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‘My journey through the system’: a grounded theory of service user-perceived experiences of recovery in forensic mental health services

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"My Journey through the System": A Grounded Theory of Service User Perceived Experiences of Recovery in Forensic Mental Health Services

This research was undertaken as a component of a doctorate in clinical psychology at Salomons Institute for Applied Psychology, Canterbury Christ Church University [CCCU] in collaboration with Oxleas NHS Foundation Trust and South London and Maudsley NHS Foundation Trust

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Abstract

The 'Recovery Approach' is widely regarded as the guiding principle for mental health service delivery in the UK. Forensic services face unique challenges in applying this approach. Numerous studies have explored themes associated with recovery in these settings but it is unclear how themes relate to each other. This study set out to build a theoretical model of service user experiences of recovery in forensic mental health settings. Semi-structured interviews were conducted with sixteen service users about their recovery. Grounded Theory methodology, with a constructivist epistemology, was used to analyse the data. A cyclical model was developed, with five core recovery processes that inter-related; these were: the environment, connectedness, hope for the future, who I am and empowerment. These occurred in three phases of 1) feeling safe and secure, 2) moving forwards, and 3) empowerment. These processes were encompassed by two additional themes of arriving at hospital and changes over time. This study is the first to provide a clear model of service user experiences of recovery in this setting.

Keywords: recovery, forensic mental health, service user

Introduction

"Recovery" is a term used in mental health theory and policy since the 18th century (Roberts & Wolfson, 2006). From the 1980's attention was re-focused on recovery, and a distinction was made between 'clinical recovery' and 'personal recovery' (Davidson & Roe, 2007). 'Clinical recovery' was considered a concept rooted in a medical understanding of difficulties, focusing on alleviation of symptoms and returning to a pre-morbid functioning (Lieberman & Kopelowicz, 2002). 'Personal recovery' was differentiated as a subjective and a whole-person concept (e.g. Lovejoy, 1984; Coleman, 1999; Deegan, 1988).

Anthony (1993) provided the most widely accepted definition of recovery:

> "*A deeply personal process of changing one's attitudes, values, feelings, goals, skills and roles... a way of living a satisfying life even with limitations, caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness*".

This demonstrates personal recovery prioritises considerations of how to live well alongside mental health difficulties and beyond clinical recovery.

A conceptual framework of recovery was proposed (Leamy, Bird, Boutillier, Williams & Slade, 2011); key themes of connectedness, hope, identity, meaning, empowerment and spirituality, were identified. This is in line with proposals that social factors rather than medical interventions are the main determinants of recovery (Tew, 2013).

Support for personal recovery is an explicit goal for modern mental health services (Shepherd, Boardman & Slade, 2008) and is promoted as the guiding principle in the UK (Department of Health [DoH], 2007, 2009, 2011). This places service users' at the centre, where they are given real choice about services they receive (O'Hagan, 2004).

The recovery approach faces challenges; despite its collaborative nature, its application remains controlled by services, possibly requiring people to conform to a professionalised idea of recovery (Stuart, Tansey & Quayle, 2016).

Forensic mental health service users face additional challenges, typically having had contact with the criminal justice system, as well as experiencing mental health problems so severe, they have been sectioned (Drennan & Wooldridge, 2014). This duality increases the complexity of recovery (Klassen & O'Conner, 1998a). Research suggests correlations between chronic trauma and adult offending (Maxfield & Widom, 1996). This raises the question: How are individuals in this population able to feel connected to others, have hope for the future, establish a positive identity, and have meaning in their lives?

The implementation of the recovery approach initially proved contentious in forensic services, which have traditionally been led by a bio-medical model; this is often orientated towards impairment, staff-led treatment decision-making (Borrell-Carrio, Suchman & Epstein, 2004) and security and risk (Clarke, Lumbard, Sambrook & Kerr, 2016). Recovery and risk are often in tension with each other (Livingston, Nijdam-Jones & Brink, 2012). Drennan and Alred (2012) outlined how risk of potential harm to others affects all areas of service delivery and has a profound impact on how individuals' care is approached. Feelings of powerlessness and oppression are part of the subjective experience of those receiving forensic services (Livingston & Rossiter, 2011). This highlights a strain forensic practice faces within the recovery paradigm; empowerment and choice are core aspects, which is juxtaposed with the need to manage risk of recidivism (Pouncey & Lukens, 2010).

Literature reviews (Clarke et al., 2016; Shepherd, Doyle, Sanders & Shaw, 2015) have explored recovery within forensic settings from service user perspectives. Clarke et al. (2016) identified six themes: connectedness; sense of self; coming to terms with the past; freedom; hope; and health and intervention. Shepherd et al. (2015) identified three tertiary

themes: safety and security as a necessary base for the recovery process; the dynamics of hope and social networks in supporting the recovery process; and identity work as a changing feature in the recovery process. These findings sit alongside recovery concepts in general mental health but acknowledge distinctive aspects.

While there are challenges of implementing a recovery model in forensic services, they are not insurmountable. The advantages of adopting a recovery-orientated approach are systemic, not only helping the service users but society as a whole.

Rationale

At the heart of recovery is the subjective experience. An understanding of service user experiences is a crucial perspective to have (Donnelly et al., 2011). Literature reviews summarise key components of recovery processes. It is not currently clear how different components relate and interact to form the recovery process. Developing a model grounded in service user experience could help theoretical understanding of the process of recovery from when a service user enters forensic mental health services.

Methodology

A non-experimental qualitative design was used, with a Constructivist Grounded Theory [GT] approach (Charmaz, 2006). Participants were recruited from Forensic departments of two NHS mental health trusts. The researcher provided information to clinical teams and attended community meetings to present the research to service users. See Table 1 for inclusion criteria. Service users expressing an interest were discussed with clinical teams about suitability and capacity to consent, in line with the Mental Capacity Act (Department of Health [DoH], 2014). Informed consent was obtained.

A purposive theoretical sampling strategy was adopted to achieve heterogeneity in experiences drawn upon (Corbin & Strauss, 1990). In Trust A, participants resided in low-

secure and recovery wards (n=9) or in a hostel (n=1). In Trust B, participants resided in a pre-discharge ward (n=4) and in the community (n=2). The study aimed to reach 'theoretical sufficiency' (Dey, 1999) and had sixteen participants. See Table 2 for participant information.

The interviews were semi-structured, structured around the research aim but also flexible, allowing more spontaneous narratives (Brinkmann, 2014). An initial interview schedule was generated, informed by principles outlined by Charmaz (2014). In later interviews, the interviewer assumed a more active role and asked more direct questions to inform theory generation (Charmaz, 2014). Interviews were audio-recorded, and length ranged between 39-55 minutes. They were transcribed and coded using NVivo software.

Analysis was conducted concurrently with data collection. The first three transcripts were analysed with Initial Coding. Then the most common or significant codes were considered, and Focused Codes developed. Codes moved from description to conceptualisation (Glaser, 1978). Further interviews were conducted, and focused codes held in mind. Larger segments of data were coded with the discovered categories. Coding moved to Theoretical Coding, where categories started to encapsulate and explain the data, as well as relationships between analytic categories. Constant comparison (Glaser & Strauss, 1967) was employed throughout. Memo-writing kept a record of the interactive process between the earlier codes and later categories.

Table 1.

Inclusion criteria.

Inclusion	Exclusion
• Detained or have been detained under the Mental Health Act (2007) • Offending history • Clinical team agreed suitability and capacity to consent • Age range: 18-65 • Any sex or gender • Lower security accommodation or in the community	• Acute symptoms of psychosis

Table 2.

Participant characteristics.

Characteristic	Information
Age:	Range: 23-57; Mean: 41
Gender	Men: 12; Women: 4
Ethnicity	Black-British: 8; White-British: 6; White-European: 1; Iranian: 1
Section	Section 37/41: 10; Section 3: 3; Section 45A: 1; Section 41: 1; Section 117: 1
Primary diagnosis	Paranoid schizophrenia: 9; Schizo-affective disorder: 5; Emotionally Unstable Personality Disorder: 2
History of substance misuse	Yes: 13; No: 3
Index offence	Common Assault: 3; ABH: 3; Arson: 2; Murder: 1; Manslaughter: 1; GBH with intent: 2; Rape: 1; Battery: 1; Sexual assault: 1; Trespass with intent to commit a sexual offence and assault by penetration: 1
Other offences	Threats to kill; Assault; Attempted strangulation; Wounding; Indecent exposure; Rape; Sexual assault; Theft; Destroying or damaging property; ABH; Possession of a weapon; Affray; Arson
Range of time in hospital on current admission	9 months–11 years

Those discharged from hospital, length of time in community	2–5 years

Quality assurance. A number of strategies were employed to ensure quality.

Reflexivity. GT social constructivist approaches highlight the importance of researchers' pre-existing knowledge and beliefs (Cutcliffe, 2000; Charmaz, 2006). Four strategies were used to enhance reflexivity: 1) A positioning statement; 2) A bracketing interview (Tufford & Newman, 2010); 3) Supervision; 4) A reflective diary.

Inter-rater reliability. Meetings were held with supervisors to discuss and evaluate data, enabling the researcher to be open to differing interpretations and ensured theory development corresponded to the data.

Theory checking and respondent validation. Participants were invited to attend a focus group to provide feedback on the initial model, to validate whether it reflected what they had spoken about (Bryman, 2004); four participants attended. Feedback was incorporated into the final theory.

Ethical Considerations

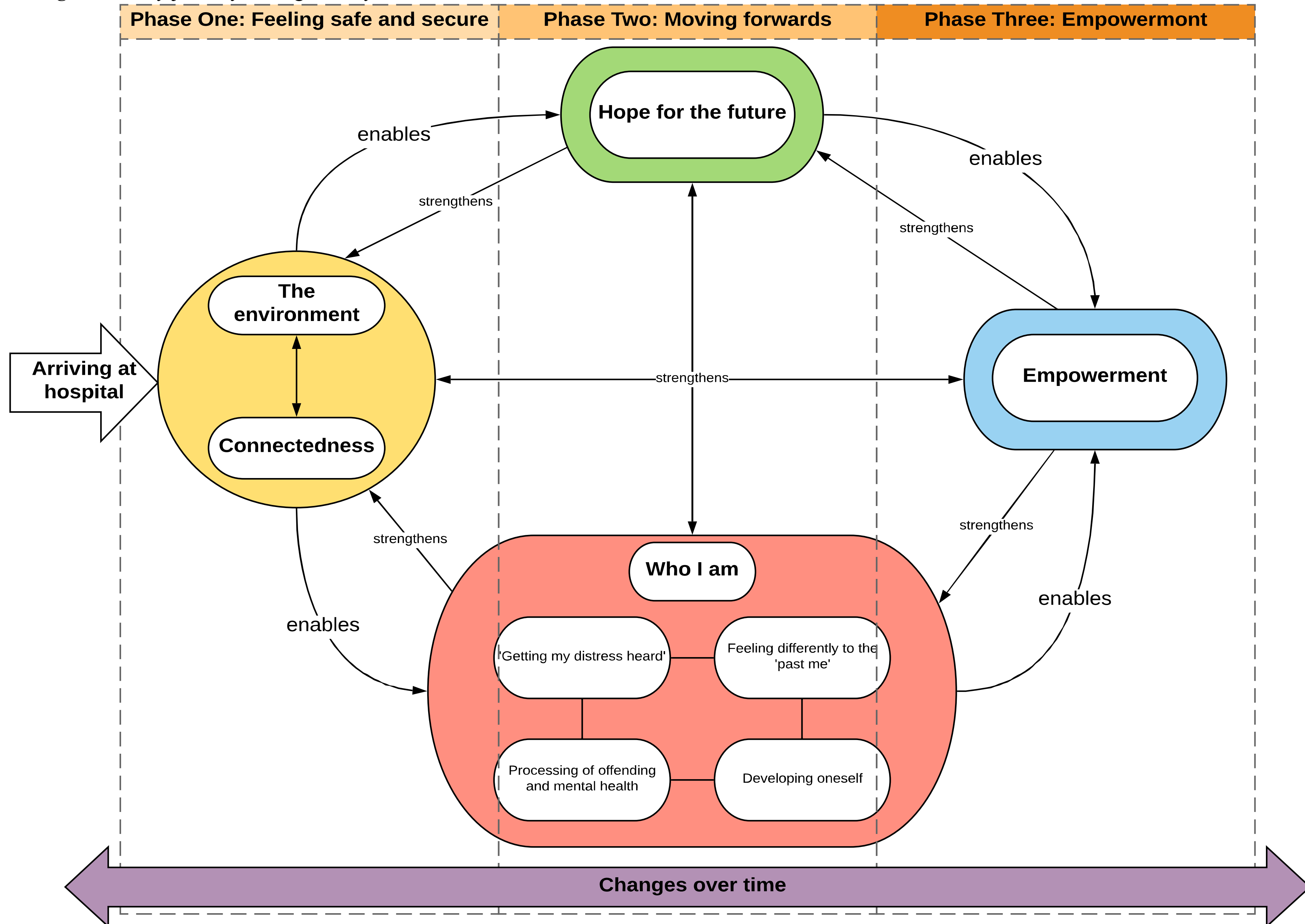
Ethical approval was granted by an NHS ethics committee, the Health Research Authority [HRA] and the Research and Development departments for the NHS trusts. Participants and clinical teams were provided with information about the research. Clinical teams assessed capacity. Participants signed consent forms before their interview. Only the researcher had access to the recordings. Identifying information was anonymised in the transcripts. Participants were reminded of limits of confidentiality. Participants were offered a debrief.

Results

Grounded Theory Model

A cyclical model was constructed representing service user experiences of recovery in forensic mental health settings. A pictorial representation of the model is presented in Figure 1.

Figure 1. “My journey through the system”



Model Summary

The model is called "*My Journey through the System*" (P16), containing five superordinate categories: the environment; connectedness; hope for the future; who I am; and empowerment. These occur in three phases: 1) feeling safe and secure, 2) moving forwards and 3) empowerment. Categories strengthened each other in a cyclical process, suggesting participants' perceived recovery as an on-going phenomenon. Two additional categories were found: 'arriving at hospital' and 'changes over time'. See Table 3 for an outline of the categories.

Participants portrayed what it was like arriving at hospital. 'Feeling safe and secure', the first phase, was described as a reciprocal relationship between 'the environment' and 'connectedness'; this provided a necessary basis for other recovery processes to occur. 'Feeling safe and secure' enabled participants to move onto a second phase: 'moving forwards'. Participants described building 'hope for the future', alongside processing and developing 'who I am'. These two categories strengthened and worked alongside one another. Having hope and developing a greater sense of 'who I am' helped empower individuals, moving to a third phase, 'empowerment'. This reinforced people feeling safe and secure, not only in their external world but also within themselves.

Table 3.

Categories and sub-categories.

Phases	Categories	Sub-categories
One: Feeling safe and secure	The environment	Having boundaries and routine Pharmacological interventions
	Connectedness	Trust between staff and service users Acceptance and belonging Others believing in me
Two: Moving forwards	Hope for the future	Having and achieving goals Envisaging the future Having faith
	Who I am	'Getting my distress heard' Processing of offending and mental health Developing oneself Feeling different to the 'past me'
Three: Empowerment	Empowerment	
Additional categories	Arriving at hospital Changes over time	

Arriving at Hospital

This was described as "*walking into oblivion*" (P6). Participants reflected on experiences of arriving at hospital as feeling chaotic and out of control:

> "*I didn't know where I was, what was happening… I didn't trust where I was*" (P16);

Phase One: Feeling Safe and Secure

The two core aspects, 'the environment' and 'connectedness', were portrayed as having a reinforcing reciprocal relationship.

The environment. There were two sub-aspects: having boundaries and routine; and pharmacological interventions.

Having boundaries and routine. The boundaries and routine of hospital were contrasted with the lack of these in the community:

> "*When I was in the community, I didn't have much structure*" (P4).

Introducing boundaries and routine enhanced a sense of safety and security. This included meeting basic physiological needs:

> "*Now I'm not naked, not hungry, not homeless*" (P11);
>
> *"I like the regularity of things being in order… of eating and sleeping, having a routine*" (P7).

Initially boundaries and routine were described as being imposed by staff. Participants described transitioning to internalising this:

> "*I make sure I get sleep every night, take my medication and occupy myself*" (P5);
>
> "*I know more so now that routine is important*" (P4).

Engaging in activities added to routine, which were experienced as respite from individuals' own minds:

> "*When I go there [art group] I'm distracted from everything and I'm doing something that is like escapism*" (P15).

Pharmacological interventions. Medication was experienced as helping participants feel safe. One participant commented, "*if anyone took clozapine away from me, I would be a mess*" (P2). It was described as lessening distressing experiences, such as voice hearing:

> "*The illness is always there but medication relieves the symptoms. It helps me function properly, to think properly*" (P13).

The alleviation of this helped participants feel safer in their own mind, "*feeling better in myself*" (P15) and see staff as safe, giving patients "*an opportunity to start relationships with staff*" (P16).

Connectedness. This category has three sub-themes: trust between staff and service users; acceptance and belonging; and others believing in me.

Trust between staff and service users. Mutual trust was described as necessary for meaningful relationships to develop. Participants described trust being created through staff being compassionate and caring:

> "*When people treat you well when you are unwell, it reflects on your whole recovery, because you feel like a human and that you can do what staff expect of you. It means I don't have a desire to get high and forget about everything*" (P8);

This enabled service users to feel like they could trust staff, and could start talking to them openly:

> "*They make me feel safe, which is important because in my past I haven't felt safe*" (P2).

Trust was demonstrated through small, yet significant acts like, "*letting me make my own cup of tea*" (P2) or being trusted with certain equipment:

> "*I would go gardening and one staff member would give me a plastic trowel and the next day they would give me a pitch- fork*" (P1).

This enabled the participant to feel like they "*had achieved something*" (P1).

Acceptance and belonging. This created a sense of connectedness. It was important for participants to maintain positive relationships outside of hospital, enabled through visits and telephone calls:

"*My mum has been supportive; she comes at least twice a week*" (P6).

This made participants feel that people do care about them:

"*She is caring and that is something I have not had in a long time*" (P3);

Participants felt these relationships provided them with motivation and hope of change:

"*I don't want to mess up or let people down*" (P14);

"*Having decent people around me makes me feel like there is something worth changing for*" (P7).

A sense of belonging was described as important:

"*A lot of my life I've been bullied and felt that I have not been wanted but my family keep coming back makes me feel a part of something*" (P1).

Having a sense of belonging to a group in the community, enabled participants to envisage being a part of that upon leaving hospital and being socially included in wider society:

"*I never had a sense of community but it is one where I can belong to*" (P10).

People had experiences that juxtaposed this, where they felt "*marginalised and treated in an unsatisfactory way*" (P8), which was described as being "*very painful'*" (P8). One participant questioned, "*if your own family do not care about you, who is going to?*" (p9), leaving them feeling alone, which was described as a hindrance to recovery.

Others believing in me. Having other people believe in participants enhanced their belief in themselves:

"*A lot of the days I couldn't see the good parts of me and even now when someone says, 'well done, you have done really well', I think, yeah alright*" (P1).

The faith of others encouraged participants to achieve things they otherwise would not have thought possible. One participant, when thinking about their role as an 'expert-by-experience', attributed this to "*other people seeing something in me I did not see in myself*" (P16).

Phase Two: Moving Forwards

This was described as being enabled through 'feeling safe and secure' and characterised by the development of hope for the future and of "*who I am*" (P7). Both superordinate categories were portrayed as occurring alongside one another and strengthening the other; the more someone felt they were developing who they were, the more hopefulness they had. The processes associated to 'moving forwards', strengthened participants' safety and security.

Hope for the future. Participants believed having hope counteracted feeling despair. They felt it offered an opportunity to see how life could be different and have belief this new way of being is worthwhile. There were three sub-categories: having and achieving goals; envisaging the future; and having faith.

Having and achieving goals. This enhanced participants' hopefulness. Short-term goals that were realistic and attainable, helped individuals see their longer-term goals were achievable. This kept participants motivated, feeling like they have something to work towards:

"*Having goals helps me navigate my way through the system*" (P16).

Envisaging the future. Achieving goals helped participants envisage their future:

> "*I can see the future more clearly. When I was young it was always about today but now, I see more than that. I can see myself getting a job. I feel more confident*" (P10).

Participants were hopeful about their future, and a new way of being:

> "*I started going out more and I started thinking there is a life outside hospital*" (P3);

Participants struggled to see a hopeful future when they received negative messages from others, about what they thought their future would look like:

> "*Everybody said I would be in high-secure until I am old. If someone tells you enough times the wall is black, you start to believe it*" (P1).

Having faith. For some, having a faith in a spiritual or religious sense provided them with hope for better things to come:

> "*It is nice to think there is a plan behind everything. Even though there is pain you have to go through… there is always a reason for it*" (P9);

Who I am. Processing and developing 'who I am' was depicted as a multifaceted process and complex interplay between a past and possible future self. This involved four sub-components: getting my distress heard, **processing of offending and mental health,** developing oneself and feeling different to the 'past me'.

'Getting my distress heard'. Participants' pasts were described as being characterised by trauma and difficult childhood experiences, having a profound impact on their life. Participants believed these experiences had not previously been addressed, holding unresolved emotion around this:

> "*She said it was a space where I could get my distress heard*" (P4).

Having a space to talk about this distress helped:

> "*For me it is like off-loading and airing it out, getting it out of me, physically out of me, for someone else to share it*" (P4).

Participants found it more challenging to talk about their distress when they felt the therapist had a different agenda, which was seen as a barrier to recovery:

> "*I wanted to talk about the emotional stuff... she wanted to talk about the practical stuff*" (P6).

Processing of offending and mental health. Participants struggled to talk about their offending and some named the shame they felt around this, which may partly explain their difficulties in discussing it:

> "*It scares me thinking about these things [offending]. The shame and guilt comes in and starts to play on your mind. It is like it is always going to be there, like a bag on my shoulder*" (P8).

Participants spoke about how groups had helped them to learn different ways of managing:

> "*I did a violence treatment programme, it made a massive difference*" (P1);
>
> "*Learning is empowering. It gives you the tools to move forwards*" (P15).

From engaging in this work, participants felt they could take responsibility for their actions and understand the potentially devastating impact they can have:

> "*The decision is yours. When you start to recover you realise the wrongs you have done and the ripple effects it causes to your family, friends and community*" (P11).

Some participants viewed offending as a secondary to other difficulties such as substance misuse and mental health, seeming to move away from taking responsibility of offending:

> "*Any offence I have committed has been when I have been so unwell I cannot remember doing it*" (P9).

A few participants said making sense of offending, did not fit with their recovery.

People talked about their mental health as if it was something of the past they no longer connected to:

> "*I was diminishing before hospital, you know when you get a virus on your computer, I felt like that. I don't feel like that now*" (P8).

Various participants spoke about the decline in their mental health being associated to substance misuse:

> "*I smoked weed at the time and I started developing weird symptoms*" (P9).

Participants reflected on the importance of learning about the effects of drug taking.

Developing oneself. Participants described putting time into developing new and different parts of who they are. This was partly achieved through people engaging in meaningful activities:

> "*I'm on a mechanics course... I'm so happy about this… I want something big like this, I need it… It gives me strength and power. It shows me I am able to do something positive in the world*" (P8).

Some participants connected this to no longer needing to engage in more negatively perceived behaviours such as drug taking:

> "*I didn't need the drugs as I was so busy with work*" (P7).

Engaging in these activities was depicted as becoming incorporated into participants' preferred sense of who they are, reinforcing beliefs they are moving on:

> "*The facilitating groups is one step forward because I am moving on*" (P13).

Even though participants were able to develop through occupation and activities, they described experiencing a societal stigma surrounding their mental health and offending, which impacted this:

> "*Having a criminal record causes a lot of difficulties in terms of getting a proper full-time job*" (P13).

Feeling different to the 'past me'. Participants distanced themselves from the "*past me*" (P3), which was resultant from the above categories:

> "*I feel separate from the past. Me when I committed the index offence, is different to me now*" (P13).

Participants struggled to incorporate aspects of how they had been in the past, with their new, more desirable sense of self:

> "*I was a hooligan, violent, a nasty piece of work*" (P1).

Phase Three: Empowerment

'Empowerment' was described as being enabled from categories in phases one and two. There was a narrative participants recognised their past cannot be changed but they had the power to change their future:

> "*You can't change your past but you can change your future and you can make whatever steps you need to make to get what you want in life*" (P1);

Participants described no longer needing to engage in behaviours such as drug taking and violence, which characterised their lives before entering hospital, and these features had less

power had over them. This empowerment reinforced individuals' belief about feeling safe and secure, not only externally but feeling safe and secure within themselves.

> "*I am now secure in myself and I feel safe, I don't need hospital anymore*" (P12).

Changes over Time

The passage of time was important for categories to occur. One participant commented they needed "*time to recover really, time to digest things and mould myself into a better person*" (P8) and that "*it is a gradual process*" (P15). Time in hospital created a space for people to have distance from potentially harmful behaviours they engaged with previously and had time to think about the its effects:

> "*Being able to be away from the environment where I can easily get it [cannabis], and having time to think about what it does to me*" (P9).

People found hospital helped prepare them for their future and living in wider society again, which is something they may not have had the opportunity to do previously.

Discussion

The aim was to develop a model of service user perceived experiences of recovery in forensic mental health services. Although recovery is a unique experience, core categories of recovery processes, and an understanding of how these come about and relate to each other, were found.

The model shares traits with Maslow's hierarchy of needs (1943). Maslow's theory articulates how humans are motivated by a hierarchy of needs; this maps onto the model, in that participants described needing to feel safe and secure enough in their environment and relationships before being able to engage with processes around their psychological needs.

The concept of feeling safe and secure is linked to the idea of psychological containment (Bion, 1962). Applying this to forensic services, the hospital and the staff act as the 'container' and the service user is the 'contained' (Clarke et al., 2008). Service users are seeking in the hospital, someone who can hold them in mind, be consistent, and can understand them, even if the service user is unable to tolerate understanding parts of the self (Clarke et al., 2008). This 'containment' being met to a 'good enough' standard (Winnicott, 1953) enables learning, change and maturation to take place.

The importance participants placed on relationships in their recovery is linked to attachment theory (Bowlby, 1988). For the development of an autonomous self, the experience of safety within an emotional relationship is essential. Participants spoke about the positive impact developing trusting relationships had on recovery processes. Adshead (1998) suggests staff in forensic settings can be positive attachment figures, particularly for those who were deprived of this in early years.

Participants articulated how the more they engaged in recovery processes the less they needed to engage in behaviours such as drug use. This links to positive psychology (Seligman, 2002) and strengths-based approaches (e.g. Wade, 1997). Much like the 'Good Lives Model' [GLM] of rehabilitation (Ward & Brown, 2004), this reflects all meaningful human action reflects attempts to achieve primary human 'goods' (Emmons, 1999); if primary goods become difficult to attain, a person may seek other ways of achieving this (e.g. achieving 'relatedness' by socialising with peers who use drugs). When participants were able to meet primary needs in more pro-social ways, they described no longer engaging in violence or taking drugs to fulfil these needs.

Limitations

Participants may have felt they needed to present themselves in a favourable light (Tan & Grace, 2008); they may have been reluctant to respond in ways they felt could jeopardise their care pathway. It is not possible to ascertain whether participants were able to present a true presentation of themselves in interviews or whether they had not psychologically reached a place of ambivalence, integrating the 'good' and 'bad' parts of themselves. Having a service user researcher interviewer may have helped, as well as adopting recovery principles via the research. This connects to another limitation of lacking service user input into the research design; this is problematic as the power remains with the researcher. Respondent validation lessened this somewhat.

Clinical Implications

The processes in the model can be implemented across all areas, from an organisational level to the ground, and be located at the heart of service delivery; it helps articulate 'the task' forensic services are working towards, and provides services with a frame of reference for what they are trying to achieve in terms of recovery.

It would be important for services to consider whether their current approaches are underpinned by recovery principles. Routine and structure being used as a tool to help patients feel safe and secure, as opposed to implementing an oppressive regime, where service users are passive recipients.

For the model to be applied usefully, it is important to be disseminated in staff training. It would be helpful to relate the proposed model to management of risk, which is a key concern in forensic settings (Pouncey & Lukens, 2010). This could be linked to the GLM (Ward & Brown, 2004), demonstrating the cross-over between recovery and rehabilitation. Promoting this model in training would hope to enhance staff compassion

towards service users, fostering recovery-orientated relationships (Gudjonsson, Webster & Green, 2010).

Research Implications

This study concentrates on how recovery processes are enabled. While participants commented on perceived barriers to recovery, this was not the focus. It would be helpful for a qualitative study to explicitly explore barriers to implementing recovery in forensic services. This would hope to direct where changes may need to be made.

While participants were service users, it may be helpful to conduct research ascertaining staff and support network perspectives of recovery in forensic services. Understanding of where differences and similarities lie would aim to raise important conversations about how to bring these together, thus facilitating power-sharing (Livingston et al., 2012).

The Developing Recovery Enhancing Environments Measure [DREEM] (Ridgway, 2004), could be used via quantitative methodology, to see how it maps onto the proposed model of recovery. It is possible DREEM may need to be adapted to forensic services, in light of unique recovery processes forensic service users report experiencing.

Conclusion

This study is the first to provide a model of recovery processes from service user perspectives in forensic mental health services. While the study has limitations, there are important implications, regarding how the model can be applied to services at all levels.

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