, with forensic mental health service users having no set release date, whereas prisoners have an earliest release date that they can use as a guide to their length of stay (Clarke et al., 2017).

Autonomy. Independence in terms of having responsibility over daily activities appeared to be important for recovery (Di Lorito et al., 2018; McKeown et al., 2016), with this theme emerging from more than two thirds of the literature. However, service users also expressed a sense of disempowerment, in which they felt a lack of control in their lives (O'Sullivan et al., 2013; Tapp, Warren, Fife-Schaw, Perkins, & Moore, 2013). This theme appears to support the recovery literature in which having some form of control over mental illness and in life is proposed as a core component of recovery (Shepherd et al., 2008).

Relating to others. Relationships with others was a clear theme that emerged; highlighted as playing a role in recovery in all of the literature reviewed. Supportive relationships with staff appear to be experienced as an aid to recovery (e.g. Clarke et al., 2017; Ferrito et al., 2012), with this seeming to help service users to feel valued and respected, in turn influencing how service users viewed themselves (Clarke et al., 2017). Social inclusion seemed to be experienced as promoting recovery (e.g. Mezey et al., 2010; Turton et al., 2011), with Mezey et al. (2010) noting that service users experienced belonging, acceptance and inclusion within the hospital. This is

appears to be consistent with the literature. into social recovery, in which overcoming social exclusion is seen as key (Drennan & Alred, 2012).

Self-identity. Self-identity separate to the label of "offender" or "mentally ill" also seemed to be perceived as important to recovery (Clarke et al., 2017), with all but one of the studies making reference to self-identity in relation to recovery. However, developing hope and self-identity appeared to be experienced as challenging in the face of disempowerment (O'Sullivan et al., 2013) and loss of freedom (Clarke et al., 2017). This may be related back to the literature into recovery from mental health in which Shepherd et al., (2008) discuss the development of a positive self-identity as another component to personal recovery.

Hope. Hope also emerged as a strong theme in the literature, with only two studies making no reference to hope in relation to recovery. Hope seemed to be perceived by service users as promoting recovery (e.g. Clarke et al., 2017; Di Lorito et al., 2018; Mezey et al., 2010; Turton et al., 2011), with service users appearing to express the importance of feeling hopeful and their future (Mezey et al., 2010). However, developing hope and self-identity appeared to be experienced as challenging in the face of disempowerment (O'Sullivan et al., 2013) and loss of freedom (Clarke et al., 2017). Again, this theme seems to reflect similarities to the recovery literature in mental health in which hope is a central component (Shepherd et al., 2018) and is widely discussed in the literature as an important yet challenging component to recovery in forensic settings (e.g. Drennan & Alred, 2012). The findings from studies in this review appear to support the suggestion that hope may be more difficult to hold on to for forensic mental health service users.

Intervention and health. Almost all the studies reviewed (93%) made some reference to the role of interventions on recovery and physical or mental health. Therapy was discussed across the literature as a positive factor to clinical recovery (e.g. Laithwaite & Gumley, 2007; Olsson et al., 2014; Tapp et al., 2013), with service users explaining that talking therapies could promote self-understanding and anger management (Tapp et al., 2013). Whilst medication seemed to be perceived as having a positive role in clinical

recovery (e.g. McKeown et al., 2016; Olsson et al., 2014; Turton et al., 2011), side effects of medication was seen as a barrier to recovery (e.g. Tapp et al., 2013; Turton et al., 2011, with service users noting long term side effects such as the slowed speech (Turton et al., 2011).

Activities. Activities was a theme identified from just over half the studies reviewed. In the studies that highlighted activities as important to recovery, service users appeared to speak positively about being involved in meaningful activities (e.g. Barsky & West, 2007; Nijdam-Jones et al., 2014), with occupying jobs within services seemingly experienced as positive (Barsky & West, 2007). On the flip side, a lack of activities appeared to be experienced as unhelpful (e.g. Chiringa et al., 2014; Nijdam-Jones et al., 2014), with this being linked to offender recovery (Nijdam-Jones et al., 2014). Meaningful activities seemed to be experienced as helpful to reduce re-offending, with boredom experienced as a result of a lack of meaningful activities (e.g. Chiringa et al., 2014), leading to "mischief" (Kelbrick and Radley, 2013). This seems to clearly link offender recovery to functional recovery.

Safety and security. Nearly two thirds of the study reviewed found issues of safety and security to relate to recovery experiences. Hospital admission appeared to be experienced as both a help and a barrier to clinical recovery. As a barrier, hospital admission seemed to be experienced as taking away service users' sense of normality (O'Sullivan, 2013), yet at the same time took away the pressures of the real world (Mezey et al., 2010; O' Sullivan, 2013) and allowed service users to focus on their mental health. Hospital constraints seem to pose clear challenges to the clinical recovery of forensic mental health service users (e.g. Di Lorito et al., 2018; Laithwaite & Gumley, 2007), with Di Lorito et al. (2018) finding that service users experienced constraints as to what they could and could not do within secure settings.

Stigma. Stigma also appeared to be a common experience (e.g. Di Lorito et al., 2018; Ferrito et al., 2012; O'Sullivan et al., 2013), with the theme emerging from nearly two thirds of the studies. These studies indicated service users perceive that they are treated negatively

and judged because of their offence or diagnosis (Ferrito et al., 2018). This is supported by evidence of public perceptions of offenders with mental health difficulties (Brooker & Ullmann, 2008), in which surveys revealed that 84% of respondents thought that tolerance towards those with mental health difficulties was important, dropping to 32% for those who had mental health difficulties and had committed an offence.

Subgroup differences

There seemed to be unique differences within these themes between subgroups. This was most notably in regards to demographic factors, such as diagnosis, age and offence rather than level of security. This may be because the different settings house a variety of these demographics and thus give rise to more generic, over-arching recovery themes. These will be explored in turn below.

Offence. In regards to offence, homicide perpetrators appeared to place a heavier emphasis on making amends as an important process in their recovery (Ferrito et al., 2012). They also cite loss of control and feelings of detachment as barriers to recovery, particularly offender recovery, as these themes were identified as being linked to their experience at the time that they committed the offence (Ferrito et al., 2012).

Age. Older adults seemed to place more emphasis on nature, age specific activities, befriending services and spirituality as important to recovery (Di Lorito et al., 2018). Barriers to recovery in this population appeared to include age discrimination, inaccessible activities with activities geared towards younger populations, lack of staff understanding of age related issues and subsequent unmet age related needs, age differences in peers and intergenerational differences, and restricted ways to meet sexual needs (Di Lorito et al., 2018). These themes seem to indicate that social and functional meanings of recovery are more challenging for this population.

Diagnosis. Diagnosis is a way of conceptualising mental health difficulties by categorising these according to clusters of symptoms and giving these clusters of symptoms diagnostic labels which are then used to plan treatment (Johnstone & Boyle, 2018). As such,

people with different diagnoses may present with different difficulties and needs. It is important to note, however, that diagnostic labels are controversial due to problems with their reliability and validity, and that each individual's experience will be different regardless of whether they have the same diagnosis (Cooke, 2016; Johnstone & Boyle, 2018). Despite this,

people with the same diagnoses may face similar challenges, such as the stigma that comes with a specific label and the internalisation of the particular label (Johnstone & Boyle, 2018). Thus exploring the experiences of those with similar diagnoses may highlight particular experiences of that subgroup. Indeed, diagnoses of dual diagnosis, Asperger syndrome, personality disorder and psychosis were found to demonstrate differences within the identified themes.

Dual diagnosis. Those with mental health difficulties with comorbid substance use problems report avoiding negative influences as a way to help recovery (O'Sullivan et al., 2013). Addiction, use of substances and conflicting cultural views around the use of substances are cited as barriers to recovery (Chiringa et al., 2014; O'Sullivan et al., 2013). These themes suggest differences in clinical and social recovery compared to the general forensic mental health population, but also suggest cultural differences, which have not been explored in research.

Asperger syndrome. Learning of social rules and consequences is stated as important to the service user with Asperger syndrome, which suggests that social recovery poses unique challenges to those on the autistic spectrum (Kelbrick & Radley, 2013). This is not necessarily surprising, as impairment in social interaction is one of the triad used for the diagnosis of autistic spectrum disorders (Leekam, Libby, Wing, Gould, & Taylor, 2002). As such it may be considered that factors aiding social recovery are particularly relevant for this sub group. These factors may be uniquely different to the factors promoting social recovery in the general forensic mental health population, and service development would need to tailor approaches to the specific needs of this subgroup.

Personality disorder. Personality disorder diagnosis is discussed as a barrier to recovery, both due to clinical, functional and social implications. In terms of barriers to clinical recovery, personality disorder may be viewed as more difficult to recover from clinically, if at all, compared to the other mental health diagnoses (Shepherd et al., 2017). Additionally, the diagnosis is associated with increased stigma and discrimination, and subsequently is linked to social and functional difficulties in terms of gaining employment and developing relationships (Shepherd et al., 2017).

Psychosis. Those with a diagnosis of psychosis seemed to place more emphasis on trust issues, appearing to regard this as more difficult due to paranoid thoughts and beliefs (Laithwaite & Gumley, 2007), suggesting additional challenges for social recovery. Mistrust is often observed in service users with a diagnosis of psychosis, with the literature suggesting that this may account for poor medication compliance (Moritz et al., 2012). As such, psychosis may result in additional challenges to clinical recovery also.

Discussion

Summary and Synthesis

This literature review synthesised the findings from 15 qualitative studies exploring forensic mental health service users' experiences of recovery, and identified nine themes through the process of thematic data synthesis: process, autonomy, relating to others, self-identity, hope, intervention & health, activities, security and stigma. Within these themes, promoting and challenging factors for recovery were identified. These themes had support from both the forensic and generic mental health literature. The recovery experiences discussed also reflected the different aspects of recovery in forensic mental health; clinical, functional, social, personal and offender recovery. Although many factors identified as helping or hindering recovery were common across the forensic mental health population, some differences were found in the recovery experiences of subgroups within this population. Diagnosis, age and offence type were demographics that posed unique challenges to recovery.

Although the studies included in the review varied in their quality, similar themes were found across the studies, which can be argued as an indicator of validity of both the studies and the themes identified. Despite this, the clear reporting of methodological design and data analysis, in addition to the consideration of the potential biases of the researchers within qualitative studies, is imperative in qualitative research to ensure validity (Coffey, 2006), and this was found to be lacking across several studies. Further, despite ethical concerns of conducting research with forensic mental health service users (Coffey, 2006), little was done to explore these particular issues in-depth, and reference to ethical considerations was mostly limited to acknowledging that ethical approval had been granted.

Strengths and limitations

The limitations of this review are that quality assessment and data synthesis was completed by one reviewer. Nevertheless, the findings of this review identify common factors influencing recovery across forensic mental health service users which have been identified by previous reviews in the area. In addition, a reflective journal and research supervision was used to attempt the limit the impact of any biases/assumptions on the part of the reviewer that may impact on the validity of the findings. Another limitation of the review is the small sample size of subgroups.

Although this reflects the limited research and the need for further research in this area, the small pool of studies included limits the extent to which generalisations about subgroups may be made.

Research Implications

Many of the studies lacked consideration of researchers' biases, ethical issues and discussion of validity. As such, future research considering these issues are required in order to enhance the validity of the evidence base. Future research would benefit from in-depth descriptions of the analysis process in order to improve transparency and the ability for readers to identify how interpretations were made (Coffey, 2006). Including reflective accounts would help readers to make sense of this process, and any limitations to interpretation. Discussion of ethical issues within forensic settings, such as the potential for

captive audiences to feel compelled to participate (Coffey, 2006), is important to note, but also to consider in methodological planning in attempting to compensate for these issues.

Despite being a research area that has been highlighted as important for service development (Anthony, 1993), this review indicates that there is still a paucity of research into recovery in forensic mental health service users, with just 15 studies identified. This review highlights an even greater gap exploring specific challenges to recovery of particular subgroups within this population, despite evidence clearly suggesting that service user characteristics has an impact on recovery experience and that different subgroups may have particular needs or challenges that influence recovery.

Despite the evidenced differences in recovery experiences across different participant characteristics, no research has explored the differences in recovery experiences of forensic mental health service users from minority ethnic backgrounds. This is an important consideration given that this population is over-represented in forensic mental health environments (Rutherford & Duggan, 2008), as such future research exploring the recovery experiences of forensic mental health service users from minority ethnic backgrounds would be beneficial in identifying similarities and differences with the forensic mental health literature, and may also be helpful in identifying specific needs of this population which may be used to improve recovery-oriented services and outcomes for this subgroup.

Clinical and Service Implications

Recovery has been identified as a priority for forensic mental health services, with policy reports, commissioning guidelines and quality standards stating that forensic mental health services should be recovery focused (Centre for Mental Health, 2011; JCP-MH, 2013; RCN, 2019). As such, this review has identified themes important to recovery for forensic mental health service users that have significant clinical implications for the development of recovery-oriented forensic mental health services.

This review has also identified that subgroups of forensic mental health service users may face particular challenges to the different areas of recovery that differ to the general

forensic mental health population and may therefore find additional factors to be an aid or a barrier to recovery, which has further clinical implications for forensic mental health services. For example, meaningful activities were highlighted across the literature as a support to recovery, with a lack of activities linked to re-offending (e.g. Chiringa et al., 2014) and prolonged hospital admissions (Centre for Mental Health, 2011), yet older forensic mental health service users experiences challenges to engaging in activities due to their inaccessibility (Di Lorito et al., 2018). This may therefore increase recidivism in this population, with implications of risk to the public and costs to the service.

Connecting to others was identified as another theme common across the literature, with social inclusion and positive relationships with staff both linked to better recovery experiences (e.g. Clarke et al., 2017; Mezey et al., 2010). However, this was found to be more challenging for those who had committed homicide, who reported feeling detached (Ferrito et al., 2012), for those with a diagnosis of psychosis who felt mistrustful of staff and services (Laithwaite & Gumley, 2007), and for those with a diagnosis of personality disorder who experiences stigma and discrimination in relation to their diagnosis (Shepherd et al., 2017). Services whose staff are respectful and caring may help to mitigate these difficulties (Laithwaite & Gumley, 2007). However, Drennan and Wooldridge (2014) highlighted the importance of services providing clinical supervision and reflective practice in order to support staff to support and develop therapeutic relationships with service users who may frequently present as challenging to work with.

Given the themes that emerged from the thematic synthesis, implications for clinical practice include practice to promote autonomy in service users, including involving service users in their care planning, developing shared goals to promote hope, and maximising as far as possible choice in their daily routine whilst balancing this with security. Security was also a theme that emerged, thus involving service users in their risk assessment and discussions around balancing security with autonomy may be beneficial. Adopting the boundary seesaw model (Hamilton, 2010), which encourages balancing of relational and physical security, may be helpful in managing the reported risk-averse attitudes (e.g. Centre

for Mental Health, 2011) in staff teams.

As service users seemed to find relationships with others helpful in promoting recovery, it may be beneficial to maximise opportunities for interactions with staff and peers, such as the use of group social activities involving both service users and staff.

Since self-identity appeared to be a consistent theme across the research in promoting recovery, offering therapy to service users may provide service users with the opportunity to develop self-understanding, as suggested by Tapp et al., (2013).

Clinical implications that may be helpful to specific subgroups include the use of restorative justice approaches (e.g. Cook, Kang, Braga, Ludwig & O'Brien, 2015) to working with homicide offenders, who seemed to place more emphasis on the importance of making amends. For older age forensic mental health service users, providing opportunities to engage in activities related to nature, such as gardening, and offering spiritual and befriending services may help promote recovery.

Systemic implications are also relevant regarding stigma, particularly for those with a diagnosis of personality disorder who report discrimination in relationships and employment. This finding has implications both on a clinical and a societal level in which shifts in understandings around diagnoses may be helpful. To such an end, adopting the Power Threat Meaning Framework (Johnstone & Boyle, 2018) may be helpful in promoting alternative understandings of stigmatised labels.

Conclusion

Given the themes that emerged from the thematic synthesis, implications for clinical practice include practice to promote autonomy in service users, including involving service users in their care planning, and maximising as far as possible choice in their daily routine whilst balancing this with security. Security was also a theme that emerged, thus involving service users in their risk assessment and discussions around balancing security with autonomy may be beneficial. Additionally, hope and autonomy may also be promoted by developing shared goals with service users.

As service users seemed to find relationships with others helpful in promoting recovery, it may be beneficial to maximise opportunities for interactions with staff and peers, such as the use of group social activities involving both service users and staff.

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Section B:

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Title: Understanding recovery experiences of forensic mental health service users of ethnic background

Word count: 7,965 (1,234)

Abstract

Background: Current models of recovery are based on forensic mental health service users' experiences. However, there is a lack of research into the experiences of those from ethnic minority backgrounds, despite over-representation within forensic mental health settings.

Aim: This research aimed to develop a framework for understanding recovery experiences of forensic mental health service users from a minority ethnic background.

Methods: Upon gaining ethical approval, semi-structured interviews were held with 10 participants. The data were analysed using a critical realist approach to Grounded Theory.

Findings: Five core categories were identified; the self, the network, the institution, recovery as a process, and the individual context. Similarities were drawn to existing models in which the self, network and institution interact to influence recovery. Differences were found regarding stigma. Individual context influenced the process, with cultural considerations regarding food, alternative treatments and spiritual beliefs playing an important role, as well as individuals' experiences of adversity.

Implications: It is concluded that the developed framework provides an initial understanding of the recovery experiences of forensic mental health service users from minority ethnic backgrounds which can be used to develop services to meet the unique needs of this subgroup. Future research expanding on these findings is discussed.

Keywords: forensic, recovery, ethnicity, service-user, experience

Introduction

Recovery in mental health

The understanding of recovery as a concept within mental health has changed over time (Anthony, 1993). In a paper outlining the movement towards recovery-oriented mental health services, Anthony (1993) discussed the needs of people with mental illness as transcending treatment for clinical symptoms of illness. He discussed the often detrimental impact of mental illness on multiple aspects of people's lives including; their social life, employment and education, and personal identity, and suggested that recovery-oriented services should address these issues. Whilst his suggestions have been incorporated into mental health policy (e.g. Shepherd, Boardman, & Slade, 2008), Drennan and Alred (2012) discuss that in their clinical experience additional considerations are required of recovery-oriented services within forensic mental health services. They drew on the recovery literature from forensic mental health settings to propose a model of 'secure recovery'.

Secure recovery

'Secure recovery' refers to the concept of recovery within forensic mental health settings, and draws parallels with the general mental health literature in referring to clinical, functional, social and personal aspects of recovery (Drennan & Alred, 2012). However, Drennan and Alred (2012) suggest that forensic mental health service users experience additional challenges to social and functional recovery, such as the stigma of being labelled as a mental health service user and as an offender. Accounts of forensic mental health service users' experiences of recovery supports the suggestion that this double stigma acts as a barrier to recovery (Mezey, Kavuma, Turton, Demetriou, & Wright, 2010). Another challenge expressed by forensic mental health service users is the involvement of the criminal justice system which can lead to conditions being placed on a person's discharge (O'Sullivan,

Boulter, & Black, 2013). O'Sullivan et al. (2013) described this as adding to service users' sense of powerlessness.

Drennan and Alred (2012) further propose an additional aspect of recovery for forensic mental health service users: offender recovery. Offender recovery refers to coming to terms with the offence and its consequences. The concept is supported by forensic mental health service user accounts of awareness of the impact of their offence and the desire to make amends (e.g. Ferrito, Vetere, Adshead, & Moore, 2012). More recently, two recent reviews exploring forensic mental health service users' experiences of recovery identified themes such as self-identity, connectedness and hope as important to forensic mental health service users' recovery (Clarke, Lumbard, Sambrook, & Kerr, 2016; Shepherd, Doyle, Sanders, & Shaw, 2016). However, despite an emerging evidence base exploring the views of forensic mental health service users, this population's experiences of recovery remains under-researched (Shepherd et al., 2016).

Recovery in forensic mental health subgroups

Within the scarce literature available, there is an increasing focus on subgroups of forensic mental health service users, with suggestions that subgroups may have additional recovery needs to those identified in existing models of recovery for forensic mental health service users (e.g. Drennan & Alred, 2012). For example, it has been theorised that those with a diagnosis of personality disorder may perceive clinical recovery to be more difficult due to the pervasive and persistent perception of the diagnosis (Drennan & Alred, 2012).

Further, individuals with this diagnosis may face unique challenges to social recovery due to difficulties in managing relationships (Drennan & Alred, 2012). Other diagnoses, including dual diagnosis and psychosis, have also presented specific challenges to recovery for forensic service users (Chiringa, Robinson, & Clancy, 2014; Laithwaite & Gumley, 2007; O'Sullivan, Boulter, & Black, 2013). Although these diagnoses and associated challenges are not unique to forensic mental health service users, these further add to the challenges experienced by service users within forensic settings.

Other subgroups that may face unique challenges to recovery include those in high secure services, who may face more stigma in terms of the labels ‘aggressive’ and ‘violent’ compared to those within lower security services (Drennan & Alred, 2012). Di Lorito, Völlm, and Dening (2018) explored experiences of recovery in older age forensic mental health service users, who placed weight on the importance of nature, age specific activities, befriending services and spirituality, but who also experienced age discrimination and inaccessible activities as barriers to recovery.

Ethnicity and recovery

Whilst this literature suggests there may be unique recovery needs and challenges of specific subgroups within forensic mental health settings, this remains an under-researched area. This is particularly true for forensic mental health service users from minority ethnic backgrounds (defined for the purpose of this research as non-White British), despite being over-represented in forensic mental health settings (Rutherford & Duggan, 2008), and despite guidelines for commissioners regarding the care of minority ethnic mental health service users (Joint Commissioning Panel for Mental Health [JCP-MH], 2014) and The Bradley Report (Department of Health [DoH], 2009) stating that a one size fit all approach regarding the model of mental health care may not be appropriate for minority ethnic service users due to additional needs. Culture, religious beliefs and ethnicity have been identified as potentially impacting on the aetiology and presentation of mental health difficulties, and may also impact on service users’ experience of mental health services.

The Power Threat Meaning Framework ([PTMF], Johnstone & Boyle, 2018) argues that basing mental health services on diagnosis and the distinction between normal and abnormal, results in institutional racism given that many non-Western cultures do not subscribe to assumptions underlying diagnosis, the distinction between normal and abnormal, and the distinction between mind and body, or the individual and the collective social group. The Kindred Minds Manifesto (National Survivor User Network [NSUN], 2018) suggest that such alternative approaches may be helpful for minority ethnic

populations.

Gopalkrishnan (2018) emphasises that cultural meanings influence whether people seek help, where they seek help from, and how well they engage with help that is offered. For example, some cultures hold beliefs that illness is caused by possession by spirits, black magic or even breaking taboos. Given these understandings, treatment is sought from traditional healers or community elders, and religion and spirituality play a key role in these models of distress. In some cultures, the service user is thought about as a whole, rather than having their mind and body thought of separately as is custom in Western cultures where physical and mental health are treated separately.

The lack of incorporation of non-Western approaches to mental healthcare and the resulting institutional racism is evidenced in disparities in mental health care between minority ethnic populations and the white-British population. For example, black people are more likely to receive a diagnosis of schizophrenia (Nacro, 2007). Further, organisational structures and processes based on Western understandings of mental health may lead to inappropriate treatment and poorer outcomes.

Institutional racism is also evidenced in the criminal justice system, with examples including higher stop and search rates for black and Asian people, harsher prosecution and sentencing outcomes for minority ethnic populations, failures to protect prisoners and minority ethnic staff from racist abuse/violence, failures to meet the religious and cultural needs of these populations, and failures to rectify these discriminatory practices (Nacro, 2007).

In forensic mental health services statistics have revealed that those from minority ethnic backgrounds are more likely to be transferred to higher security facilities (Healthcare Commission, 2005) and remain in secure services longer than White service users (Healthcare Commission, 2007). This group are also more likely to experience seclusion and physical restraint (Healthcare Commission, 2007) as well as higher doses of medication and fewer opportunities for therapeutic interventions (Nacro, 2007). These findings suggest that individuals from minority ethnic backgrounds are likely to have significantly different

experiences whilst detained within forensic mental health settings compared to White-British service users, experiences that may impact on their recovery.

Whilst there is a lack of research exploring the recovery experiences of service users of minority ethnic backgrounds within forensic mental health settings, a review within the non-forensic mental health literature identified that factors influencing personal recovery differ between ethnic minority populations and non-ethnic minority populations (Leamy, Bird, Boutillier, Williams, and Slade, 2011). Particularly, ethnic minority populations were found to place more importance on the role of spirituality and stigma on personal recovery compared to non-ethnic minority mental health populations, and further identified culturally specific considerations and collectivist approaches to recovery as being important factors (Leamy et al., 2011). Robinson, Keating, and Robertson (2011) conducted focus groups exploring the role of culture on black and minority ethnic (BME) men's beliefs about mental health and their experiences of services. They found strong beliefs of needing to fit social norms, but also beliefs around holistic approaches to mental wellbeing including acceptance of the self. They further spoke about the importance of faith and having role models from similar backgrounds in maintaining wellbeing. Barriers to wellbeing included experiences of stigma within their community, coercive experiences of mental health services and perceptions of services as stigmatising, which contributed to disengagement and feelings of isolation.

Rationale and aim

These supports and barriers to mental health recovery specific to those from minority ethnic backgrounds are lacking from current forensic recovery models (e.g. Drennan & Alred, 2012). As a result, current recovery approaches are unlikely to capture the unique needs of ethnic minority forensic mental health service users. The implications are that supports specific to this subgroup may be lacking within services, which may prolong the recovery process. This has negative financial implications given the high cost of providing secure services (NHS Improvement, 2018). Services may also lack the understanding of

barriers to engagement and recovery, perpetuating the cycle of disempowerment and disengagement (Robinson et al., 2011). This has wider implications in terms of risk to the public, with disengagement with services being found to be a predictor of risk of violence (Doyle & Dolan, 2018). Thus, developing a theoretical understanding of the recovery needs and barriers to recovery for forensic mental health service users of minority ethnic background is essential for developing recovery-oriented forensic mental health services suited to the needs of this population. Developing services' understanding of the specific needs and challenges faced by this population may promote engagement and recovery, and subsequently reduce costs and risk.

The aim of this research is to therefore develop a framework for understanding recovery from the perspective of forensic mental health service users of minority ethnic background. It is hoped that the development of a framework will enable the following question to be answered: What are the recovery experiences of forensic mental health service users of minority ethnic background?

Method

Ethical considerations

Ethical approval (Appendix D) was granted by the Health Resource Authority (HRA) and the Research Ethics Service (REC). Particular ethical considerations included capacity to consent, confidentiality and data protection. Details of how these issues were managed are provided in the procedure.

Design

Due to the lack of literature in the research area, Grounded Theory (Strauss & Corbin, 1998) was used to develop a framework for understanding the experiences of forensic mental health service users of minority ethnic background. A critical realist approach was taken, making the assumption that recovery is an objective phenomenon with objective factors that help or hinder. However, within this epistemology it is acknowledged that subjectivity is applied to the understandings of these phenomena (Strauss & Corbin, 1998), and as such researcher assumptions and biases may influence interpretations made of the data. A number of steps were taken to limit the bias, these shall be discussed later.

Participants

Participants were recruited from two secure mental health hospitals within Trust 1. Participants were recruited via purposive sampling in accordance with the inclusion/exclusion criteria (see Table 1). Ten of thirteen potential participants agreed to participate, three declined but did not provide a reason. In order to protect confidentiality, only summary demographics have been provided (see Table 2). Participant numbers are debated within qualitative research (Mason, 2010), and may depend on factors including the aims of the research and the heterogeneity of the sample. Whilst this number may be too few to develop a comprehensive framework, theoretical sufficiency could be achieved for the main themes (Mason, 2010), thus providing an overview of recovery in forensic mental health service users of minority ethnic background and meeting the aim of the research.

Table 1. Inclusion and exclusion criteria

Inclusion	Exclusion
Detained within a mental health hospital	Lacking capacity to consent
Non White-British	White British
	Non-English language speakers
	Not deemed suitable by clinical team for clinical/risk issues

Table 2. Range of demographics represented by participants

Age range	Gender	Ethnicities	Hospital security	Section	Diagnoses
18-65	Male	White Syrian, mixed white and black Caribbean, black British/ African/Caribbean, black African, black British, mixed British, Other, Kurdish	Low and medium	37/41 47/49	Schizoaffective disorder, paranoid schizophrenia, personality disorder, drug induced psychosis, PTSD, depression

Procedure

A service user forum within Trust 1 was accessed to consult service users on aspects of the research methodology. Service users wondered whether participants could decline to answer questions deemed too personal, and accepted the response that participants would not be under any obligation to answer any questions they did not wish to. Concerns were also raised about the length of the information sheet (Appendix E); however, due to ethical requirements for informed consent, it was not possible to remove information. We discussed that the information sheet could be read out to participants to overcome this barrier.

A pilot case (included in the analysis) was used to gain feedback about the research procedure, including the information sheet, consent process (see Appendix F for consent form) and interview questions. The pilot case appreciated having a copy of the information sheet to take away, and appreciated having the information read to them. No concerns were raised.

Potential participants were informed about the research during community ward meetings, and were approached to be invited to participate once identified as meeting the inclusion/exclusion criteria by the staff team (responsible clinicians were informed of the research – see Appendix G). Potential participants were given an information sheet. Interviews were arranged with those wishing to participate, and held in a private room within the hospitals. Prior to interview, participants' consent was taken using a consent form.

Semi-structured interviews were conducted following an interview schedule (Appendix H). It was discussed in research supervision that forensic mental health service users may at times find open ended questions difficult to answer and elaborate on without prompting. It was therefore agreed that open ended questions would be used at the start to give participants opportunity to provide unprompted answers, with a structure in place to provide prompts about areas of recovery that may be relevant to participants where participants found the open ended questions difficult. As such, the interview schedule developed was based on that used by Mezey et al. (2010), which was developed from existing literature and their own qualitative research about areas of recovery suggested to be relevant to the forensic mental health population. The interview schedule was used as a guide; participants' answers were followed up with prompts to encourage more detailed responses. The interview schedule was amended (see Appendix I) after six participants in line with grounded theory processes (Urquhart, 2013) to focus on categories emerging from the data that had not reached saturation, which included participants' sense of identity and if/how this was influenced by labels of 'offender', 'ethnic minority' or 'mental health service user'.

The interviews were audio recorded and stored securely on an encrypted USB. After interviewing, participants were thanked for their participation and received £10 for their time.

Feedback was sought at the end of each interview. Participants expressed appreciation for the opportunity to share their views, and some expressed appreciation for the

opportunity to reflect on their experiences.

Some audio transcripts were transcribed by the researcher, others by a transcription company that used secure technology to handle the recordings. In the latter case, the transcription company signed a confidentiality agreement (Appendix J) prior to receiving any recordings, and transcripts were checked for their accuracy.

Where possible, grounded theory procedure of interviewing and analysing data from one participant at a time was followed in order to allow changes to the interview schedule based on previous interviews. However, at times this was not possible as a few participants were due to be discharged within a short amount of time. In this case, interview questions were amended based on what had come up in previous interviews. For instance, one service user spoke about their experience of substance use. This was then included as a question for the next participant.

A research journal (see Appendix K for extracts) was kept to identify assumptions and biases of the researcher, and to record decision making processes to enable reflection on the way in which the researcher's own personal subjectivity influenced the data. A bracketing interview (Ahern, 1999) was conducted part way through data collection to enable the researcher to reflect on decisions made and the direction of the research.

Data analyses

The data were analysed using the Strauss and Corbin (1998) approach to grounded theory. Guidance in the approach to data analyses was also taken from Urquhart (2013). Open coding was applied to identify categories on a phrase by phrase basis, which was decided upon due to the nature of the responses given. This was followed by axial coding, which sought to elevate and/or combine categories and to make theoretical links between codes (Urquhart, 2013). Selective coding was the final stage of coding in which core categories were identified as emerging from the data. Constant comparison was used throughout to maintain consistency to the coding paradigm, and memos were used to

develop links between categories. Selective coding was conducted in reference to the existing literature to build a theory connecting the core categories.

Results

Five core categories (selective codes) emerged from the analysis; recovery, self, network, institution and individual context. These core categories comprised a number of sub-categories (axial codes). Table 3 summarises these categories. The role and relationship between these different levels of categories is illustrated in Figure 1 outlining the framework for understanding the recovery experiences of forensic mental health service users of minority ethnic background.

Table 3. Core categories and sub-categories

Core category	Sub-category
Recovery	Making sense of recovery Wanting a normal life Making sense of mental health
Self	Feeling positive about recovery Feeling responsible Experiencing negative feelings Developing self-identity
Network	Connecting with others Experiencing others as unhelpful Experiencing others as supportive and helping recovery Feeling silenced/oppressed Reflecting on stigma
Institution	Making sense of detention Reflecting on experience of hospital Reflecting on treatment Experiencing activities as helpful to recovery
Individual context	Feeling an impact of individual context

This section will first describe the sub-categories with anonymous quotes from the data to demonstrate how they emerged from open codes and how they are represented in the data (see Appendix L for coding table and Appendix M for an example of a coded transcript). Quotes were chosen to reflect views from a range of participants but also that represented the category. At times participants gave brief answers to questions and so longer responses reflective of participants' own views were chosen as to not represent an affirmation of a closed follow up question.

The sub-categories will then be described in relation to the literature, with links between these explored and discussed in relation to theoretical memos and the literature. Finally, the five core categories that emerged from the sub-categories will be discussed, and the theory developed by exploring the relationship between core categories and sub-categories will be presented and discussed in relation to the existing literature.

Sub-categories

Aiming for a normal life

This sub-category reflected participants' expressions of hopes and goals for the future, reflecting hope and future thinking identified in the recovery literature as an important part of the process (Shepherd et al., 2008). Open codes including: wanting to be a part of the community, wanting a job, wanting a partner and wanting to be financially stable. These seemed to reflect participants' hopes that they would one day re-enter the community and lead a life typical for someone of their age living in the community:

> '*Go out in the community and mix with the public'* – John[2] on his desire to be a part of the community

> *'Achieve something in a qualification or hold down a career of some sort, a place of work'* – Steven on his desire for educational or employment progression

> '*Saving up money as well, might sound weird, for the future'* – James on

[2] Pseudonyms have been used throughout to protect anonymity

the importance of financial stability

'*Get your independence…. you can start to show that you can look after yourself'* – John expressing a desire for freedom

Developing self-identity

This sub-category appeared to be linked to identifying with some sense of self through learning about themselves, having a personal life (i.e. personal interests), expressing themselves or distancing themselves from labels:

'*Look inside yourself and know yourself*' – David on learning about himself

'*Myself I play guitar, and then talking to other people who play guitar'* – Jack on having a personal life with personal interests

'*It's [offence] definitely not who I am, now, or who I would want to sort of be in the future'* – Steven distancing himself from his past offender self

This sub-category links with the recovery literature which argues that finding a positive new identity is central for recovery (Shepherd et al., 2008).

Feeling responsible

Within this sub-category was the sense that participants felt the need to do something to facilitate recovery, which again links with ideas found in the literature that responsibility and control for one's life is a central part of recovery (Shepherd et al., 2008). Participants also reflected on their choices, including the use of substances, and spoke about making sense of relapse, making changes, learning from mistakes and making amends:

'*If I choose to do something it has an effect on what the outcome might be'* – John's awareness of the consequences of his choices

'*Re-analyse everything that I'm doing wrong, so I don't do it wrong, and do it right'* – Liam on learning from his mistakes

'*I knew the reasons why I was keep coming into hospital was 'cos of the*

drugs, but I was being ignorant to it' – David reflecting on his experience of relapse.

Feeling positive about recovery

Participants expressed a sense that positive feelings were helpful, and reflected feeling positive about their recovery, feeling a sense of achievement and feeling resilient:

'*I always knew there'd be hope there, in me, you know, because I knew I wouldn't die in the hospital system, but like I could achieve being back out there again'* - James

'*Now I've just got my confidence really, I can engage in all these activities'* – Hozan on the benefits of feeling positive

'*Every time I fall down I always get back up'* – David's experience of resilience

This sub-category seem to link with feelings of hope, optimism for the future and self-esteem, which have all been highlighted as essential for recovery (Shepherd et al., 2008).

Experiencing negative feelings

If hope and positive feelings support recovery, it would follow that negative feelings such as uncertainty, vulnerability and disconnection may get in the way. Indeed, these feelings were spoken about, and were perceived as unhelpful:

'[If I was…] Feeling low, I wouldn't be very happy, it would cause me problems, either in the hospital or outside the hospital. I might be sad, I might get aggressive with other people' – Adnan on the consequences of negative feelings

'*It felt like everyone knew what was going on, so everyone knew, I can't hide, I can't lie, I can't hide'* – David's experience of feeling vulnerable

'*You can't talk about it to other people 'cos they wouldn't understand where you were coming from'*. – David's experience of feeling disconnected from others

Experiencing others as supporting recovery

Participants talked about being helped by others, feeling accepted, receiving validation,

experiencing others as important and learning from others. This included staff, peers, family and friends:

'*People saying the right things you need to hear, it does help you, they're bigging you up'* – David

'[Staff] help you to make sure you get out of this place and never come back' – Ibrahim

'*They support me in a good way, they give me, again, they give me hope for the future'* – Adnan on the role of his family in recovery

'*To phone someone or have a chat with someone, if something's on your mind, there's someone at the end of the phone'* – John on the importance of friends and family to recovery

This links with recovery guidelines which suggest that those who provide support to service users, including staff, family and friends, play a crucial role in promoting recovery by providing encouragement to work towards goals (Shepherd et al., 2008).

Connecting with others

Particularly valued by service users was being able to connect with others in terms of developing positive relationships, but also in being treated as a person and being listened to:

'*People are here to help and listen to you'* - David

'*When we talk about it, er, in groups like recovery group, er, everything's listened to'* – James

'*Laughs and jokes and a bit of banter as they call it, 'cos that's healthy, that's sort of, normal, no-one's robots'* – Steven

'*Getting to socialise with other patients on a regular basis'* – Hozan

This links with literature that suggests that social inclusion is key for promoting recovery (e.g. Nijdam-Jones, Livingston, Verdun-Jones, & Brink, 2014).

Experiencing others as unhelpful

Whilst practical and emotional support seem important for recovery, a lack of support in these areas may get in the way of recovery. This was reflected in participants' experiences in which others led them to feel different, disrespected and lied to. Participants reflected on feeling unsupported by staff who they at times experienced as lacking understanding. Participants also reflected on unhelpful relationships in their lives and times at which it had been difficult to be around peers. These experiences are reflected below:

> '*I think I've always been the black sheep of the family'* – Sam discussing how he feels like the other
>
> '*Staff nurses making you small because you aint paying attention enough to fill in a brochure or a form or something'* – Liam
>
> '*I would like staff to be more understanding of what our illness is'* - Adnan
>
> '*I might want to talk about something, where someone else may not be able to comprehend or keep up with what I'm talking about, and they go off on their own tangent, or put their own perspective in'*
> – Steven on his experience of engaging with his peers

Feeling silenced/oppressed

This code emerged from experiences of participants which led them to feel silenced, oppressed, or on the receiving end of injustice:

> '*Doctor's don't want to bring it [sexual needs] up into the open and say this and say that, you know what I meant, I was just like, well everyone's on one page can't have sex'* – Liam on his experience of feeling silenced when talking about sexual needs
>
> '*I aint done nothing wrong really, nothing at all, I have a cigarette a day got me two extra days, I rolled it in the toilet, and everyone else was smoking and they didn't get shit, everyone's got out three times in the time I been here once, and I*

haven't got out' – Liam on feeling a sense of injustice

Feeling able to speak out is important for seeking help and also challenging unjust practices that may get in the way of recovery.

Reflecting on stigma

Some participants spoke about experiencing stigma and discrimination, others reflected on stigma and labels but did not feel that they had experienced stigma or discrimination themselves. Anticipation of and overcoming stigma were also discussed. Reflections included:

'Not all the time that they're very direct about it, but maybe indirectly…. Maybe staff wanting to get you into trouble for something you haven't really done, or they'll make up a lie and try to write it in the notes' – Jack on his experience of discrimination

'*These hospitals had been built, just to house black people in prisons'* – David on his experience of stigma

'*All of my diagnoses are in complete dispute, like they're arguing it all, do I even suffer from this? So I'm thinking well, what have I been doing for the last five years? You've been giving me over the years a medication list as long as my arm, and now I'm not on anything. So, how can they say I was this then, but now I'm not?*' – Steven reflecting on mental health diagnoses

'*If I just went to jail and stayed in jail, and I done my time and that's it, justice is served in the eyes of the public, but I'm not saying it's good, but when you add mental health into the mix, it can make, I'm assuming, it makes things more difficult for people to get their heads around'* – Steven discussing intersectionality of mental health and offending

Stigma is widely noted in the literature to impact on mental wellness (e.g. Corrigan, 2004), and institutional racism has also been discussed in the literature as

impacting on engagement with services, treatment offered and mental health outcomes (Johnstone & Boyle, 2018). As such stigma and discrimination can be interpreted as a barrier to recovery.

Making sense of detention

For some participants, mental illness was perceived to be the reason for detention, others acknowledged risk as playing a factor in their detention. Participants spoke about detention being for treatment. These understandings are demonstrated below:

'Contained a risk, alongside treating my illness' – Steven

'If you're ill, you just need help and everything, you need to be there in a hospital for a little time that they can help you to be better' - Ibrahim

'Making sure everything's all good and even when I go out I don't do any offence again' – Ibrahim

'The reason why I moved to this hospital is to finish my psychology therapy and get discharged' – Adnan

Making sense of detention is important for developing shared service user focused goals through which recovery can be worked towards and measured (JCP-MH, 2013).

Reflecting on the experience of hospital

Participants frequently expressed feeling that the hospital environment was restrictive. Participants also spoke about institutionalisation, discharge support and the length of detention:

'*My stay in this hospital is unnecessary anymore'* – Adnan discussing the length of his hospital admission

'*Sometimes people will hug me and I'll hug them, barriers, you got barriers and sometimes I don't listen to barriers and that's what's got me into trouble'* – Liam

discussing hospital restrictions

'*The many years that I've done in here, I've sort of, I've learnt to be a certain way'* – Steven on experiencing institutionalisation.

This sub-category raises the issue of balancing restrictions required for public protection with promoting recovery through autonomy, a challenge for forensic mental health services (JCP-MH, 2013). This sub-category also raises the important role of the hospital in keeping service users safe, which involves detaining service users under the Mental Health Act (1983). It is important to note that guidelines for commissioners state that restrictions should be as less restrictive as possible in order to promote recovery (JCP-MH, 2013).

Reflecting on treatment

Some participants spoke about finding medication helpful, whereas others found that it made no difference. Many participants discussed experiencing side effects, and psychology was also spoken about as a helpful intervention:

'*Which are not very helpful, tiredness, aching muscles'* – Jack on side effects of medication

'*Really bad side-effects, if you like, If I get drowsy or things like that'* – Sam

'*Reduce my energy'* – Liam on the effects of medication

'*Control your emotion and know your feelings, to accept the realities and all sorts of psychology techniques which you can help yourself when you're on your own, like grounding techniques'* – Hozan on the benefits of psychological therapy

Treatment has been linked to clinical recovery in terms of reducing symptoms of mental illness (e.g. Mezey et al., 2010), and also personal recovery (Tapp, Warren, Fife-Schaw, Perkins, & Moore, 2013), in supporting service users in developing self-understanding. However, previous research also highlights treatments as potentially having

side-effects that make service users feel worse physically (e.g. Mezey et al., 2010).

Engaging in activities

Participants appreciated the value of group activities in helping to develop knowledge and skills, and also in helping to pass the time during their detention. Participants spoke about a wide range of groups that they had engaged in within the hospital:

'*What helped is doing groups'* – John

'*It's very helpful to engage in activities'* - Hozan

Activities have been suggested to be important for improving self-esteem and social connectedness (Nijdam-Jones et al., 2014), separate subcategories that emerged from the data as important for recovery.

Making sense of recovery

Participants discussed the meaning of recovery, with a clear perception emerging of recovery as meaning changing for the better and living in the community without symptoms of mental illness. This meaning making is consistent with the literature into recovery (e.g. Shepherd et al., 2008). Participants reflected that there are different aspects to recovery and spent time reflecting on their journey through the forensic and mental health system. Widely discussed was the idea of recovery being a process that takes time, and participants also reflected on differences between their own point of recovery and that of their peers.

'*Erm, recovery means to me is er, I change into a different, into a better person'* – Adnan

'*I'll say that [living in the community] means you've recovered'* – Ibrahim

'*Recovery means to me, er, well from experience, er, recovery from the symptoms of the illness I was going through'* – James

'*Erm, because things they don't just happen sometimes, you know, if you have mental illness it's not just going to well, I think, it's not just going to go away*

tomorrow, just like that, I think, I think it takes a bit of time for that to happen' – Ibrahim

Making sense of mental health

This code emerged from participants' reflections on their experience of being unwell and the isolation that comes with that. It seemed that developing an understanding of their mental health was important for recovery. This is supported by the literature which argues that making sense of illness is an essential element of recovery (Shepherd et al., 2008). The following extracts provide examples:

'*I couldn't go to the shopping centre with the crowds or see many people, always escaping from, avoiding socialising and meeting other people'* – Hozan talking about his experience of isolation during his illness

'*If you didn't have any idea about your mental health, you wouldn't know what's what'* – John on the importance of understanding mental illness.

Feeling an impact of individual context

It became apparent that wider individual context also played a role in their experiences of recovery, with participants expressing cultural and spiritual needs, and reflecting on their backgrounds prior to admission that has shaped their lives and subsequently their experiences within hospital. This is reflected in the following extracts:

'*What goes on in your world, your world is totally different from mine, I don't know how you think, you know what I mean? I think differently to you, I'd think different because of my culture, I'm a black man and I got a different needs, you know?*' – David reflecting on the role of culture

'*Listening to the spiritual side of what I believe is truth'* – Liam reflecting on the importance of spirituality

'*Also, I believe how I feel is it's, like, a holistic approach to health'* – Jack talking about holistic approaches

Individual context is argued as crucial for improving engagement, appropriate treatment and better outcomes, with a one-size-fits all approach suggested as not meeting the needs of certain populations (e.g. JCP-MH, 2014).

Relating sub-categories to the literature

Figure 1 illustrates a framework for understanding recovery from the perspective of minority ethnic forensic mental health service users. At the core of this framework is the idea that participants are aiming for a normal life. This is consistent with previous research (Turton et al., 2011), and can be understood in the context of wanting to belong to society, which has long been thought of as a basic human need (Maslow, 1954). Human evolutionary psychology can help us to understand wanting to belong to society by explaining that belonging to a group enhances our likelihood of survival compared to being on our own (Barrett, Dunbar, & Lycett, 2002).

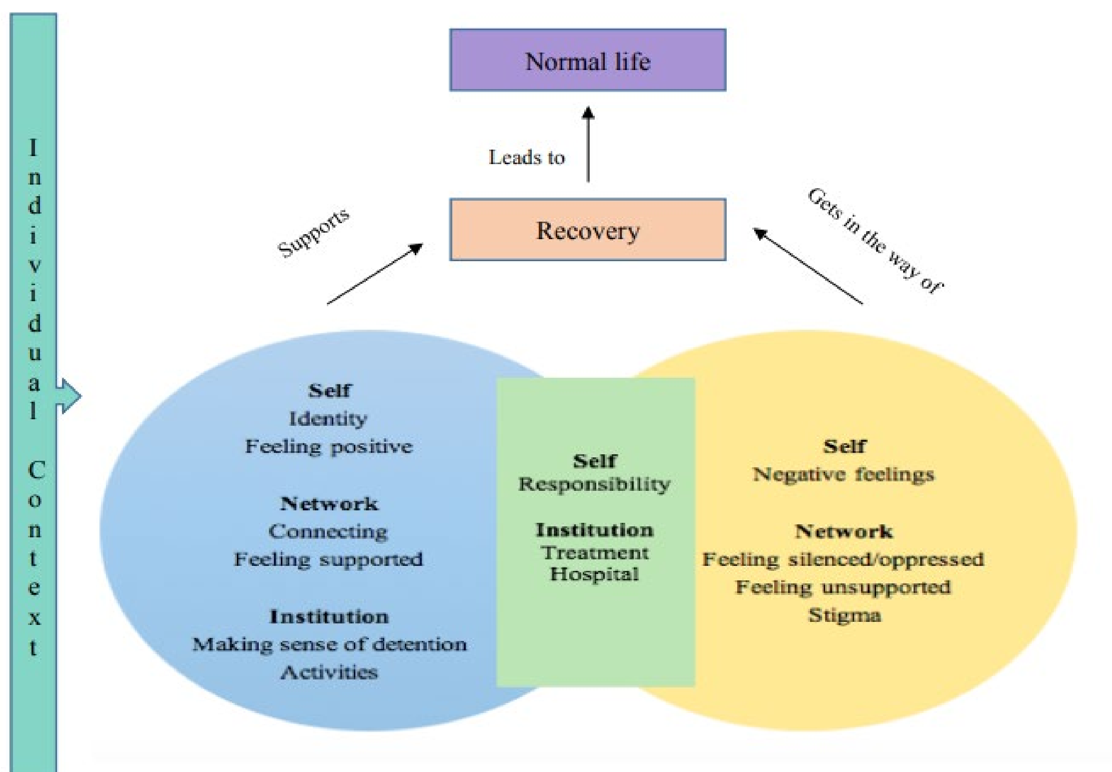

Figure 1. Framework for understanding recovery experiences of forensic mental health service users of minority ethnic background.

The framework developed incorporates a multitude of factors which help or get in the way of achieving this normal life, consistent with previous literature which evidences multiple aids and barriers to recovery (e.g. Mezey et al., 2010). For instance, there is an overall sense of responsibility that participants expressed regarding what they felt that they personally needed to change in order to achieve a normal life. This is consistent with other findings in which participants expressed the need to make positive changes (e.g. Mezey et al., 2010). However, some participants expressed feeling under pressure by the responsibilities of living in the community, and reflected that the hospital environment enabled them to feel less pressured in this regard. As such, self-responsibility seemed to be an aid and at times a barrier to recovery.

Development of self-identity was found to aid recovery as this allowed participants to learn about themselves and consider what it is that they want from a normal life. John sums this up by saying ‘if you know who you are and you know what you're about you'd know what you want in life, so yeah, you can say this is what I want for my journey, and this is what I want for my recovery’. This fits with goal theory (Locke & Latham, 2002), in which personal goals motivate action, and self-efficacy and satisfaction are linked to goal attainment. Thus, feeling positive about recovery supports participants in working towards their goal of living a normal life. On the other hand, negative feelings such as anger and lack of hope could get in the way of living a normal life.

Consistent with the literature, negative feelings resulted from experiences of others as being unhelpful (e.g. Mezey et al., 2010), feeling silenced and/or oppressed, and experiences of stigma (West, Yanos, & Mulay, 2014), linking these factors together. On the other side, positive feelings about recovery are supported by experiences of others as supportive and being able to connect with others (Mezey et al., 2010). Connecting with others is also linked to the development of a sense of identity. This is clear within theories of identity formation in which self-identity is influenced by society (Stryker, 1980) and also our social connections in which we develop social identities (Turner, Hogg, Oakes, Reicher,

& Wetherell, 1987).

Experiences of stigma, particularly of being labelled, also influences the development of self- identity, with research finding that stigmatising labels regarding mental illness, race and offending have the potential of being internalised (West et al., 2014). This is particularly relevant for this population who may experience what is referred to as 'triple stigma' (West et al., 2014), that is, combined stigma resulting from each of these identities. The experience of stigma is linked to feelings of being silenced and/or oppressed, which participants seemed to experience as a consequence of stigma.

The experiences that participants have of others being unhelpful, of feeling silenced and/or oppressed, and of others being supportive, were all found to influence the overall experience that the participant has of the hospital, which is in line with the findings of Mezey et al. (2010). In addition, the sense participants make of why they are being detained, as well as their views on their treatment, also influence their experience of hospital. For example, some participants viewed detention as a punishment, whereas others viewed hospital detention as necessary to recovery from mental illness. Some viewed treatment as supportive and helpful, whereas others expressed treatment to be unnecessary and producing negative side effects. This is consistent with other findings in the recovery literature (e.g. Mezey et al., 2010).

Service users' individual contexts influenced each of these axial codes, and as such was elevated to become a selective code, and will be discussed in relation to the supporting literature in the next section.

Selective codes and emergent theory

On a broader conceptual level, sub-categories could be grouped into core categories based on patterns that emerged between the sub-categories. What seemed apparent was that some sub-categories seemed to reflect the role of the individual on recovery, whereas others reflected the role of the individual's network on recovery, or the role of the institution on recovery. Other sub-categories seemed to refer to recovery as a concept, while others still

seemed to refer to the wider context of the individual that had an influence on each of these core categories.

Some sub-categories within core categories of self, network and institution at times seemed to have an effect on each other, as discussed in the section above (e.g. support from others helping others to feel positive about their recovery). Examples of quotes from specific core categories that highlight these links to other core categories are provided in Table 4.

Table 4. Quotes from core categories that link to other core categories

Quote	**Core category (subcategory)**	**Other core category linked to**
Now I've just got my confidence really, I can engage in all these activities'	Self (feeling positive)	Institution (activities); feeling confident is linked to engaging in activities
People saying the right things you need to hear, it does help you, they're bigging you up'	Network (feeling supported)	Self (feeling positive); others can promote positive feelings about the self
'*Staff nurses making you small because you aint paying attention enough to fill in a brochure or a form or something'*	Network (feeling unsupported)	Self (negative feelings); others can promote negative feelings about the self
'*What goes on in your world, your world is totally different from mine, I don't know how you think, you know what I mean? I think differently to you, I'd think different because of my culture, I'm a black man and I got a different needs, you know?*	Individual context	Recovery & Normal life
'*Also, I believe how I feel is it's, like, a holistic approach to health'*	Individual context	Treatment

These apparent links led to the understanding of the core categories of self, network and institution as interacting with each other. This is consistent with Onken, Dumont, Ridgway et al.'s (2002) idea that recovery results from dynamic interaction between the individual, the environment and interactions with others. This interaction could either have a positive effect on recovery, or get in the way of the recovery process. Example quotes have been provided in Table 5 demonstrating how subcategories could be understood as aids or barriers to recovery.

Table 5. Quotes reflecting how subcategories formed aids/barriers to recovery.

Aids to recovery	**Barriers to recovery**	**Factors that may aid and get in the way**
'*Getting to socialise with other patients on a regular basis'* – connecting with others, and the inclusion that brings, is discussed as an aid to recovery	*'[If I was…] Feeling low, I wouldn't be very happy, it would cause me problems, either in the hospital or outside the hospital. I might be sad, I might get aggressive with other people'* –Negative feelings are discussed as having potentially harmful consequences to recovery	'*If I choose to do something it has an effect on what the outcome might be'* – feeling responsible is linked to choices that could aid or hinder recovery
'*They support me in a good way, they give me, again, they give me hope for the future'* – Support from others is discussed as an aid to recovery	'*Doctor's don't want to bring it [sexual needs] up into the open and say this and say that, you know what I meant, I was just like, well everyone's on one page can't have sex'* –Feeling silenced leads to difficulties discussing needs	
'*The reason why I moved to this hospital is to finish my psychology therapy and get discharged'* – understanding the reason for detention is linked to shared goals which promote recovery	'*If I just went to jail and stayed in jail, and I done my time and that's it, justice is served in the eyes of the public, but I'm not saying it's good, but when you add mental health into the mix, it can make, I'm assuming, it makes things more difficult for people to get their heads around'* – stigma is discussed as having a potentially negative impact on achieving the aimed for normal life	

The interaction of these core categories were central to the process of recovery, identified as a separate core category, which was the process towards living a normal life. Informing each of these core categories was the individual's context.

Consideration of a person's wider context has largely been lacking in research exploring recovery in forensic mental health service users. This is particularly problematic given that those of minority ethnic background, who are over-represented within forensic mental health services (Rutherford & Duggan, 2008), have been found in general mental health services to place greater emphasis on the role of spirituality and stigma on recovery (Leamy et al., 2011). Leamy et al. (2011) discussed that for people of minority ethnic background, having a religion or a belief in a higher power is more important to recovery than for White-British service users, and stigma and discrimination was experienced not only in relation to mental health, but also in respect to their race. These minority populations also spoke about culturally specific alternative treatments. These are experiences that have been mirrored in this study by forensic mental health service users of

minority ethnic background.

An additional part of participants' contexts was that of their past adversity. It is widely accepted that our early experiences shape our mind and how we interact with others and make sense of the world. In fact, this premise is central to psychological understandings of the inner experiences of individuals; cognitive behavioural theory, for example, views early experiences as shaping our core beliefs about ourselves, others and the world, and the future (Beck, 1991), and attachment theory posits that our early relationships provide us with a template for relating to others and making sense of the world (Siegel, 2015). As such, it can be theorised that individuals' experiences of adversity may influence how they make sense of recovery, and influence their self-identity, how they relate to others, and their perceptions of services. Adversity is particularly relevant to the forensic mental health population, with Stinson, Quinn, and Levenson (2016) reporting higher incidences of adversity in early life common in these populations compared to the general population.

Discussion

The model developed represents the process of recovery of forensic mental health service users of minority ethnic background. This model draws similarities to existing models of recovery for forensic mental health service users, but highlights some differences pertinent to those from minority ethnic backgrounds.

Comparable to the existing literature on recovery in forensic mental health populations were discussions of different aspects of recovery including clinical, functional, social, personal and offender recovery (e.g. Drennan & Alred). In terms of aids to recovery, themes of connecting with others, developing self-identity and receiving support from others emerged from the data, consistent with previous research (e.g. Clarke, Sambrook, Lumbard, Kerr, & Johnson, 2017). Experiences of negative feelings such as anger, and feeling unsupported by others also emerged as themes that are found in the overall forensic mental health population (e.g. Mezey et al., 2010). Additionally, stigma in relation to offence history or mental health emerged, again mirroring existing research (e.g. Ferrito et al.,

2012).

However, this particular subgroup differed from the general forensic mental health population in that some participants raised issues of stigma in relation to their ethnicity. Whilst not all participants reported having been discriminated against because of their ethnicity, it was spoken about in terms of institutional racism and micro-aggressions. Given that perceptions of services as stigmatising has been found to lead to disengagement with services in people from minority ethnic backgrounds (Robinson et al., 2011), this has implications for forensic mental health service users' not only in terms of compliance with treatments, but also in complying with conditions post-discharge. This is supported by evidence that those of non-white ethnicities are more likely to be recalled, and in a shorter amount of time (Jewell, Cocks, Cullen, Fahy, & Dean, 2018).

Another difference was the importance of individual context; particularly regarding the role of culture, spirituality and adversity. Culture was spoken about in terms of culturally specific needs such as food and alternative treatments, particularly holistic approaches to care that incorporated spirituality. Spirituality was spoken about in terms of believing in something of a higher order. The inclusion of spirituality in care has been suggested to support recovery (Chidarikire, 2012), with discussions of the literature linking spirituality to hope and improved mental health outcomes (Bassett, Lloyd, & Tse, 2008). Holistic approaches to mental health care have also been discussed as involving social needs (Chidarikire, 2012). In terms of social impacts on mental health, adversity has been linked to mental health difficulties (Schilling, Aseltine, & Gore, 2007). This aligns with the findings of this study in which adverse experiences were discussed in relation to childhood experiences and social injustices surrounding socioeconomic disadvantages, and is further supported by research evidencing that early childhood adversity predicts recall (Jewell et al., 2018).

This research has made a step towards hearing the voice of those who have historically been neglected within research. Whilst research into the experiences of forensic mental

health service users may have incorporated the views of those from minority ethnic backgrounds, no research to date has given space to this subgroup to explore potential differences in their experiences and needs. The findings of this study suggest that experiences of stigma and the influence of individual context may differ in this subgroup compared to the general forensic mental health population. The implications of these findings are discussed below.

Theoretical and clinical implications

The findings have clinical implications in that recovery-oriented services based on current recovery paradigms may not meet the needs of forensic mental health service users of minority ethnic background. This has been discussed as having potentially negative implications for engagement and recovery outcomes, and may subsequently lead to greater costs due to increased recall rates and detention length.

This model has significant implications for clinical practice. For instance, given that early experiences of adversity and experiences of oppression appeared to influence participants' experiences of recovery, offering therapy to help think with service users about the impact of their adverse experiences may be beneficial for this population in making sense of their experiences and the impact that those have on their goals and their preferred support systems. Further, involving service users in the risk assessment process may support service users in developing a shared understanding of the reasons for their detention, seemingly important for participants.

The use of mentors, role models and advocates from ethnic minority groups may be helpful in practice given participants' discussed the importance of role models. This ties in with recommendations made by the Kindred Minds Manifesto (NSUN, 2018) which calls for funding for BME service user led peer support. Given participants' preference for holistic approaches, other sources of support such as healers, may be beneficial for this population. This fits with Gopalkrishnan's (2018) assertion that treatment preferences will reflect beliefs regarding the causes of illness.

Further considering participants' preference for holistic approaches to their care, efforts to approach physical and mental ill health together may also be important in clinical practice, and again addresses recommendations made by the Kindred Minds Manifesto (NSUN, 2018). An example of how this may be applied in practice is the consideration of the physical side effects of medications prescribed to manage mental ill-health, which participants' in this research described as posing a barrier at times to their recovery.

Given participants' emphasis on the importance of holistic interventions, additional recommendations made by the Kindred Minds Manifesto (NSUN, 2018), such as adopting alternate approaches to the biomedical model of mental distress and healthcare, may also be beneficial for ethnic minority service users**.** One such approach is the Power Threat Meaning Framework (Johnstone & Boyle, 2018), which may helpful in developing formulations that are sensitive to the individual's experiences, needs and cultural beliefs, and which may be helpful in developing awareness of differing needs in team formulations.

These implications are particularly relevant given recent guidelines, which highlight that engagement and outcomes are poorer where cultural and ethnicity factors relevant to the development and presentation of mental health difficulties are not considered (JCP-MH, 2014).

The findings also have implications on a systemic level. Given the evidenced institutional racism in the mental health and criminal justice systems, monitoring these underlying biases in these systems is important for raising awareness of the scale of the problem and for calling for just change. This again links with recommendations made by the Kindred Minds Manifesto (NSUN, 2018) which calls for mental health hospitals to publish data on the use of physical force in order to comply with the Mental Health Units (Use of Force) Act (2018), and further calls for race-based differences in sentencing, bail and parole to be monitored.

Another important implication is in terms of the diversity amongst professionals of different levels, with figures demonstrating that the NHS workforce is not representative,

with a lower percentage of minority ethnic professionals holding very senior or senior management positions compared to the percentage working within the NHS[3] (HM Government, 2018).

Strengths and limitations

The small sample size limits the degree to which saturation was able to be reached. Whilst the main, selective codes have saturation and are represented across the participants, the axial codes differ in their levels of saturation, with some codes reaching higher saturation than others. With a larger sample, it may have been possible to develop these codes further.

Although the coding process was checked for face validity with the project supervisors, the lack of second coder has implications for the validity and reliability of the coding process, and thus the validity of the emergent codes. Despite this, the codes that emerged from the data were largely consistent with findings from similar research. It is important to note that the main researcher was of White-British ethnicity, and thus may have placed importance on different aspects of what the participants brought based on the lived experience of being a majority ethnicity who holds certain privileges and power, and may have neglected areas that may have been important. This is important as the researcher held the power to interpret the experiences of an historically disempowered population.

Including service users during more stages of the research, such as having an ethnic minority peer mentor co-interviewing, could have helped to reduce this power imbalance. Despite this, the service users' views on the proposed research methodology were sought which was a strength of the research.

The interview schedule consisted of questions relating to different factors that have been evidenced as impacting on recovery, which poses the danger of finding what is being looked for. However, the use of open ended questions at the start of the interviews provided participants the opportunity to give unbiased answers, and the structure was helpful in

[3] It is important to note that those from Asian, Chinese, Mixed and Other ethnicities are over-represented in medical roles. Only those from Black ethnicities are under-represented in both medical and managerial roles.

providing prompts where participants found it difficult to answer the open ended questions. Despite the highly structured nature of the schedule, this was used as a guide; follow up questions were asked in response to participants' answers to encourage more detailed responses, and the schedule was amended over time in line with grounded theory processes to explore less saturated emerging themes.

In terms of the sample, this study benefited from recruiting participants from both a low secure and medium secure unit, as this enabled hearing experiences of service users from different stages of recovery and experiencing different levels of security. Despite this, the research could have been enhanced by recruiting from different NHS trusts, and from non-NHS forensic mental health hospitals, as this would have provided a more representative picture of service users' experiences**.** Further considerations relating to the sample used include the wide variety of ethnicities included, which grouped all non white-British ethnicities together. This may present issues as each ethnic group may present with specific needs compared to other ethnic groups. However, given that this area is under-researched inclusion of any non white-British ethnicities invited a broad range of experiences of minority experiences of recovery. Whilst future research could explore specific ethnic differences, this was not the aim of this research. Another potential issue with the sample is that all participants were male. Gender did not inform the inclusion/exclusion criteria, rather this omission reflected the lack of female minority ethnic forensic mental health service users in the services recruited from.

Future research

Expanding the research to include service users from NHS trusts across the UK, as well as from non-NHS forensic mental health hospitals and those discharged into the community, would increase the representativeness of views and support the voice of this historically neglected population to be heard.

Future research would also benefit from involving service users in developing interview questions and in the coding process, as this would increase the validity of the research.

Having an interviewer of minority ethnic background may also be beneficial in overcoming potential issues of cross-racial interviewing, such as interviewees' inhibition of communication (Rhodes, 1994).

Considering the lack of consideration of the role of the individual context on recovery, particularly in regards to holistic approaches to mental health and experiences of adversity, analysing recall rates for ethnic minority service users discharged from services adopting bio-psycho-social-spiritual approaches would be beneficial in evaluating the benefit of adopting such an approach in forensic mental health settings.

Conclusion

This research set out to develop a framework of the recovery experiences of forensic mental health service users of minority ethnic background, as the views of this subgroup was missing from the forensic mental health literature.

The findings suggest similarities between models of recovery for the general forensic mental health population and this subgroup, although some service users of minority ethnic background experienced additional stigma of ethnicity in addition to mental health and offence history. Differing to previous models of recovery, this subgroup placed particular emphasis on the role of their individual context in terms of culture, spirituality and experiences of adversity. These particular contexts were discussed as influencing experiences of recovery and the dynamic relationship between the self, the network and the organisation in recovery. This framework provides a starting point for supporting services to consider the recovery experiences and needs of this population.

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Section C:

Laura McKenzie-Smith BSc (Hons), MSc

Appendices and Supporting Material

Appendix A. Quality assessment (two tables)

Paper	**Does the paper clearly state its aims and relevance?**	**Is qualitative methodology appropriate?**	**Was the research design appropriate to meet the aims?**	**Was recruitment appropriate to meet the aims?**	**Was the data collected in a way to meet the research issue?**
Barsky & West (2007)	Yes	Yes	Partly	No	No
Chiringa et al. (2014)	Partly	No	No	No	Partly
Clarke et al. (2017)	Yes	Yes	Yes	Yes	Yes
Di Lorito et al. (2018)	Yes	Yes	Yes	Yes	Yes
Ferrito et al. (2012)	Yes	Yes	No	Yes	Yes
Kelbrick and Radley (2013)	Yes	Partly	No	No	No
Laithwaite and Gumley (2007)	Yes	Yes	Partly	Yes	Yes
McKeown et al. (2016)	Partly	Yes	No	No	Partly
Mezey et al. (2010)	Yes	Yes	Yes	Yes	Yes
Nijdam-Jones et al. (2015)	Partly	Yes	Yes	Yes	Yes
O'Sullivan et al. (2013)	Yes	Yes	Yes	Yes	Yes
Olsson et al. (2014)	Yes	Yes	Yes	Partly	Yes
Shepherd et al. (2017)	Yes	Yes	Yes	Yes	Yes
Tapp et al. (2013)	Partly	Yes	Yes	Yes	Yes
Turton et al. (2011)	Yes	Yes	Yes	Yes	Partly

Paper	Has the relationship between researcher and participant been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of the research findings?	Is the research valuable?
Barsky and West (2007)	No	No	Partly	Yes	Yes
Chiringa et al. (2014)	No	No	Yes	Yes	Partly
Clarke et al. (2017)	Yes	Partly	Partly	Yes	Yes
Di Lorito et al. (2018)	No	Yes	Partly	Yes	Yes
Ferrito et al. (2012)	No	Yes	Partly	Yes	Yes
Kelbrick et al. (2013)	No	No	N/A	No	No
Laithwaite and Gumley (2007)	Yes	Yes	Yes	Yes	Yes
McKeown et al. (2016)	Partly	Partly	Partly	Partly	Yes
Mezey et al. (2010)	Partly	Yes	Partly	Yes	Yes
Nijdam-Jones et al. (2015)	No	Partly	Partly	Yes	No
O'Sullivan et al. (2013)	No	Yes	Partly	Yes	Yes
Olsson et al. (2014)	No	No	Partly	Yes	Yes
Shepherd et al. (2017)	Yes	Yes	Yes	Yes	Yes
Tapp et al. (2013)	Yes	Partly	Partly	Yes	Partly
Turton et al. (2011)	Partly	Partly	Partly	Yes	Partly

Appendix B Table of theme progression

Study	Initial codes	Descriptive theme	Analytic theme
Clarke et al. 2017	· Recovery as a journey	Journey	Process
	· Putting the past behind	Moving forward	Process
	· Having a map to know what to do/guide	Pathway	Process
	· Power	Independence	Autonomy
	· Control	Independence	Autonomy
	· Trust	Trust in relationships	Relational
	· Voice	Being heard	Relational
	· Freedom – community leave	Independence	Autonomy
	· Achievements	Self development	Self-identity
	· Staff support/relationships/connectedness	Relationships	Relational
	· Hope	Feeling positive	Hope
	· Self-discovery/reflection	Self learning	Self-identity
	· Therapeutic input/understanding	Intervention	Intervention
	· Self-identity	Self learning	Self-identity
	· Rights	Being treated well	Relational
	· Independence	Independence	Autonomy
	· Learning from mistakes	Self learning	Personal responsibility
	· Self-acceptance	Feeling positive	Self-identity
	· Recovery as a long process	Journey	Process
	· Feeling stuck; discrimination	Negative interactions	Relational
	· Feeling vulnerable	Negative feelings	Self-identity
	· Feeling like victims of intimidation and violence – helplessness	Negative interactions/Negative feelings	Relational/Self-identity
	· Loss of freedom	Loss of independence	Autonomy
	· Loss of power	Loss of independence	Autonomy
	· Loss of control	Loss of independence	Autonomy
	· Lack of trust	Negative interactions	Relational
	· Feeling let down	Feeling unsupported	Relational
	· Unhelpful staff relationships	Feeling unsupported	Relational
	· Loss of rights	Negative interactions	Relational
	· Loss of independence	Loss of independence	Autonomy
	· Uncertainty – length of detention	Journey	Process
Turton et al. 2011	· Future/Hope/Goals	Feeling positive	Hope
	· Process/Journey	Journey	Process
	· Understanding	Being understood/Self learning	Self-identity/Relational
	· Social inclusion/Community	Relationships	Relational
	· Medication	Intervention	Intervention
	· Staff support	Support from others	Relational
	· Self-esteem and confidence	Feeling positive	Self-identity
	· Clinical recovery from symptoms	Health	Intervention
	· Physical health	Health	Intervention
	· Control	Independence	Autonomy
	· Mental illness	Health	Intervention

	· Isolation	Lack of relationships	Relational
	· Side effects	Intervention	Intervention
	· Fear of community/discharge (loss)	Lack of security	Security
	· Unhelpful staff (pay)	Feeling unsupported	Relational
	· Recovery as difficult	Journey	Process
	· Side effects of medication	Intervention	Intervention
	· Unhelpful staff relationships	Feeling unsupported	Relational
	· Constriction	Restrictive	Security
	· Constraints on living environment	Restrictive	Security
	· Poverty	Lack of security	Security
	· Discrimination	Negative interactions	Relational
	· Lack of control	Loss of independence	Autonomy
Mezey et al. 2010	· Symptom reduction	Health	Intervention
	· Social inclusion	Relationships	Relational
	· Ordinary life	Independence	Hope
	· Self-esteem/confidence	Feeling positive	Self-identity
	· Hope/future	Feeling positive	Hope
	· Self-acceptance	Feeling positive	Self-identity
	· Process	Journey	Process
	· Medication	Intervention	Intervention
	· Understanding	Being understood/Self learning	Self-identity/Relational
	· Therapeutic input	Intervention	Intervention
	· Safety	Feeling secure	Security
	· Financial security	Feeling secure	Security
	· Fewer pressures	Feeling secure	Security
	· Time	Journey	Process
	· Supportive staff	Support from others	Relational
	· Peer relationships	Relationships	Relational
	• Mental illness	Health	Intervention
	• Isolation	Lack of relationships	Relational
	• Side effects	Intervention	Intervention
	• Fear of community/discharge (loss)	Feeling insecure	Security
	· Unhelpful staff (pay)	Feeling unsupported	Relational
Barsky & West 2007	· Activities	Activities	Activities
	· Achievements	Self development	Self-identity
	· Freedom	Independence	Autonomy
	· Trust	Trust in relationships	Relational
	· Socialising with peers	Relationships	Relational
	· Hope	Feeling positive	Hope
	· Independence	Independence	Autonomy
	· Social inclusion	Relationships	Relational
	· Self-confidence	Feeling positive	Self-identity
	· Therapeutic input	Intervention	Intervention
	· Restricted space in hospital	Restrictive	Security
	· Violent peers	Negative interactions	Relational

McKeown et al. 2016	· Meaningful occupation	Activities	Activities
	· Trust	Trust in relationships	Relational
	· Good relationships with staff	Relationships	Relational
	· Understanding	Being understood/Self learning	Self-identity/Relational
	· Personal relationships	Relationships	Relational
	· Medication	Intervention	Intervention
	· Hope	Feeling positive	Hope
	· Self-reflection	Self learning	Self-identity
	· Achievement	Self development	Self-identity
	· Personal responsibility	Responsibility	Personal responsibility
	· Independence	Independence	Autonomy
	· Stigma	Negative interactions	Relational
Tapp et al. 2013	· Fewer pressures	Feeling secure	Security
	· Understanding	Being understood/Self learning	Self-identity/Relational
	· Control	Independence	Autonomy
	· Achievements	Self development	Self-identity
	· Goals/future	Feeling positive	Hope
	· Learning from others	Relationships	Relational
	· Self-reflection	Self learning	Self-identity
	· Therapeutic input	Intervention	Intervention
	· Supportive relationships	Support from others	Relational
	· Personal relationships	Relationships	Relational
	· Safety	Feeling secure	Security
	· Medical interventions	Intervention	Intervention
	· Meaningful activity	Activities	Activities
	· Self-esteem/confidence	Feeling positive	Self-identity
	· Detached from family	Lack of relationships	Relational
	· Lack of responsibility	Loss of responsibility	Personal responsibility
	· Hopelessness	Lack of hope	Hope
	· Lack of control	Loss of independence	Autonomy
	· Loneliness	Lack of relationships	Relational
	· Staff turnover	Feeling unsupported	Relational
	· Being bullied	Negative interactions	Relational
	· Side effects	Intervention	Intervention
Nijdam-Jones et al. 2015	· Activities	Activities	Activities
	· Achievement	Self development	Self-identity
	· Control	Independence	Autonomy
	· Social inclusion	Relationships	Relational
	· Safety	Feeling secure	Security
	· Adherence to rules	Understanding risk	Security
	· Staff support	Support from others	Relational
	· Peer relationships	Relationships	Relational
	· Personal relationships	Relationships	Relational
	· Personal responsibility	Responsibility	Security

	· Self-confidence	Feeling positive	Self-identity
	· Medication	Intervention	Intervention
	· Hope	Feeling positive	Hope
	· Self-growth	Self learning	Self-identity
	· Limited access to activities	Lack of activities	Activities
	· Boredom, agitation and aggression	Lack of activities	Activities
	· Non-compliance with rules	Lack of security	Security
	· Stigma/prejudice	Negative interactions	Relational
	· Uncaring staff (pay)	Feeling unsupported	Relational
	· Isolation	Lack of relationships	Relational
	· Uncertainty	Journey	Process
	· Hopelessness	Lack of hope	Hope
	· Long stay	Journey	Process
Olsson et al. 2013	· Medication	Intervention	Intervention
	· Therapeutic input	Intervention	Intervention
	· Feeling safe	Feeling secure	Security
	· Freedom	Independence	Autonomy
	· Hope/goals	Feeling positive	Hope
	· Self-reflection	Self learning	Self-identity
	· Activities	Activities	Activities
	· Achievement	Self development	Self-identity
	· Supportive staff	Support from others	Relational
	· Journey	Journey	Process
	· Time	Journey	Process
	· Personal relationships	Relationships	Relational
	· Self-confidence	Feeling positive	Self-identity
	· Trust	Trust in relationships	Relational
	· Powerlessness	Loss of independence	Autonomy
	· Fear	Negative feelings	Self-identity
	· Mental illness	Health	Intervention
	· Lack of control	Loss of independence	Autonomy
	· Side effects	Intervention	Intervention
	· Uncertainty	Journey	Process
	· Feeling let down	Feeling unsupported	Relational
	· Hopelessness	Lack of hope	Hope
	· Violent peers	Negative interactions	Relational
	· Unsupportive staff	Feeling unsupported	Relational
	· Long	Journey	Process
	· Loss	Lack of relationships	Relational
Laithwaite & Gumley 2007	· Understanding	Being understood/Self learning	Self-identity/Relational
	· Self-reflection/learning	Self learning	Self-identity
	· Feeling safe	Feeling secure	Security
	· Personal relationships	Relationships	Relational
	· Therapeutic input	Intervention	Intervention
	· Supportive staff relationships	Support from others	Relational

	· **Trust due to paranoia**	Trust in relationships	Relational
	· Time	Journey	Process
	· Respect	Being treated well	Relational
	· Activities	Activities	Activities
	· Achievements	Self development	Self-identity
	· Feeling trapped	Restrictive	Security
	· Frightening experience of illness	Health	Intervention
	· Uncertainty of date	Journey	Process
	· Hopelessness	Lack of hope	Hope
	· Hospital constraints	Restrictive	Security
	· Isolation	Lack of relationships	Relational
Shepherd et al. 2017	· Support from staff	Support from others	Relational
	· **Diagnosis**	Health	Intervention
	· Staff not understanding	Feeling unsupported	Relational
	· Staff unhelpful (job)	Feeling unsupported	Relational
Kelbrick & Radley 2018	· Understanding	Being understood/Self learning	Self-identity/Relational
	· Talking to people	Relationships	Relational
	· **Learning social rules and consequences**	Relationships/Understanding risk	Relational/Security
	· Isolation	Lack of relationships	Relational
	· Causing mischief	Lack of security	Security
	· Boredom	Lack of activities	Activities
Chiringa et al. 2014	· Awareness of conditions	Understanding risk	Security
	· Personal relationships	Relationships	Relational
	· Staff support	Support from others	Relational
	· Hope/future	Feeling positive	Hope
	· Achievements	Self development	Self-identity
	· Meaningful activities (work)	Activities	Activities
	· Independence	Independence	Autonomy
	· Accepting responsibility	Responsibility	Personal responsibility
	· Injustice	Negative interactions	Relational
	· Uncertainty	Journey	Process
	· Stigma/discrimination (criminals)	Negative interactions	Relational
	· Defensive practice	Restrictive/Negative interactions	Security/Relational
	· Restricted rights	Negative interactions	Relational
	· **Addiction**	Health	Intervention
	· Lack of control	Loss of independence	Autonomy
	· Poor care post discharge	Lack of security	Security
	· Lack of activities	Lack of activities	Activities
	· Unhelpful staff	Feeling unsupported	Relational
	· Isolation	Lack of relationships	Relational
	· Accommodation restrictions	Restrictive	Security
	· Feeling let down	Feeling unsupported	Relational
	· Financial difficulties	Lack of security	Security
	· Travel difficulties	Lack of security	Security

	· Poor communication	Feeling unsupported	Relational
O'Sullivan et al. 2013	· Self-identity	Self learning	Self-identity
	· Time (getting older)	Journey	Process
	· Responsibility	Responsibility	Personal responsibility
	· Control	Independence	Autonomy
	· **Avoiding negative influences**	Responsibility	Personal responsibility
	· **Substitution**	Intervention	Intervention
	· Self-awareness and reflection	Self learning	Self-identity
	· Understanding	Being understood/Self learning	Relational/Self-identity
	· Fewer pressures	Feeling secure	Security
	· Meaningful activity	Activities	Activities
	· Hope/future	Feeling positive	Hope
	· Personal relationships	Relationships	Relational
	· Mental illness	Health	Intervention
	· **Substance use**	Responsibility	Personal responsibility
	· Hospital admission	Restrictive	Security
	· Medication	Intervention	Intervention
	· **Addictive thinking**	Health	Intervention
	· **Conflicting views (i.e. cultural)**	Feeling unsupported	Relational
	· Disempowerment	Loss of independence	Autonomy
	· Relapse	Health	Intervention
	· Helplessness	Negative feelings	Self-identity
	· Lack of meaningful activity in community	Lack of activities	Activities
	· Social exclusion/isolation	Lack of relationships/Negative	Relational
	· Stigma/discrimination (job)	Negative interactions	Relational
Di Lorito et al. 2018	· Self-agency	Independence	Autonomy
	· Control	Independence	Autonomy
	· Future/Hope	Feeling positive	Hope
	· Personal relationships	Relationships	Relational
	· Activities	Activities	Activities
	· Community contact/social inclusion	Relationships	Relational
	· **Nature**	Activities	Activities
	· **Age specific activities**	Activities	Activities
	· Staff support	Support from others	Relational
	· Relationships with peers	Relationships	Relational
	· **Befriending schemes**	Relationships	Relational
	· Journey	Journey	Process
	· **Spirituality**	Relationships	Relational
	· Therapeutic input	Intervention	Intervention
	· Physical activity	Activities	Activities
	· Achievement	Self development	Self-identity
	· Learning from each other	Relationships	Relational
	· Hospital constraints	Restrictive	Security
	· Lack of control	Loss of independence	Autonomy

	· **Stigma/discrimination (being older)**	Negative interactions	Relational
	· Relapse	Health	Intervention
	· Fear	Negative feelings	Self-identity
	· Uncertainty	Journey	Process
	· **Inaccessibility of activities**	Lack of activities	Activities
	· Length of time	Journey	Process
	· Isolation	Lack of relationships	Relational
	· **Ignorance of age issues (staff)**	Feeling unsupported	Relational
	· **Unmet age needs (food)**	Feeling unsupported	Intervention
	· Financial difficulties	Lack of security	Security
	· Mental illness	Health	Intervention
	· **Age differences in peers**	Differences in relationships	Relational
	· **Restricted way to meet sexual needs**	Restrictive	Security
	· **Treatments tailored to younger**	Intervention	Intervention
	· **Intergenerational differences**	Differences in relationships	Relational
	· Under-staffing	Lack of relationships	Relational
Ferrito et al. 2012	· Understanding	Being understood/Self learning	Relational/Self-identity
	· Therapeutic input	Intervention	Intervention
	· Medication	Intervention	Intervention
	· Sense of self/identity	Self learning	Self-identity
	· Being given a second chance	Support from others	Relational
	· **Making amends**	Responsibility	Personal responsibility
	· Hope/Future	Feeling positive	Hope
	· Staff support	Support from others	Relational
	· Social isolation	Lack of relationships	Relational
	· Helplessness	Negative feelings	Self-identity
	· Powerlessness	Loss of independence	Autonomy
	· Unhelpful staff	Feeling unsupported	Relational
	· Stigma	Negative interactions	Relational
	· Mistrust	Lack of relationships	Relational
	· **Loss of self-control**	Loss of independence	Autonomy
	· **Feeling detached**	Lack of relationships	Relational

Note: Bold initial themes identify themes unique to a specific subgroup

Appendix C Overview of reviewed studies

Study	**Population**	**No. Pps**	**Participant demographics**						
			Gender	**Age**	**Ethnicity**	**Diagnosis**	**Section**	**Length of stay**	**Offence**
Barsky & West 2007	Medium secure	6	Male (6)	NP	NP	NP	NP	M=12 years	NP
Chiringa et al. (2014)	Recalled Dual diagnosis (not spec)	6	Male (6)	35-57	Asian (1) Black African-Caribbean (2) White British (3)	Dual-diagnosis (6) Paranoid Schizophrenia (6)	NP	6 months -1.5 years post recall	NP
Clarke et al. (2017)	Low secure	6	Male (6)	32-59	Black British (1) White British (5)	Schizophrenia (6) - Comorbid dissocial PD (1) - Comorbid ASD (1)	3 (1) 47/49 (1) 37/41(4)	1-7 years	NP
Di Lorito et al. (2018)	Older adults (high/med/low)	15	"Representative"						
Ferrito et al. (2012)	Homicide (High)	7	Male (7)	25-46	Black British (2) Mixed (1) Black African (1) White British (1) White Irish (1)	Schizophrenia (5) - Comorbid BPD (1) Psychopathic (2) - Comorbid Schizoaffective (1) Comorbid Antisocial PD (1)	NP	NP	Homicide (7)
Kelbrick and Radley (2013)	Asperger syndrome (low – LD)	1	Male	26	White British	Asperger syndrome	NP	5 years	Common assault/ABH
Laithwaite & Gumley 2007	Psychosis (high secure)	13	Male (12) Female (1)	22-60	NP	Schizophrenia (11) Bipolar Affective Disorder (2)	NP	6 months –10 years	Sexual offence (4) Manslaughter (1) Attempted murder (3) Assault (3) Attempted rape (1) Murder (1)

									Violent Assault (1)
McKeown et al. (2016)	High secure	25	NP		NP	NP	NP	NP	NP
Mezey et al. (2010)	Medium secure	10	Male (8) Female (2)	M=37.1	White (4) BME (6)	Paranoid Schizophrenia (7) Schizoaffective disorder (3)	3 (2) 37/41 (7) 37 (1)	M=4 years	Manslaughter (2) GBH/ABH (5) Rape (1) Arson (2)
Nijdam-Jones et al. (2015)	Canadian (low/med/high)	30	Male (24) Female (6)	M=40	White (26) Not reported (4)	Schizophrenia (18) Schizoaffective (5) Bipolar Affective Disorder (3) Not reported (4)	NP	M=23 months	NP
Olsson et al. (2014)	Swedish High secure	10	NP	M=36	NP	NP	NP	M=4.7 years	NP
O'Sullivan et al. (2013)	Dual Diagnosis Recalled Medium secure	5	Male (5)	26-42	White British (1) Black African-Caribbean (3) Mixed (1)	Paranoid Schizophrenia (2) Schizophrenia (1) Schizoaffective (1) Not reported (1)	NP	NP	NP
Shepherd et al. (2017)	Prison (16) Hospital (4)	20	Male (10) Female (10)	18+	White British (15) Not reported (5)	NP	NP	M=12 years	NP
Tapp et al. (2013)	High secure	12	NP	M=44.6	Black/Black British (4) White British (8)	Schizophrenic disorder (7) Personality disorder (4) Not reported (1)	NP	M=9.5 years	Homicide (4) Attempted homicide (1) Violence (4) Child sexual offence (2) Adult sexual offence (1)
Turton et al. (2011)	Medium secure	6	Male (4) Female (2)		NP	Serious mental illness without personality disorder (PD) or alcohol/substance misuse	NP	NP	NP

*NP=Not Provided

Appendix D Ethics and R&D approval

REC approval

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HRA approval

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Trust 1 R&D Approval

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Trust 2 R&D approval (contingency trust)

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Appendix E Participants information sheet

Participant Identification Number for this study:

Information about the research

Study Title: How do ethnic minorities experience recovery in a forensic mental health hospital?

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

What is the purpose of the study?

- This study aims to look at ethnic minorities' experience of recovery (being able to live a meaningful and satisfying life) within secure services.

Why have I been invited?

- All participants detained in a secure service, of ethnic background, and who understand and speak English will be invited to be involved in the research

What will I be asked to do?

- If you agree to be involved, you will be asked to sign a consent form
- You will then be asked to attend an interview with myself, lasting up to 50 minutes
- The interview will focus on your experience of living a meaningful and satisfying life within a secure service, and the questions will relate to this
- For the purposes of the research, the interview will be audio-recorded so that I can remember what we talked about

Are there any risks involved?

- The interview may raise some negative feelings for you
- Before the interview a named nurse will be assigned to you. If you experience any negative feelings during the interview, please tell me and I will notify your named nurse who will assist you.

What are the possible benefits of taking part?

- You will receive £10 for your participation
- You have the opportunity to share your unique experiences
- Any understanding which is gained may be used to promote recovery in others who are detained in secure mental health hospitals who are also of ethnic origin
- The information you share may be used to improve services

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

- Yes – although your responsible clinician will be informed about your participation, your views will remain confidential in line with the Data Protection Act
- Our discussion will be audio recorded. This will be stored securely on an encrypted USB
- When our discussion is typed up, all identifiable information will be changed and the audio recording will then be deleted
- Your consent form agreeing to participate in the study and to be audio recorded will be kept for five years in order to comply with the university's research procedures. These will be kept in a locked filing cabinet in a building with 24-hour security.

- Our discussion will be typed up by a transcriber who will be required to sign a confidentiality agreement, and who will delete the audio recording after transcription
- The written transcript will be kept for ten years on a password protected folder on a secure computer after which time it will be deleted
- If I become concerned about risk of harm to yourself or another person I may have to share that information. I will discuss this with you beforehand.

What should I do if I want to take part?

- If you would like to take part, please ask a member of your team to contact me.

What happens if I change my mind?

- You can choose to withdraw from the study at any time
- If you would like to withdraw after the interview you can ask your clinical team to contact me and I will destroy any information collected
- You may withdraw up to the point of data analysis, and this will not affect your treatment

What will happen to the results of the research study?

- A summary of the results will be sent to you
- The results of the research will be written up for my degree and may be published in a journal and presented at conferences
- Anonymised quotes from your interview will be used in published reports.

Who is organising and funding the research?

- This research is being organised and funded by Canterbury Christ Church University.

Who has reviewed the study?

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

What if there is a problem/What if I want to complain about the research?

- If you have a concern, please tell me and I will try to address your concerns
- You can also contact [specific contact person for site]
- If you remain unhappy and want to make an official complaint, you can do this by contacting Professor Paul Camic, Research Director at Salomons Centre for Applied Psychology via Canterbury Christchurch's research telephone number on 01227 92 7070 and leaving a message, or writing to Canterbury Christ Church University, 1 Meadow Road, Tunbridge Wells, Kent. TN1 2YG.

Further information and contact details

- If you would like to find out more about the study or have questions about it answered, please ask me, or alternatively contact [specific contact person for site]. To do this, please ask your named nurse to contact one of us.

Thank you for taking the time to read this information sheet.

Appendix F Consent form

Participant Identification Number for this study:

CONSENT FORM

Title of Project: How do ethnic minorities experience recovery in a forensic mental health hospital?
Name of Researcher: Laura Mills, Trainee Clinical Psychologist

Please read each box carefully and initial if you agree:

- I confirm that I have read and understand the information sheet. I have been able to consider the information, ask questions, and have had these answered satisfactorily. ☐
- I understand that my participation is voluntary and that I am free to withdraw at any time up until my data is analysed. I understand that withdrawing will not affect my medical or legal care. ☐
- I understand that my responsible clinician will be informed of my involvement in this research project. ☐
- I understand that the data collected during the study may be looked at by the project supervisors, Dr Caroline Clarke and Dr John McGowan and give permission for this. ☐
- I understand that my participation will be audio recorded and kept securely in line with the Data Protection Act on an encrypted USB stick and password protected CD for a period of five years before being destroyed. ☐
- I agree that anonymous quotes from my interview may be used in published reports of the study findings ☐
- I agree to take part in the study ☐

Name of Participant____________________Date________________

Signature ___________________

Name of Person taking consent______________Date_____________

Signature ____________________

Appendix G Responsible Clinician information sheet

Information about the research – for Responsible Clinicians

Study Title: How do ethnic minorities experience recovery in a forensic mental health hospital?

Hello. My name is Laura Mills and I am a trainee clinical psychologist at Canterbury Christ Church University. You have received this information sheet because a service user under your care has agreed to participate in a research study that I am leading. This information sheet is designed to inform you about the research and what it will involve for the service user.

What is the purpose of the study?

- This study aims to look at ethnic minorities' experience of recovery (being able to live a meaningful and satisfying life) within secure services.

Why has the service user under my care been invited?

- All participants detained in a secure service, of ethnic background, and who understand and speak English will be invited to be involved in the research.

What the service user be asked to do?

- If the service user agrees to be involved, they will be asked to sign a consent form.
- They will then be asked to attend an interview with myself, lasting up to 50 minutes.
- The interview will focus on the service user's experience of living a meaningful and satisfying life within a secure service, and the questions will relate to this.
- For the purposes of the research, the interview will be audio-recorded so that I can remember what was discussed.

Are there any risks involved?

- The interview may raise some negative feelings for the service user.
- Before the interview participants will be assigned a named nurse. If the participant experiences negative feelings because of the interview, they will be encouraged to tell me and I will call for their named nurse to assist them.

What are the possible benefits of taking part?

- Service users will receive £10 for their participation.
- Service users will have the opportunity to share their unique experiences.
- Any understanding which is gained may be used to promote recovery in others who are detained in secure mental health hospitals who are also of ethnic origin.
- The information service users share may be used to improve services.

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

- Yes – although you as the responsible clinician are being informed about their participation via this information sheet, service users' views will remain confidential in line with the Data Protection Act.
- The interview will be audio recorded, which will be stored securely on an encrypted USB.
- Once the interview has been typed up, all identifiable information will be changed and the audio recording will then be deleted.
- Participants' consent form agreeing to participate in the study and to be audio recorded will be kept for five years in order to comply with the university's research

procedures. These will be kept in a locked filing cabinet in a building with 24-hour security.
- The interview will be typed up by a transcriber who will be required to sign a confidentiality agreement, and who will delete the audio recording after transcription.
- The written transcript will be kept for ten years on a password protected folder on a secure computer after which time it will be deleted.
- If I become concerned about risk of harm to the service user or another person I may have to share that information. Service users will be informed of this before participation. I will discuss any concerns with the service user before sharing.

What happens if the service user changes their mind?
- Service users can choose to withdraw from the study at any time.
- If service users would like to withdraw after the interview they can ask their clinical team to contact me and I will destroy any information collected.
- Service users may withdraw up to the point of data analysis.

What will happen to the results of the research study?
- A summary of the results will be sent to the service users.
- The results of the research will be written up for my degree and may be published in a journal and presented at conferences.
- Anonymised quotes from interviews with service users will be used in published reports.

Who is organising and funding the research?
- This research is being organised and funded by Canterbury Christ Church University.

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

What if there is a problem/What if I want to complain about the research?
- If you have a concern about any aspect of this study, please tell me and I will do my best to address your concerns. You can also contact [specific contact person for site].
- If you remain unhappy and want to make an official complaint, you can do this by contacting Professor Paul Camic, Research Director at Salomons Centre for Applied Psychology via Canterbury Christchurch's research telephone number on 01227 92 7070 and leaving a message, or writing to Canterbury Christ Church University, 1 Meadow Road, Tunbridge Wells, Kent. TN1 2YG.

Further information and contact details
- If you would like to find out more about the study or have questions about it answered, please ask me, or alternatively contact [specific contact person for site].

Thank you for taking the time to read this information sheet

Appendix H Interview schedule (based on Mezey et al. 2010's interview schedule)

Hello, I'm [name], and I'm a trainee clinical psychologist. Thank you for your interest in this study.

I would like to remind you of a few details in order to check that you would still like to take part in this study, and if you do I will then ask you to sign a consent form.

As explained in the information sheet, this study is exploring the process of recovery for those using forensic mental health services who are of ethnic origin. I am particularly interested in hearing about your own personal views and experience. This could last for up to 50 minutes but may be shorter.

Taking part is entirely voluntary, and if at any point you would like to end the interview, please let me know and I will stop the interview. Anything that has been recorded up until that point will not be included in the research if you decide to withdraw.

Nothing you say will be shared with your care team, unless I am concerned about your safety or that of others, as mentioned before. It is possible that you may find some topics personal or distressing; please feel free to take breaks as you need them, and if there are any questions you would prefer not to answer, that's Ok too. If you feel distressed after the interview, please feel free to talk with me, or alternatively a member of your care team.

I would like to remind you that personally identifiable information will be removed once the interview is typed up. All written accounts of the interview will be kept on a password protected USB, and all audio recordings will be deleted upon completion of the research.

Do you have any questions?

Would you still like to take part in the study? [Ask to fill in consent form if in agreement]

**************************START TAPE RECORDING***************************

N.B. The following broad questions will be used but further, more specific questions will be asked as guided by the interview responses and theoretical sampling (based on answers of previous participants and questions that arise from data collected).

1. Demographics
    a. Some people do not always identify with their ethnicity of origin and I was wondering what ethnicity you identify with?
2. History of being a forensic mental health service user
    a. People's experiences of recovery may change over time; how long have you been using forensic mental health services?
    b. Can you tell me about when you were first admitted to a forensic mental health hospital? What was your first day in hospital like?

        i. Prompts: What did you see, hear, feel, think? What did you do? What was happening? What was that like?
    c. What is your understanding of why you are here in this hospital?
3. Understanding of recovery
    a. “Recovery”, or the idea of progress or improvement, can mean different things to different people, and can involve not only recovery from mental health symptoms, but also in a person’s personal life. Could you tell me what “recovery” means for you?
        i. In your view, what does it mean to recover? What would this look like? How would you know if you had recovered?
        ii. How might “recovery” apply to you?
    b. In terms of your own experiences, how much improvement do you feel you have made?
        i. What changes have there been so far?
        ii. How did those changes happen?
        iii. What else do you feel you have to change?
    c. Signs of recovery
        i. What, in your opinion, are signs of your recovery?
        ii. If you have a bad day, how does that impact on how you view your recovery?
        iii. How do you decide how well your recovery is going?
        iv. Do the opinions of others influence how you see your recovery is going? In what way?
    d. Factors contributing to recovery
        i. What, if anything, do you think is or has been important to your recovery?
            1. In what way/why has that been important?
        ii. Are there any barriers or set backs to making changes? If so, what?
            1. In what way/how has that been unhelpful?
    e. Treatment
        i. What types of help, if any, has been important for your improvement?
            1. In what way/why has that been important?
        ii. Is there any type of help you have received outside of the hospital that you have found helpful? If so, can you tell me more about this?
            1. In what way/why has that been important?
        iii. What types of help, if any, do you feel has made no difference on your progress?
        iv. Are there any aspects of help you have received that have acted as a barrier or set back to improving?
            1. In what way/how has that been unhelpful?
        v. Were there any types of help that you feel caused you harm?

1. In what way/how has that been harmful?

vi. Were there any types of help that you felt undid some of the progress you had made?
   1. In what way/how has that been unhelpful?

vii. If you could make some changes to the treatments you had received, or have had different treatments, what would they be?
   1. In what way/how would that be helpful?

f. Processes involved in recovery

i. Self-identity
   1. How do you think your view of yourself relates to your recovery, if at all?
   2. Is building a positive self-image important for your recovery?
   3. Can you tell me more about that?
   4. Could you tell me why you think that's important?

ii. Hope
   1. Do you feel that recovery is possible for you?
   2. Can you tell me more about that?
   3. Why do you think that is important?

iii. Opportunity
   1. Can you tell me about how activities in your life help your recovery, if at all?
   2. Can you tell me more about that?
   3. Could you tell me why you think that's important?

iv. Relationships
   1. Can you tell me about how positive and supportive relationships impact on your recovery, if at all?
   2. What role, if any, do friends and family play in your recovery?
   3. Can you tell me more about that?
   4. Could you tell me why you think that's important?

v. Meaning
   1. Can you tell me how gaining an understanding of your mental health problems and difficulties plays a part in your recovery, if at all?
   2. Can you tell me more about that?
   3. Could you tell me why you think that's important?

vi. Personal responsibility
   1. Do you think that independence and self management, e.g. in terms of being involved in your care plans, taking responsibility for your actions and having some control over your life, is important for your recovery?
   2. Can you tell me more about that?
   3. Could you tell me why you think that's important?

vii. Stigma
   1. Does stigma have a negative effect on your recovery?
   2. RE mental health problems/offending/ethnicity
   3. Can you tell me more about that?
   4. Could you tell me why you think that's important?

viii. Community
   1. Is being part of the community important for your progress?
   2. Can you tell me more about that?
   3. Could you tell me why you think that's important?

ix. Individual rights
   1. Are there any issues about your rights as an individual that have impacted on your progress? For example, being treated with respect, the right to advocacy and information, the the right to care and non-discriminatory practice.
   2. Can you tell me more about that?
   3. Could you tell me why you think that's important?

x. Social care
   1. How do financial and housing issues impact on your recovery, if at all?

xi. Hospital setting
   1. Does the hospital setting in terms of it's comfort, safety and rules impact on your recovery, if at all?
   2. What aspects are important?
   3. Can you tell me more about that?
   4. Could you tell me why you think that's important?

xii. Staff
   1. Do the attitudes of the staff that are treating you impact on your recovery?
   2. In what ways do staff attitudes affect your recovery?
   3. Are there other ways staff can affect recovery? How?
   4. Can you tell me more about that?
   5. Could you tell me why you think that's important?

xiii. Physical/mental health
   1. Does looking after your physical or mental health impact on your recovery?
   2. Are there ways of looking after your health that are important to your recovery?
   3. Can you tell me more about that?
   4. Could you tell me why you think that's important?

g. Do you have any final thoughts or comments that you would like to make about what we have discussed today?

****************************STOP TAPE RECORDING***************************

De-brief

Do you have any further comments or questions you would like to ask me?

[Check the participant is not feeling distressed or worried by the interview]

Thank you for participating in this study today.

[End the interview]

Appendix I Amended interview schedule

Interview schedule

Hello, I'm [name], and I'm a trainee clinical psychologist. Thank you for your interest in this study.

I would like to remind you of a few details in order to check that you would still like to take part in this study, and if you do I will then ask you to sign a consent form.

As explained in the information sheet, this study is exploring the process of recovery for those using forensic mental health services who are of ethnic origin. I am particularly interested in hearing about your own personal views and experience. This could last for up to 50 minutes but may be shorter.

Taking part is entirely voluntary, and if at any point you would like to end the interview, please let me know and I will stop the interview. Anything that has been recorded up until that point will not be included in the research if you decide to withdraw. Nothing you say will be shared with your care team, unless I am concerned about your safety or that of others, as mentioned before.

It is possible that you may find some topics personal or distressing; please feel free to take breaks as you need them, and if there are any questions you would prefer not to answer, that's Ok too. If you feel distressed after the interview, please feel free to talk with me, or alternatively a member of your care team.

I would like to remind you that personally identifiable information will be removed once the interview is typed up. All written accounts of the interview will be kept on a password protected USB, and all audio recordings will be deleted upon completion of the research.

Do you have any questions?

Would you still like to take part in the study? [Ask to fill in consent form if in agreement]

***************************START TAPE RECORDING****************************

1. Demographics
   a. Some people do not always identify with their ethnicity of origin and I was wondering what ethnicity you identify with?
2. History of being a forensic mental health service user
   a. People's experiences of recovery may change over time; how long have you been using forensic mental health services?
   b. What has been your journey through forensic mental health services?
      i. Has your journey influenced your views on recovery?
3. Understanding of recovery
   a. "Recovery", or the idea of progress or improvement, can mean different things to different people, and can involve not only recovery from mental health symptoms, but also in a person's personal life. Could you tell me what "recovery" means for you?
      i. In your view, what does it mean to recover? What would this look like? How would you know if you had recovered?
   b. Factors contributing to recovery

        i. What, if anything, do you think is or has been important or unhelpful to your recovery?
        ii. How has that been helpful/unhelpful?

4. How does your culture/religion/mental health impact in your view of medication/substances/treatment/psychology/mental health, if at all?
5. What is your experience of yourself as a person with mental health difficulties/offender/religion/minority ethnicity?
    a. Do you identify with that label?
    b. Have you ever been treated differently because of that label?
        i. How?
        ii. What impact has that had?
6. Do these identities; mental health/offender/religion/minority ethnicity interact/connect?
    a. How?
7. How is staff support similar and/or different to family support?
8. When you interact with staff can you be yourself?
9. What, if any, sense of belonging do you experience in the hospital and to different groups?
10. Do you have any final thoughts or comments that you would like to make about what we have discussed today?

****************************STOP TAPE RECORDING****************************

De-brief

Do you have any further comments or questions you would like to ask me?

[Check the participant is not feeling distressed or worried by the interview]

Thank you for participating in this study today.

[End the interview]

Appendix J Confidentiality agreement

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Appendix K Extracts from research journal

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Appendix L Coding table

Selective Code	Axial code	Open code
Individual context	Feeling an impact of individual context	Experiencing an impact of culture Experiencing racial difference Looking to spirituality Believing in alternative treatments Reflecting on intersectionality Feeling an impact of adversity
Self	Feeling positive about recovery	Feeling positive about recovery Experiencing positive feelings as helpful Feeling in control Feeling resilient Feeling a sense of achievement
	Feeling responsible	Feeling the need to do something to recover Reflecting on choices Making changes Learning from mistakes Making amends Toeing the line Feeling an impact of substances Making sense of relapse
	Experiencing negative feelings	Perceiving negative feelings as unhelpful Feeling uncertain Feeling vulnerable Feeling hopeless Feeling disconnected
	Developing self-identity	Learning about self Having a personal life Expressing self Distancing from label
Network	Connecting with others	Being listened to Connecting with others Being treated as a person
	Experiencing others as unhelpful	Reflecting on unhelpful relationships Feeling like the other Feeling disrespected Being lied to Experiencing bad attitudes Experiencing staff as unsupportive Finding it difficult to be around peers Viewing others as lacking understanding
	Experiencing others as supportive and helping recovery	Being helped by others Feeling accepted by others Receiving validation from others Experiencing others as important to recovery Learning from others
	Feeling silenced/oppressed	Feeling silenced/oppressed Reflecting on injustice
	Reflecting on stigma	Experiencing stigma/discrimination Reflecting on stigma Reflecting on labels Overcoming stigma Anticipating stigma
Recovery	Making sense of recovery	Perceiving recovery to mean changing for the better Perceiving recovery to mean living in the

		community Perceiving recovery to mean living without symptoms Highlighting different aspects of recovery Reflecting on recovery journey Waiting to move on Reflecting on differences between peers' stages of recovery Perceiving recovery as a process Experiencing improvement across time
	Wanting a normal life	Wanting a normal life Wanting to be a part of the community Wanting a job Wanting a partner Wanting to be financially stable Wanting material things Wanting freedom Wanting a better education
	Making sense of mental health	Reflecting on experience of illness Experiencing isolation during illness Understanding mental illness
Institution	Making sense of detention	Perceiving mental illness as reason for detention Perceiving risk as reason for detention Perceiving detention to be for treatment Understanding reason for detention
	Reflecting on experience of hospital	Reflecting on experience of hospital Feeling detention is too long Experiencing hospital as restrictive Experiencing institutionalisation Acknowledging the function of staff Reflecting on discharge support
	Reflecting on treatment	Experiencing side effects Experiencing no need for medication Perceiving medication to help recovery Experiencing psychology as helpful
	Experiencing activities as helpful to recovery	Perceiving group activities as helpful Experiencing a range of activities

Appendix M Coded transcript

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Appendix N Author guidelines for the Journal of Forensic Psychiatry & Psychology

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Appendix O End of study form

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Appendix P Participant feedback form

End of study report for participants

Study: Recovery in ethnic minorities using forensic mental health hospitals

Aim:

- There is a lack of research into the recovery experiences of forensic mental health service users of ethnic background.
- As such, models of recovery for forensic mental health service users may not be applicable to this population, who may face specific needs/challenges to recovery.
- The aim of this research was to develop a framework for understanding the recovery experiences of forensic mental health service users of ethnic background.

Method:

- Interviews were held with 10 forensic mental health service users of ethnic background, asking about their experiences of recovery
- Interviews were analysed using Grounded Theory, which involved looking for themes in what participants had said

Findings:

- The study found five core categories that were suggested to be central to the developed framework; the self, the person's network, the institution, recovery as a process, and the person's individual context.
- The framework developed proposed that the self, the person's network and the institution interact to influence the person's recovery process.
- This is similar to existing models of recovery for forensic mental health service users.
- However, differences to existing models of recovery included the role of stigma in regards to ethnicity, and the role of the individual context.
- This framework also differed in that the individual context was proposed to influence the interaction between the self, the network and the institution in the person's recovery process.
- The individual context was understood in terms of the person's culture, which informed culturally specific needs such as food, and cultural beliefs informing beliefs around alternative treatments and spirituality.
- Adversity also seemed to play a role in that experiences of disadvantage informed beliefs regarding detention and stigma, and informed views of mental health and recovery.

Implications:

- The findings of this research suggest that current models of recovery for forensic mental health service users may not necessarily meet the needs of those from ethnic backgrounds.

- This research has therefore developed a framework that could provide an initial understanding of the recovery experiences of forensic mental health service users of ethnic background.
- This framework could be used to inform services of the specific needs of this population.

Thank you for your participation in this study. Please do not hesitate to contact me if you have any questions regarding the study.

Yours Sincerely,

Laura Mills
Trainee Clinical Psychologist

Salomons Centre for Applied Psychology 1
Meadow Road
Tunbridge Wells
TN1 2YG.

Appendix Q Feedback form for ethics panel and R&D departments

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