Oxford Doctoral Course in Clinical Psychology

PERSPECTIVES ON RECOVERY AND RECALL TO HOSPITAL IN FORENSIC MENTAL HEALTH

OWEN PAUL RYE

A thesis submitted in partial fulfilment of the requirements of the degree of Doctor of Clinical Psychology, validated by the University of Oxford

(Trinity Term)

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Perspectives on Recovery and Recall to Hospital in Forensic Mental Health

Owen Paul Rye, Harris Manchester College, University of Oxford,

Doctorate in Clinical Psychology (Trinity Term, 2017)

Abstract

People who are mentally unwell and have committed a criminal offence are cared for by forensic mental health services. Their treatment is provided in secure hospitals so that any risks to the public are minimised. The complex nature of the mental health difficulties experienced by this clinical population means that they are typically treated in secure hospitals for several years, incurring high economic and personal costs. The need for meaningful approaches to treatment and management of these individuals is therefore paramount. The first paper systematically reviewed eighteen qualitative research papers that explored stakeholder perspectives on the personal recovery approach to care in forensic contexts. Principles of personal recovery were perceived to be meaningful and applicable in forensic contexts if adaptations were made to overcome inherent barriers such as restrictions due to risk management. Methodological quality of the reviewed studies was limited by shortcomings in the transparency of study procedures. The second paper explored the experiences of a significant subpopulation of forensic service users who were discharged to the community subject to conditions including ongoing monitoring, then recalled back to a secure hospital due to a relapse in their mental state or other indicators of increased risk. Using grounded theory, a theoretical model was developed of how these individuals make sense of being recalled. This was found to be a recursive process influenced by their perceptions of events before their recall, during the recall itself, and their subsequent experiences.

Acknowledgements

I am incredibly grateful to a very many people for supporting me in completing this doctoral dissertation. Not least for what it represents in my career and education, but also in my personal senses of accomplishment and effort.

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I am hugely appreciative of the people who participated in my empirical study for their invaluable insights, which I was honoured to be able to hear from them and use as part of my research, which I hope will pay it forward to others in the future.

I wish to thank many of my friends, but I especially want to thank Josh.

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I am indescribably grateful to my mum and dad who have helped me to get this far and will doubtlessly support me as this journey continues for years to come.

And lastly I thank myself for the credit that this achievement conveys on me.

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PAPER A

RECOVERY IN FORENSIC MENTAL HEALTH: A SYSTEMATIC REVIEW

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Recovery in forensic mental health: A systematic review

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Abstract

Purpose: UK forensic mental health policy advocates that forensic services apply principles of personal recovery. However, the meaning and relevance of these principles in forensic services is questionable, given the inherent prioritisation of managing risk. This review examined the growing body of qualitative research into this topic.

Design/methodology/approach: A systematic review was conducted, searching five databases using search terms relating to personal recovery, forensic mental health, and qualitative methods. Studies were included if they used a qualitative or mixed methods design, primarily focused on personal recovery, and described personal recovery. Selected studies were evaluated for methodological quality using an established appraisal tool.

Findings: 18 studies were identified. A range of qualitative approaches were used to explore the perspectives on recovery of forensic service users, staff, and non-staff carers. Overall, recovery principles were perceived to be meaningful and applicable in forensic services if adaptations were made to overcome challenges, such as restrictions due to risk management. Only inpatient services were represented and transparency of study procedures was often limited, especially regarding recruitment and researcher reflexivity.

Research implications: Future qualitative research should explore this topic in community contexts and report study procedures transparently.

Practical implications: Principles of personal recovery can be meaningfully applied in forensic mental health contexts if adaptations are made to accommodate specific complexities, such as managing risk.

Originality/value: This systematic review included studies exploring the perspectives of a range of relevant stakeholders in forensic services, and appraised them comprehensively.

Keywords: Recovery, Qualitative, Forensic mental health

Article classification: Literature review

Chosen journal: Journal of Forensic Practice (for author guidelines see Appendix A)

1. Introduction

1.1 Recovery in Mental Health

Recovery in mental health has been conceptualised in two ways: ‘clinical recovery’ and ‘personal recovery’ (Slade *et al*., 2008). Clinical recovery is traditionally used within the medical model of mental illness to describe the remission of a person’s symptoms and their return to a standardised level of functioning (Resnick *et al*., 2005). This accords with symptom-based approaches to diagnosis and outcome measurement (Zisman-Ilani *et al*., 2013). The concept of personal recovery developed within the context of the ‘consumer-survivor movement’, and is thus rooted in individuals’ accounts of living with serious mental illness (Frese and Davis, 1997). Personal recovery is intentionally distinct from clinical recovery because it recognises that people can lead meaningful lives despite continuing to experience symptoms of their mental health condition (Onken *et al*., 2007). This perspective offers hope to people living with long-term mental health difficulties, and thus promotes their agency in the process of their recovery (Lysaker and Leonhardt, 2012). Although the medical model of clinical recovery continues to predominate in mental healthcare, the principles of personal recovery have been increasingly integrated into policy and practice over recent years (Jacob, 2015). In the UK, the adoption of personal recovery principles have been enshrined in the cross-government mental health outcomes strategy *‘No health without mental health’* (HM Government, 2011), and implementation of personal recovery-oriented policies in clinical practice has been supported by a non-governmental organisation, Implementing Recovery through Organisational Change (ImROC; e.g., Shepherd *et al*., 2010).

The nature of personal recovery is inherently unique to each individual, so there is no consensus on a single definition of it (Mountain and Shah, 2008). However, conceptualisations of personal recovery commonly include having hope for the future, re-establishing one's identity, having meaning and purpose in life, empowerment by having responsibility and choice, a focus on strengths, and connectedness with others (Anthony, 1993; Andresen *et al*., 2003; Slade, 2009; Leamy *et al*., 2011; Stickley and Wright, 2011). The current review focuses on forms of personal recovery that are consistent with this conceptualisation. In line with the majority of literature on this topic, hereafter the concept is simply referred to as 'recovery'.

1.2 Recovery in Forensic Mental Health

The expanding implementation of recovery principles has prompted consideration of their applicability in specialist services, including forensic mental health contexts (Turton *et al*., 2011). Forensic services provide care and containment for people who are mentally unwell and have committed a criminal offence, or are at high risk of doing so (McInerny and Minne, 2004). The dual aim of forensic services is to support the needs of forensic service users (FSUs) by engaging them in multiple forms of rehabilitative treatment to address both their mental health difficulties and their offending behaviour, whilst also protecting the public from the potential of harmful behaviour by FSUs (Sugarman and Dickens, 2015).

Managing risks in forensic services often involves the containment of FSUs in secure hospital wards, and/or restricting their liberties, such as with curfews and alcohol intake limits (Dickens *et al*., 2015). This inherent emphasis on risk presents a significant challenge to implementing recovery principles that aim to promote service users’ autonomy (Barker, 2012). Similarly, it is difficult to foster hope for FSUs who are detained as inpatients for indefinite durations until they are judged by professionals to present sufficiently low risks; indeed, many FSUs stay longer in secure hospitals than if they had served custodial sentences (Völlm *et al.*, 2016).

Despite these and other challenges, the potential utility of applying recovery-oriented approaches in forensic contexts has been advocated by researchers, practitioners, and policy-makers (Drennan *et al.*, 2014; Hillbrand *et al.*, 2010; Mitchell and Callaghan, 2015).

1.3 Research into Recovery in Forensic Mental Health

As with any form of healthcare intervention, it is important that the wide-scale implementation of recovery-oriented approaches is supported by an empirical evidence base (Shepherd *et al.*, 2014). Furthermore, in order to employ recovery principles in a way that is meaningful and not tokenistic, it is crucial that their implementation is based specifically on empirical evidence that accounts for the complexities of forensic contexts (Mann *et al.*, 2014).

The body of literature about recovery in forensic mental health has grown steadily over the past decade; it now comprises a mixture of theoretical papers (e.g., Dorkins and Adshead, 2011), practice-based evidence of the feasibility and effectiveness of its application (e.g., Corlett and Miles, 2010; Gudjonsson *et al.*, 2011), and exploration of the meaning and process of recovery-oriented approaches from the perspectives of those who experience them in action, primarily FSUs and forensic service staff (e.g., McKeown *et al.*, 2016).

This last category, research into lived experiences of recovery in forensic contexts, is closely aligned with the spirit of the consumer-survivor movement from which philosophies of recovery evolved. Given that recovery is a personal process, in order for its evidence base to be meaningful, it should be rooted in lived experiences (Andresen *et al*., 2010). Coffey (2006) has advocated that understanding the views of FSUs is important in order to develop services in ways that are acceptable to their consumers, on the basis that services that are more acceptable to their consumers will thereby have more clinical utility. This has been echoed in policy guidance for implementing recovery in mental health services (Shepherd *et al*., 2008). Additionally, the value of appreciating the experiences and opinions of forensic service staff and other non-staff carers of FSUs (such as family and friends) becomes evident once we recognise the vital roles they have to play in the collaborative process of recovery for the people in their care (Hillbrand *et al*., 2010).

Qualitative research methodologies offer a systematic approach to investigating the subjective experience of individuals and groups (Thompson and Harper, 2012). The value that qualitative research places on service users' perspectives is deemed to be more acceptable and meaningful to FSUs (MacInnes *et al*., 2011), and the typically inductive (bottom-up) nature of qualitative methods is generally better placed to generate novel insights from individuals than the deductive (top-down) approaches used in quantitative research (Tapp *et al*., 2013). Qualitative research can therefore be considered to constitute the keystone in forming an evidence base for recovery-oriented approaches in forensic mental health contexts.

1.4 Qualitative Research into Recovery in Forensic Mental Health

The growing rate of qualitative studies of recovery principles in forensic contexts reflects the impetus for meaningful empirical evidence in this field, driven by policy needs.

Two systematic reviews have recently been published which both aimed to evaluate and synthesise this research literature. Clarke *et al.,* (2016) identified 11 studies of FSUs' perceptions of recovery, evaluated these using criteria described by the Critical Appraisal Skills Programme (CASP; 2013), and conducted a thematic synthesis that generated six superordinate themes. Shepherd *et al.,* (2016) identified only five studies of FSUs' experiences of recovery, and also evaluated them using CASP (2013) criteria, and conducted a meta-synthesis that generated three overarching themes.

Whilst these two reviews synthesised emergent themes of FSUs' views on recovery, they excluded research into the views of forensic service staff and other carers of FSUs, who are also recognised as key stakeholders in making recovery a reality (Shepherd *et al*., 2008). Clarke *et al.* (2016) also appear to have prioritised synthesising the qualitative literature rather than describing a comprehensive critical appraisal of its methodological quality, except for appraising the ethical considerations of identified studies. Although Shepherd *et al.* (2016) reported their critical appraisal in detail, they only identified and reviewed five studies; given that Clarke *et al.* (2016) identified several more studies that were published before the date of Shepherd *et al.*'s (2016) search, this suggests that their search strategy and selection criteria may have been too narrow. Moreover, this body of literature has continued to grow since the search dates of these two reviews.

1.5 Aims for the Present Review

Qualitative research constitutes the keystone of empirical evidence for recovery, and the implementation of recovery principles in forensic mental health contexts should be based on recommendations that are derived from studies of sufficient methodological quality.

Although two systematic reviews in this field have recently been completed, these either prioritised synthesising findings of FSUs' perspectives at the expense of reporting a comprehensive critical appraisal of the methodological quality of studies in this literature, or there is evidence to suggest that their strategy for selecting studies may have been too narrow. They also limited their focus to research with FSUs, excluding other important stakeholders.

The present review aims to identify and summarise the qualitative research literature of recovery in forensic mental health contexts, and to critically appraise this literature's methodological quality. Fulfilling these aims should provide a foundation on which practitioners, researchers and policy-makers can critically apply the empirical evidence base to meaningfully implement and evaluate recovery in forensic contexts.

2. Method

2.1 Search Strategy

A systematic search was conducted on 7th May 2017 using the National Institute for Health and Care Excellence's Healthcare Databases Advanced Search facility (https://hdas.nice.org.uk). Five online electronic databases were searched: AMED (Allied and Complementary Medicine), BNI (British Nursing Index), CINAHL (Cumulative Index to Nursing and Allied Health Literature), Medline, and PsycINFO. The search was constructed using a combination of key terms relating to recovery, forensic mental health, and qualitative research methods (see Appendix B for a detailed description of searches). Duplicate results were removed manually.

Eligibility for inclusion was assessed in three stages according to the criteria below. First, the titles of identified papers were reviewed, then abstracts of papers not excluded in the first stage were reviewed, and finally the full texts of papers not excluded in the previous two stages were reviewed.

To identify additional relevant papers, the reference lists of fully reviewed papers were hand searched, the contents pages of key journals (*Journal of Forensic Psychiatry and Psychology, Criminal Behaviour and Mental Health, International Journal of Forensic Mental Health,* and *Journal of Forensic Practice*) were hand searched, and key terms were also entered into the academic search engine Google Scholar. Additional papers were only counted as search results if the title and abstract were judged to be relevant. The full texts of these additional papers were then reviewed to assess their eligibility for inclusion.

2.2 Eligibility Criteria

Studies were included in the review if they were published in English, as a full research article in a peer-reviewed journal that was available in printed or online form. Included studies had to primarily focus on recovery in forensic mental health contexts, using a qualitative or mixed methods research design. To be included, studies had to describe recovery in accordance with the conceptualisation set out earlier (see Section 1.1), and this description had to be given in the introduction section prior to data collection or analysis; this was an attempt to exclude studies that sought to investigate clinical recovery, and studies which applied the recovery concept retrospectively in light of their findings.

Studies were excluded if they used a purely quantitative research design.

The study selection process was conducted primarily by O.R., who initially identified twenty studies that appeared to meet this review's eligibility criteria. These twenty studies were secondarily rated for selection by C.Ch. using the same eligibility criteria. The final selection of these studies was discussed between O.R. and C.Ch., which led to the exclusion of two studies that were judged to not explicitly describe recovery in accordance with this review's conceptualisation in their study introductions. One other study was also considered for exclusion on this same basis, but it was ultimately included because it was judged to sufficiently espouse recovery principles.

See Figure 1 for a flowchart of the eligibility screening process.

2.3 Data Extraction and Critical Appraisal

A data extraction form (Appendix C) was developed and used to capture key features of the reviewed studies: location, service context, research questions, research aims, methodological approaches, data collection methods, data analysis methods, sampling criteria, participant demographics, and key findings and themes.

The methodological quality of reviewed studies was evaluated using the 'RATS' (Relevance, Appropriateness, Transparency, and Soundness) critical appraisal tool (Clark, 2003) (see Appendix D). The RATS tool was selected for use in this review because it is specifically designed for appraising qualitative research, and it is more comprehensive than many other equivalent tools, such as the CASP (2013) criteria.

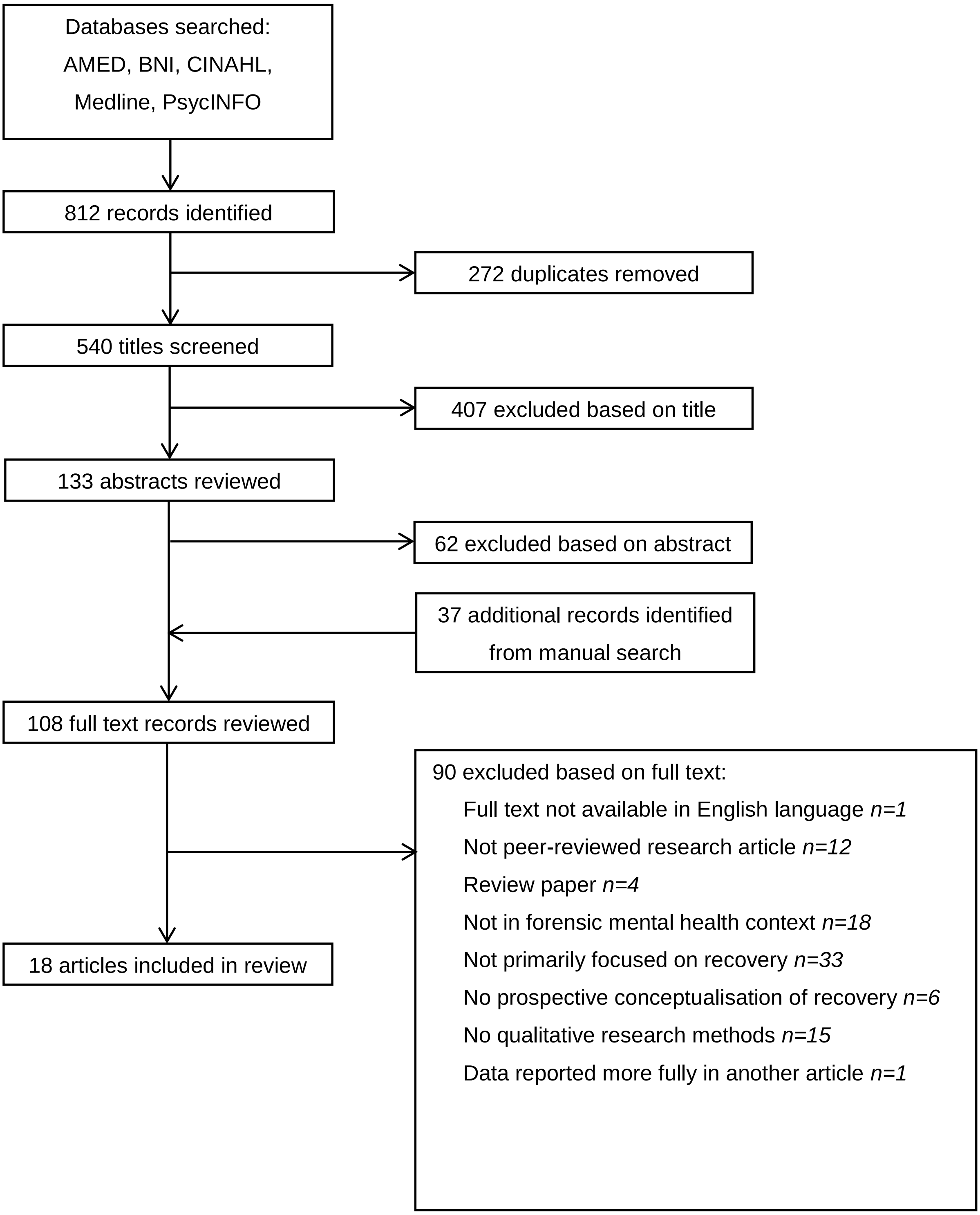

Figure 1. Flow chart of study selection process

3. Results

Eighteen studies were identified for inclusion in this review. A summary of each study is presented in Table 1, and an overview of their characteristics and key findings is described below. Each study was allocated a number in the first column of Table 1, so that for the rest of this review the studies could be cited either by these numbers or by using the conventional citation format.

3.1 Characteristics of Reviewed Studies

Twelve studies (1-8, 11, 12, 16, 17) were based in the United Kingdom, of which nine (1-5, 8, 11, 16, 17) were each based in one of the UK's four high-secure hospitals: Ashworth, Broadmoor, and Rampton in England, and the State Hospital in Scotland. The other three UK studies (6, 7, 12) were based in medium-secure and/or low-secure inpatient services in England. Three studies (9, 10, 18) were based in Australia's south-eastern state of Victoria, across two inpatient services of unspecified security levels. Two studies (14, 15) were based in a maximum-security hospital in northern Sweden. The final study (13) was based in British Columbia, Canada, in a hospital with high-, medium-, and low-security units. All of the reviewed studies conducted research in inpatient contexts, with no outpatient participants.

Three studies (2, 6, 7) used mixed methods designs, and the other fifteen studies (1, 3-5, 8-18) used purely qualitative methodologies. Three of the purely qualitative studies (3, 4, 17) used action research approaches, and two (3, 18) used ethnographic research approaches. Many studies reported using multiple methods of data collection and analysis. Data collection methods used were: face-to-face individual interviews (twelve studies: 5, 6, 8-15, 17, 18), focus groups (six studies: 3,

Table 1.

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
1	Adshead (2015) Broadmoor Hospital, Berkshire, England High-secure hospital, only male FSUs admitted.	"Not explicitly a research study" (p.74) but implicitly aimed to explore which themes of recovery were evident in therapy groups for male FSUs who had perpetrated homicide.	1) Review of clinical process notes from two therapeutic groups for FSUs who had perpetrated homicide. One group was for FSUs who knew the homicide victim - this had been running for 10 years. The second group was for FSUs to whom the homicide victim was a stranger - this had been running for 4 years. All group sessions were one-hour long in duration, but the frequency of them is not reported. Group sessions were facilitated by three therapists. The clinical process notes were made immediately after the group sessions based on therapist recall, with content of notes agreed between therapists, including main themes, and verbatim quotes as much as	FSUs only, not reported clearly in terms of *n*. The sample of clinical process notes reviewed was drawn from over 400 data sets based on 41 FSUs who attended either therapy group over a 10-year period. The most recent 2-year period was specifically sampled (160 sets of notes), and unspecified previous data sets from the full 10-year period were also referred to, based on "relevance". <u>FSUs</u> Genders: All male, none female. Ages: Mean = Not reported. Range = 19-63 years. Ethnicities: Not reported. Psychiatric diagnoses: All FSUs admitted to the facilities were "diagnosed with severe mental illnesses (such as paranoid	Therapy groups for male FSUs who had perpetrated homicide offered a structured and supportive environment. This facilitated 'narrative shifts' in the FSUs' self-expressed identities, which were interpreted as the FSUs coming to terms with and taking responsibility for having offended, as part of the process of recovery. The therapists' roles in facilitating these narrative shifts included being curious, not expressing judgment, and encouraging FSUs to

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
1 (ctd)			possible. 2) A pragmatic approach based on thematic analysis (Aronson,1994) that was actively focused on identity and sense of self.	schizophrenia and/or severe personality disorder, usually of an antisocial or borderline category)”. Index offences: “All homicide - including murder, manslaughter on the basis of diminished responsibility, and unfitness-to-plead.”	take responsibility for what was discussed. No themes were explicitly identified or described.
2	Ayres (2015) Broadmoor Hospital, Berkshire, England High-secure hospital, 210 adult male FSUs.	“To determine patient and staff views of the recovery approach in a forensic high-secure service” (p.30).	Mixed quantitative and qualitative design. Qualitative aspects were: 1) Self-report questionnaires: qualitative data collected from written responses to open-ended items of the DREEM OC-R for staff and DREEM RM for FSUs (Ridgway 2014). 2) Qualitative data analysed using inductive thematic analysis (no specific form is cited).	FSUs and staff. *N*=387 across two time points[2]: *n*=194 at T1, *n*=193 at T2. <u>FSUs</u> - *N*=143 (*n*=75 at T1, *n*=68 at T2) Genders*:* 143 male, 0 female. Ages: Not reported. Ethnicities: Not reported. Psychiatric diagnoses*:* Not reported. Index offences: Not reported.	The qualitative findings from both FSU and staff participants identified four main themes: (i) “Engage patients in meaningful activity, occupation, education and therapies” (ii) “Be there to listen to and understand patients” (iii) “The journey to recovery is long and hard”

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
2 (ctd)				Other - Ward type: 55 on assertive rehabilitation ward, 42 on high dependency ward[3] Staff - *N*=244 (*n*=119 at T1, *n*=125 at T2) Genders: Not reported. Ages: Not reported. Ethnicities: Not reported. Professions[4]: 115 qualified nurses, 47 health care assistants, 11 therapy assistants, 5 qualified occupational therapists, 1 occupational therapy assistant, 15 psychiatrists, 9 psychologists, 24 technical instructors, 1 social worker.	These themes showed "a strong correlation with the values and beliefs required to support the recovery approach in a forensic high secure setting" (p.26).
3	Chandley (2014) Ashworth Hospital,	"To explore the concept, and application, of "recovery" in the care and clinical	Action research and ethnography. 1) Participant observation, a monthly focus group, internal teaching including co-production	FSUs and staff. Not explicitly reported, possibly due to action research design. Focus groups were "attended by upwards of 20 patients and 20 nurses".	Many core principles of recovery were already implemented in service delivery, to the extent that they had a "taken for

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes[1]*
3 (ctd)	Merseyside, England High-secure hospital, provided by NHS.	management of patients detained in one UK high-security hospital." (p.203).	and co-delivery of personal stories and lectures on recovery. 2) No method of analysis is explicitly described.		granted" (p.210) status. Staff participants viewed recovery principles as an essential part of their role. There were "constraints and contradictions" (p.203) when applying recovery principles in forensic service contexts. No themes were explicitly identified or described.
4	Cromar-Hayes (2015) Ashworth Hospital,	1) To "move practice - so that the language of recovery is embedded in the ward's	Action research. 1) Focus groups, which were audio recorded and transcribed. 2) Thematic analysis (no specific form cited).	Staff only. Not reported in terms of *n*, possibly due to action research design. Focus groups of nursing staff (qualified and unqualified) weekly; 2 concurrent groups (1 per ward); 3 cycles of 4 months with staff	Recovery was evident in the high secure services, but "some of the core values are limited by the tension created by competing priorities; that

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
4 (ctd)	Merseyside, England High-secure hospital, two high-dependency wards (one for mental illness, one for 'personality disordered' FSUs), only male FSUs admitted.	language, both in documentation and discourse" 2) To "alter the ward experience - it was hoped that by embracing the essence of recovery those on the wards would experience a positive change" 3) To "empower nurses" (p.33).		from different shifts. 53 total focus group sessions (28 on mental illness ward, 25 on personality disordered ward).	is, care versus custody" (p.32). Eight emergent themes: (i) "Whose recovery?" - the issue of whether recovery is imposed on FSUs by staff (ii) Relationships - risks and benefits of building rapport, collaboration and empowerment (iii) Hope - including the dilemma for nursing staff of creating false hope (iv) Honesty - can be difficult due to risk issues (v) Control - nursing staff had a "perceived lack of control" in the care team

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
4 (ctd)					(vi) Power - nursing staff felt oppressed (vii) Fear - due to risks (viii) Protective factors - nursing staff needed to feel secure before they could support recovery
5	Ferrito (2012) Broadmoor Hospital, Berkshire, England High-secure hospital, only male FSUs admitted.	"To explore the process of 'recovery' and redemption in the narratives of a sub-group of homicide perpetrators who were admitted to a secure hospital for treatment" (p.329).	1) Individual semi-structured interviews using an interview schedule, which were audio recorded and transcribed. 2) IPA (Smith, 1996).	FSUs only, *N*=7. Genders: 7 male, 0 female. Ages: Mean = 30.86 years. Range = 25-46 years. Ethnicities: Not reported. Psychiatric diagnoses: 4 schizophrenia, 1 schizophrenia and BPD, 1 schizoaffective and psychopathic disorder, 1 psychopathy and ASPD. Index offences: 7 homicide.	Themes of recovery and redemption had meaning for FSUs who had perpetrated homicide. Six superordinate themes: (i) "The role of past experiences" (ii) "Impact on personal development" (iii) "Periods of 'loss of grip on reality'" (iv) "Reframing: events

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
5 (ctd)					via therapeutic intervention" (v) "Internal integration" (vi) "Roadblocks to the process of recovery".
6	Frayn (2016) Langdon Hospital, Devon, England Secure hospital with 4 medium-secure wards, 2 low-secure wards, and 2 open facilities, 110 male FSUs.	The only explicitly stated aim is clinical rather than research: "To reproduce the principles of the recovery college approach in a forensic setting in Devon" (p.29). Implicitly, the study's research aim is to describe that	Mixed quantitative and qualitative design case study. Qualitative aspects were: 1) Semi-structured interviews, and standardised participant feedback forms (a type of questionnaire). 2) No method of analysis is explicitly described.	FSUs and staff. Not reported clearly in terms of *n*. 8 participants were interviewed, including recovery college facilitators (both staff and people with lived experience of mental health problems) and recovery college students (FSUs). Other *n* (i.e., feedback forms completed by recovery college students) are not reported.	"It is possible to successfully adapt recovery college principles to the unique context and constraints of a forensic campus […] it has provided positive educational experiences, broadened horizons and generated hope" (p.34). Two identified themes: (i) The recovery college approach supported a shift in emphasis from

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
6 (ctd)		process as a case example.			treatment to education (ii) The value of co-facilitation. A dilemma was identified of encouraging more FSUs to attend whilst maintaining the appeal for FSUs that attending is their choice.
7	Green (2011) South-east England Medium-secure unit.	"To develop a brief and simple questionnaire […] to measure service-users' experience of recovery over their in-patient journey that is	Mixed quantitative and qualitative design. Qualitative aspects were: 1) Focus groups, guided by a comprehensive review of the recovery approach literature. 2) Qualitative data analysed using content analysis techniques (specific form uncited).	FSUs only, *N*=12. Genders: 12 male, 0 female. Ages: Mean = 35 years. SD = 7.5 years. Ethnicities: Not reported.	The qualitative findings identified five themes: (i) "Working together" (ii) "Support and preparation" (hope, working towards goals) (iii) "Empowering service-users" (iv) "Providing good role

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes[1]*
7 (ctd)		reliable and feasible for use in forensic mental health services" (p.255).		Psychiatric diagnoses: 12 'mental illness', 7 of which had comorbid diagnosis of 'personality disorder'. Index offences: Not reported.	models" (v) "Things to do" (opportunities to engage in activities). These themes were used to develop and validate a measure of recovery.
8	Laithwaite (2007) The State Hospital, Carstairs, Scotland Maximum-security hospital with 11 wards covering admissions, rehabilitation	"To generate a vivid account of the perspectives and experiences of people with psychosis residing in maximum security" (p.313).	1) Individual unstructured interviews, which were audio recorded and transcribed. 2) Grounded theory (Strauss and Corbin, 1990; Charmaz, 1990).	FSUs only, *N*=13. Genders: 12 male, 1 female. Ages: Mean = 39.15 years. Range = 22-60 years. Ethnicity: Not reported. Psychiatric diagnoses: 10 schizophrenia, 3 bipolar affective disorder. Index offences: 3 sexual offence, 1 manslaughter, 3 attempted murder, 3 assault, 1 attempted rape, 1 murder and sexual offence, 1 violent assault.	Two themes identified: (i) "Past experiences of adversity" (ii) "Recovery in the context of being in hospital". Two reciprocally related higher-order concepts evident across both themes: (i) "Relationships" (ii) "A changing sense of self".

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
8 (ctd)	and continuing care, male and female FSUs				'Tasks' involved in recovery included: (i) "The importance of Relationships" (ii) "Development of trust" (iii) "Coping" (iv) "Valued outcomes".
9	McKenna (2014a) Melbourne, Australia Secure 'extended-care' facility; adult inpatient unit with 26 beds that is an external wing of a metropolitan hospital.	"To provide a description of service delivery in a secure in-patient mental health service, which has developed a self-professed recovery orientation as its model of care. The intent was	1) Individual interviews with FSUs and with staff, which were guided by an interview schedule and prompts, and were audio recorded and transcribed. One focus group with non-staff carers of FSUs, which was recorded with written field notes. 2) Content analysis, using a general inductive approach (Thomas, 2006), then codes aligned deductively with pre-existing domains of recovery.	FSUs, staff, and non-staff carers of FSUs. Total *N*=20. <u>FSUs</u> - *n*=4 Genders: Not reported. Ages: Not reported. Ethnicities: Not reported. Psychiatric diagnoses: Not reported. Index offences: Not reported. <u>Staff</u> - *n*=11 Genders: Not reported.	Stakeholders of a forensic service were able to "embrace the challenges of imposed recovery and […] maintain a recovery-oriented focus" (p.69). Participants across all three groups described aspects of service delivery which integrated into the eight content domains of recovery that

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
9 (ctd)		to determine the extent to which elements of service delivery resemble the domains of recovery-oriented care specific to the demands of the Australian jurisdiction” (p.64)		Ages: Not reported. Ethnicities: Not reported. Professions: 1 consumer consultant, 1 manager, 1 lead nurse, 3 registered nurses, 1 enrolled nurse, 1 consultant psychiatrist, 1 social worker, 1 occupational therapist, 1 psychologist. <u>Non-staff carers of FSUs</u> - n=5 Gender: Not reported. Ages: Not reported. Ethnicities: Not reported. Relation to FSUs: Not reported.	the interview schedule was based on: (i) “A common vision: a journey toward “a life worth living”” (ii) “Promoting hope” (iii) “Promoting autonomy and self-determination” (iv) “Meaningful engagement” (v) “Focusing on strengths” (vi) “Holistic and personalized care” (vii) “Community participation and citizenship” (viii) “Managing risks by taking calculated risks”.

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
10	McKenna (2014b) Melbourne, Australia Secure 'extended-care' facility; adult inpatient unit with 26 beds that is an external wing of a metropolitan hospital.	"To describe the organizational procedure that enabled the systematic transformation of a custodial mental health service to a service with a self-professed recovery orientation as its model of service delivery" (p.227).	1) Individual interviews with FSUs and with service staff, which were audio recorded and transcribed. Reviewing written documents. 2) Thematic analysis, using a general inductive approach (Thomas, 2006)	FSUs, staff, and written documents. *N*=20. <u>FSUs</u> - *n*=4 Genders: Not reported. Ages: Not reported. Ethnicities: Not reported. Psychiatric diagnoses: Not reported. Index offence: Not reported. <u>Staff</u> - *n*=12 Genders: Not reported. Ages: Not reported. Ethnicities: Not reported. Professions: 1 consumer consultant, 1 manager, 1 lead nurse, 3 registered nurses, 1 enrolled nurse, 1 consultant psychiatrist, 1 social worker, 1 occupational therapist, 1	The service transformed to a recovery-oriented model, demonstrating that this is possible in forensic contexts. The culture shift required a clear conceptualisation of recovery, commitment to change, awareness of limitations, adaptations, and leadership. Four major themes: (i) ""We had this whole paradigm shift that needed to happen"" (ii) ""Think recovery": the development of a manualized guide" (iii) ""Stepping out my recovery": adaptation of

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
10 (ctd)				psychologist, 1 quality improvement manager. <u>Documents</u> *n*=4	the service guide to the secure care context" (iv) "Developing the culture", which was subcategorized to consist of (a) "The right people" (b) "Education" (c) "Reflective learning" (d) "Leadership".
11	McKeown (2016) Ashworth Hospital, Merseyside, England High-secure hospital, only male FSUs admitted	"To explore diverse viewpoints regarding how people make sense of recovery and experiences of recovery oriented	1) Semi-structured individual interviews. Additionally, a series of three focus groups with a subsample of five FSUs. Interviews and focus groups were all guided by a list of topics devised by the research team in consultation with an FSU representatives group. Interviews	FSUs and staff. *N*=55 <u>FSUs</u> - *n*=25 Genders: 25 male, 0 female. Ages: Not reported. Ethnicities: Not reported. Psychiatric diagnoses: Not reported[5]. Index offences: Not reported[5].	"Innovations for recovery oriented practice are being enacted in high secure environments and, notwithstanding institutional imperatives of security and control, do have palpable meaning for service users and staff" (p.240)

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
11 (ctd)		assessment and treatment initiatives within the hospital" (p.235).	and focus groups were all audio recorded and transcribed. 2) Thematic analysis (Coffey and Atkinson, 1996).	Staff - *n*=30 Genders: Not reported[6]. Ages: Not reported[6]. Ethnicities: Not reported[6]. Professions: 10 nurses, 7 health care assistants, 10 occupational staff/technicians, 3 "other staff roles".	Four themes identified: (i) "The importance of meaningful occupation" (ii) "Valuing relationships" (iii) "Recovery journeys and dialogue with the past" (iv) "Recovery as personal responsibility".
12	Mezey (2010) South London, England 4 wards in a medium secure unit.	"To explore forensic psychiatric patients' perceptions and experiences of recovery and to identify whether they had different narratives and	1) Face-to-face interviews co-conducted by two researchers - a service user researcher and a psychiatric trainee. The interviews were developed through discussion and piloting with team members and three FSUs. The interviews were divided into two sections: first, a narrative section with open-ended questions and	FSUs only, *N*=10. Genders: 8 male, 2 female. Ages: Mean = 37.1 years. Range = 24-56 years. Ethnicities: 4 white, 6 BME. Psychiatric diagnoses: 7 paranoid schizophrenia, 3 schizoaffective disorder. Index offences: 2 manslaughter, 5 GBH/ABH, 1 rape, 2 arson.	"Core recovery concepts of hope, self-acceptance, and autonomy are more problematic and appear to be less meaningful to individuals, who are detained for serious and violent offences" (p.683). Participants defined recovery in terms of symptom reduction,

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes¹*
12 (ctd)		patients, that could inform service planning and interventions" (p.684).	probes, and second a series of semi-structured questions. The interviews were audio recorded and transcribed 2) A thematic analysis using the open coding tools of grounded theory (Strauss and Corbin, 2009), followed by a directed content analysis (Hsieh and Shannon, 2005).		feeling better about oneself, and generally being able to live an ordinary life. Five themes identified about what helped to bring about recovery: (i) "Diagnosis, psycho-education and medication" (ii) "Secure detention as a route to recovery" (iii) "Security vs. sanctuary" (iv) "Time" (v) "Positive relationships and attachments". Impediments to recovery were the physical environment/atmosphere,

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
12 (ctd)					stigma, negative relationships and interactions.
13	Nijdam-Jones (2015) BC Forensic Psychiatric Hospital, British Columbia, Canada 190 beds across 9 low-, medium- and high-secure	"To understand the qualities of service that were identified as being important and meaningful to recovery in this forensic hospital" (p.159).	Part of a broader mixed quantitative and qualitative methodology evaluation. This study only reported qualitative aspects. 1) Individual semi-structured interviews using a mixed-method interview guide, which included standardised quantitative measures and open-ended	FSUs only, *N*=30. Genders: 24 male, 6 female. Ages: Mean = 40 years. Ethnicities: 26 white, 4 "other". Psychiatric diagnoses: 18 schizophrenia, 5 schizoaffective disorder, 3 bipolar disorder, 2 "stated psychotic disorder", 2 "did not know their diagnosis". Index offences: Not reported.	Five themes emerged: (i) "Involvement" in psychosocial programmes (ii) "Belief and adherence to social norms and rules" (iii) "Attachment to supportive individuals: Staff, friends and family" (iv) "Commitment" to

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
13 (ctd)	units, adult FSUs.		questions. Interviews were audio recorded and transcribed. 2) Thematic analysis (Braun and Clarke, 2006), using a hybrid inductive and deductive approach (Fereday & Muir-Cochrane, 2006).	Other - Substance abuse: 16 FSUs reported a history of alcohol or substance abuse. Other - Previous admissions: Mean = 3. Median = 2. Range = 0-15. SD = 3.6. Other - Length of stay for current admission: Mean = 46.1 months. Median = 23 months. SD = 54.8 months.	work-related activities (v) Concern about the indeterminacy and "length of stay". The first four themes mapped closely onto Hirschi's (2002) criminologically-derived social bonding theory, as well as relevant literature on recovery.
14	Olsson (2014) Sundsvall Forensic Psychiatric Hospital, Sundsvall, Sweden	"To explore how forensic patients who had decreased their assessed risk of violence experienced their turn towards	1) Individual interviews, using an interview guide. Interviews were audio recorded and transcribed. 2) Latent content analysis (Graneheim and Lundman, 2004).	FSUs only, *N*=10. Genders: 8 male, 2 female. Ages: Mean = 36 years. Range = 26-62 years. Ethnicities: Not reported. Psychiatric diagnoses: Not reported.	The journey from high-risk to recovery was "long and arduous" (p.510), but was aided by a safe environment and supportive nursing care. Three themes identified: (i) "The high-risk phase:

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
14 (ctd)	Maximum-security clinic, approximately 100 beds divided into 8 care units.	recovery" (p.506).		Index offences: Not reported. Other - Length of stay for current admission: Median = 4.7 years. Range = 3-7 years.	facing intense negative emotions and feelings" (ii) "The turning point phase: reflecting on and approaching oneself and life in a new way" (iii) "The recovery phase: recognising, accepting and maturing".
15	Olsson (2016) Sundsvall Forensic Psychiatric Hospital, Sundsvall, Sweden	"To determine what resources key workers and forensic staff use to avoid or prevent violent situations. The aim is to explore how these	1) Individual interviews using a semi-structured interview guide with open-ended questions. Interviews audio recorded and transcribed. 2) Content analysis (Hsieh and Shannon, 2005).	Staff only, *N*=13. Gender: 7 male, 6 female. Ages: Mean = 40 years. Range = 30-60 years. Ethnicities: Not reported.	Staff 'key workers' avoided and prevented violent situations through knowledge, support, and actions on three levels: (i) "Internal knowledge", including perceiving FSUs' frames of mind

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
15 (ctd)	Maximum-security forensic psychiatric hospital.	practices resemble the domains of recovery-oriented care and to provide a baseline understanding of practice in preparation for transformation to recovery-oriented services in forensic care" (p.507).		Professions: 3 registered mental health nurses, 1 registered nurse, 9 assistant mental nurses. Other - Years in the forensic profession: Mean = 7 years. Range = 2-35 year.	and ward atmosphere (ii) "Peer security" through shared collegial responsibility (iii) "Control-oriented strategies" including risk management and having a clear mission. These three levels were related to domains of recovery, including hope, collaboration, strengths-based approaches, empowerment and choice.

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes[1]*
16	Skinner (2014) Rampton Hospital, Nottinghamshire, England High-secure hospital.	"This evaluation explores the extent to which a program, at the earliest stage of a treatment pathway in a high secure hospital, can achieve its goal of contributing to the recovery process" (p.89).	1) Focus groups, following five steps (Cronin, 2008) including open-ended questions. Focus groups were audio recorded and transcribed. 2) Thematic analysis (Braun and Clarke, 2006) along with its reconceptualisation as saliency analysis (Buetow, 2010).	FSUs only, *N* = 7. Genders: 7 male, 0 female. Ages: Mean = 33.71 years. Range = 23-57 years. Ethnicities: 1 Asian Pakistani, 1 Asian Kurdish, 2 Black African, 1 Black Caribbean, 1 White British, 1 White Irish. Psychiatric diagnoses: 1 schizophrenia, 3 paranoid schizophrenia, 3 other psychotic illnesses. Index offences: 1 no index offence, 3 murder, 3 GBH. Other - MHA Section: 1 Section 3 admission for treatment, 3 Section 37/41 hospital order with restrictions, 1 Section 38 interim hospital order, 2 Section 47/49 Home Office transfer.	A motivational group program promoted principles of recovery. "It is possible to incorporate recovery principles even at the earliest stage of the treatment pathway in high secure hospital" (p.99). Five key themes: (i) "Gaining confidence" (ii) "Hope" (iii) "Gaining control and taking responsibility" (iv) "Identifying strengths" (v) "Social support".

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
17	Souter (2015) Rampton Hospital, Nottinghamshire, England High-secure hospital, men's personality disorder admission ward, provided by NHS.	"To gauge the level of understanding among the qualified nurses on the ward on the importance and perceived relevance of recovery" (p.72).	Action research. 1) 12-item semi-structured questionnaires, which participants had the options to self-complete in written form or to answer the questions in an informal interview. 2) A three stage framework of qualitative analysis (Miles & Huberman 1994).	Staff only, *N*=8. Genders: Not reported. Ages: Not reported. Ethnicities: Not reported. Professions: 8 qualified nurses. Other - Years qualified: ≥10 years = 2 5-10 years = 3 ≤5 years = 3	More recently qualified nursing staff were more knowledgeable and positive about the recovery approach than nursing staff who had been qualified for longer. "The findings highlight that further development is required in staff training and education on recovery" (p.72). No themes were explicitly identified or described.

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
18	Walker (2013) 'TEH', Fairfield, Victoria, Australia Rehabilitation ward of a secure forensic psychiatric services facility with 118 FSUs.	"To understand staff and patients' understandings of the function of community day leaves (CDLs) conducted as an aspect of rehabilitation in a secure forensic psychiatric services facility in Australia (TEH), and to evaluate how a recovery model	Ethnography (Minichiello *et al.* 2004). 1) Observations, field notations, and semi-structured individual interviews. Interviews were audio recorded and transcribed. 2) Thematic analysis (Liamputtong and Ezzy 2006) guided by a comparative method. Synthesis of findings from different sources was guided by a process of narrative analysis (Polkinghorne 1995).	FSUs and staff, *N* = 19 (across 10 Community Day Leaves). FSUs - *n*=9 Genders: 9 male, 0 female. Ages: Not reported. Ethnicities: Not reported. Psychiatric diagnoses: "Predominant diagnosis of patients was schizophrenia" (p.112). Index offences: Not reported. Other - Length of stay for current admission: Mean = 7 years. Staff - *n*=10 Genders: Not reported. Ages: Not reported. Ethnicities: Not reported.	FSU participants and staff participants expressed their understanding differently, but had a similar understanding of the function of community day leaves: to successfully reintegrate and practice daily living skills. "Recovery principles practiced included developing a sense of connectedness to others, power over their own lives, the roles they value, and therefore, hope for themselves." (p.109).

Table 1. (continued)

Summary of reviewed studies

#	*First author (publication year)* *Location* *Service context*	*Research aim(s)*	*Methodological approach(es)* *1) Data collection method(s)* *2) Data analysis method(s)*	*Participant demographics*	*Key findings and themes*[1]
18 (ctd)		was enacted" (p.110).		Professions: 7 psychiatric nurses employed at the hospital, 1 agency psychiatric nurse, 1 occupational therapist, 1 psychiatric support officer. Other - Years of employment: Mean = 5 years. Range = 18 months - 18 years.	No themes were explicitly identified or described.

Notes:

[1] Themes presented in inverted commas are repeated verbatim from the source material without assignation of paginated references.

[2] Participants included at each time point were independent volunteer samples from the same population, and due to anonymity procedures the study authors were blind to how many participants from T1 and T2 were the same individuals and how many were unique individuals.

[3] Subsample participant numbers are those reported in the study, but they do not add up correctly to any reported sample total.

[4] Total *N* across both time points reported, not broken down into T1 and T2.

[5] McKeown *et al.* (2016) explicitly stated that "To encourage as wide as possible participation, we did not collect information regarding service user participants' index offence, length of stay, or diagnosis" (p.235).

[6] McKeown *et al.* (2016) explicitly stated that "For the staff, we restricted ourselves to identification of participants' job role" (p.235).

ABH = Actual bodily harm; ASPD = Anti-social personality disorder; BME = Black and minority ethnicity; BPD = Borderline personality disorder; DREEM = Developing Recovery Enhancing Environments Measure; FSUs = forensic service users; GBH = Grievous bodily harm; IPA = Interpretative Phenomenological Analysis; MHA = Mental Health Act; NHS = National Health Service; OC-R = Organisational Climate-Recovery; RM = Recovery Markers; SD = Standard deviation; T1 = Time point 1; T2 = Time point 2.

4, 7, 9, 11, 16), questionnaires (three studies: 2, 6, 17), and reviews of written clinical notes or other documents (two studies: 1, 10). Data analysis methods used were: thematic analysis (nine studies: 1, 2, 4, 10, 11-13, 16, 18), content analysis (five studies: 7, 9, 12, 14, 15), grounded theory approaches (two studies: 8, 12), interpretative phenomenological analysis (one study: 5), narrative analysis (one study: 18), saliency analysis (one study: 16). In one study (17) a “three stage framework” for analysis was used, and in two studies (3, 6) no methods of data analysis were explicitly reported.

In terms of study participants, eight studies (1, 5, 7, 8, 12-14, 16) used data collected exclusively from FSUs, seven studies (2, 3, 6, 9-11, 18) used data collected from both FSUs and staff (in one of these studies [9], data were additionally collected from non-staff carers of FSUs), and three studies (4, 15, 17) used data collected exclusively from staff.

3.2 Key Findings of Reviewed Studies

3.2.1 Principles of Recovery

Sixteen studies (1, 2, 4-9, 11-18) explicitly identified in their findings at least one of the principles of recovery that comprise the conceptualisation of recovery adopted for this review (see Section 1.1):

- ‘Hope for the future’ was identified in ten studies (4-7, 9, 14-18)
- ‘Re-establishing one’s identity’ was identified in three studies (1, 5, 8)
- ‘Having meaning and purpose in life’ was identified in nine studies (2, 5-7, 9, 11, 13, 16, 17)
- ‘Empowerment by having responsibility and choice’ was identified in eight studies (1, 4, 6, 7, 9, 11, 13, 15)
- ‘A focus on strengths’ was explicitly identified in four studies (9, 14-16)
- ‘Connectedness with others’ was identified in eleven studies (2, 4, 7, 8, 11-16, 18).

Chandley *et al.* (2014) discussed their findings with reference to principles of recovery, but did not explicitly identify any of the principles in their own data. McKenna *et al.* (2014b) did not explicitly identify any principles of recovery in their findings, although this may be because the anomalous focus of this study was on the processes of a service's operational change to a recovery orientation, rather than directly exploring recovery itself.

3.2.2 Challenges, Barriers and Dilemmas

A range of challenges, barriers and dilemmas to implementing recovery in forensic contexts were identified in the findings of reviewed studies.

Nine studies (3, 4, 9-12, 14, 15, 17) explicitly identified the dilemma of implementing recovery principles (particularly empowerment) in forensic contexts where managing risks and ensuring safety almost invariably takes precedence. Methods of managing risks (ranging from restrictions on liberties and inpatient detainment to mechanical restraint and tranquilisation) were described as "coercive" (Olsson *et al*., 2014, p.507) and "controlling" (Chandley *et al*., 2014, p.204), and were widely regarded as disempowering to FSUs due to limiting their opportunities to develop autonomy. However, Olsson and Schön (2016) found that ensuring safety on inpatient wards was an important prerequisite to facilitating recovery.

Four studies (3, 5, 12, 18) identified that issues of stigma experienced or perceived by FSUs not only included mental health stigma, but double or even triple stigma about FSUs' offending behaviour and their detainment in secure care. These additional forms of stigma presented challenges to FSUs' recovery, especially the process of self-acceptance involved in re-establishing their identities, and being accepted by others as an aspect of connectedness.

Nijdam-Jones *et al.* (2015) identified another, more practical, barrier to FSUs having connectedness with others: simply being in hospital isolates them from family and friends.

Two studies (4, 6) identified the dilemma created by the unilateral imposition of recovery models by organisational policies and forensic service staff. Frayn *et al.*'s (2016) case study of a recovery college illustrated this irony: the staff wanted higher attendance of FSUs at college in order to engage them in recovery-oriented activities, but having attendance as an optional choice was imperative to supporting the recovery principle of empowerment.

Four studies (4, 12-14) identified another dilemma faced by forensic service staff: their efforts to foster FSUs’ hopes for the future could easily lead them to create false hope, compounded by the indeterminacy of many inpatient FSUs’ length of stay in secure hospitals.

Other identified challenges and barriers to implementing recovery in forensic contexts were the sometimes volatile atmospheres of secure hospital wards (12, 14, 15), FSUs experiencing breakdowns in communication with forensic service staff (5, 12, 17), the opposition of forensic service staff to adopting recovery principles in their practice (10, 17), and the difficulty many FSUs had in trusting others due to past experiences of trauma (5, 8).

3.2.3 Strengths and Ways of Overcoming Barriers

Three studies (3, 4, 9) identified the vital role of nursing staff in proactively building relationships with FSUs in order to foster hope, help FSUs feel connected with others, and empower FSUs by giving them choices as part of collaborative approaches to care planning.

Two studies (9, 18) identified that ‘positive risk-taking’ was an approach that forensic service staff used in an attempt to overcome the barriers created by issues of risk management. Olsson and Schön (2016, p.508) identified that “shared collegial responsibility” among nursing staff helped to support atmospheres of safety on inpatient wards, which facilitated recovery.

Four studies (6, 9, 11, 18) identified that FSUs must have access to facilities within the restrictions imposed on them if they are to engage in rehabilitative activities that can contribute to them having a sense of meaning and purpose. For inpatient FSUs with sufficient leave privileges, this included reintegration into the local community (9, 18) and attending off-ward but on-site leisure, education and workshop facilities (6, 11). For inpatient FSUs who were restricted to staying on their ward, this was facilitated by on-ward activities (11).

Two studies (3, 10) identified that engaging forensic service staff in education and reflection about recovery principles enhanced their adoption of recovery-oriented practices.

McKenna *et al.* (2014b) identified that forensic service staff's implementation of recovery principles was aided by having a manual for this, which incorporated adaptations for the forensic context.

3.2.4 Relevance and Applicability of Recovery in Forensic Contexts

Ten studies (3-6, 9-11, 16-18) explicitly concluded that principles of recovery were relevant and applicable in forensic contexts, and a further six studies (1, 2, 8, 13, 14, 15) were judged to implicitly support the same conclusion. Many of these studies acknowledged that the nature of forensic services presented challenges to applying recovery principles, and therefore adaptations were necessary for recovery-oriented approaches to be implemented.

Mezey *et al.*'s (2010, p.683) conclusions also acknowledged such challenges and the need for adaptations, but they additionally concluded that recovery principles "appear to be less meaningful" to FSUs; it was not explicit whether this study supported the application of recovery principles in forensic contexts, but this additional conclusion suggested it might not.

Green *et al.* (2011) did not state any conclusions about the relevance or applicability of recovery principles in forensic mental healthcare, which is likely due to this study's focus on the development of a measure of recovery.

No studies explicitly concluded that recovery was irrelevant in forensic contexts.

This review's critical appraisal of the eighteen studies is presented below, following the structure of the domains and questions of the RATS tool (Clark, 2003; see Section 2.3).

3.3 Relevance of Study Question

Is the research question explicitly stated and justified? Is it important for medicine or public health? Is it linked to the existing knowledge base (literature, theory, practice)?

Only three studies (4, 16, 18) explicitly stated their research questions. The other fifteen studies (1-3, 5-15, 17) did not explicitly state any research questions; nevertheless, the line of enquiry in these studies was implicitly evident from the literature discussed in their introductions.

All but one study (Ayres *et al*., 2015) were judged to be sufficiently linked with the existing knowledge base (in terms of theory, previous empirical evidence, policy, and practice) such that the rationale for conducting their research was justified, interesting, and ultimately relevant to advancing the field of forensic mental health. Ayres *et al.* (2015) did not set out a sufficient rationale - the authors relied upon only citing their own earlier work as the empirical basis for their present research, without further describing the work they cited.

3.4 Appropriateness of Qualitative Method

a) Is qualitative methodology the best approach for the study aims?

In seventeen studies (1-16, 18), qualitative methodology seemed to be the best approach for the studies' aims; their aims were predominantly exploratory, seeking to understand the perspectives of people with lived experiences of recovery in forensic contexts, for which qualitative methods are well-suited. The remaining study (17) aimed to evaluate staffs' understanding of recovery - its qualitative methodology was indeed suited to eliciting "variability of the responses" (p.73) that it sought, but a mixed-methods design incorporating additional quantitative measures may have been better able to fulfil its aims as an evaluation.

b) Is the study design justified? Why was a particular method (for example, interviews) chosen?

In terms of the specific qualitative methodological approaches to research design (incorporating data collection and analysis), five studies (10, 12-14, 16) offered complete justifications for selecting the approaches used.

Six studies (2, 4, 5, 7, 8, 17) sufficiently justified their approach to at least one but not all methodological elements. For instance, Cromar-Hayes and Chandley (2015) provided a clear rationale for using an action research design, however, whilst they described their data collection method of facilitating focus groups and their use of thematic analysis, no justification of the last two aspects was offered to illustrate why these particular approaches were favoured over alternatives.

Seven studies (1, 3, 6, 9, 11, 15, 18) did not sufficiently justify any aspects of their selected methodological approaches.

3.5 Transparency of Procedures

3.5.1 Sampling Strategy

Are criteria for selecting the sample explained and justified? Why were these participants selected as the most appropriate to provide access to the type of knowledge sought by the study?

The criteria for selecting the sample used was fully explained and justified in seven studies (5, 8, 11, 13-15, 18), all of which adopted purposive sampling approaches in an attempt to include the perspectives of specific individuals or groups who had direct experience of the phenomena under investigation. One further study (17) justified its use of a purposive sampling strategy, although it did not explicitly state the inclusion and exclusion criteria that were applied.

Eight studies (1, 3, 6, 7, 9, 10, 12, 16) did not justify their sampling strategy explicitly, although they all gave sufficient background for an informed reader to infer that the samples they selected were likely to be the most appropriate for providing the type of knowledge that they sought.

The final two studies (2, 4) provided insufficient detail on which to judge the appropriateness of the samples they selected. Ayres *et al.* (2015) recruited FSUs and staff from a high-secure hospital, but did not provide a theoretically-grounded or policy-driven rationale for doing so. Cromar-Hayes and Chandley (2015) explored nurses' views on implementing recovery in two high-secure wards, but they provided no clear reason for excluding other staff groups or FSUs. Although the samples used in these two studies had reasonable face validity, the lack of explicit detail about their sampling criteria makes it indeterminable whether these samples were the *most* appropriate to meet these studies' aims.

3.5.2 Recruitment

a) How and by whom was recruitment conducted?

Only Ferrito *et al.* (2012) explicitly described how and by whom recruitment was conducted. Six studies (1, 4, 8, 13, 16, 18) reported how their recruitment was conducted, but were ambiguous about who was involved. Three of these studies (4, 13, 18) gave no indication who conducted the recruitment, and the other three (1, 8, 16) described only who was involved in identifying potential participants but not who made the approach to invite potential participants to join the study.

The remaining eleven studies (2, 3, 6, 7, 9-12, 14, 15, 17) did not sufficiently describe either how or by whom recruitment was conducted. Two (7, 12) of these studies described who identified potential participants but not who approached them. Additionally, whilst McKeown *et al.* (2016) credited two of their authors with roles in recruitment, it is unclear what aspects of recruitment their involvement extended to. The other eight studies (2, 3, 6, 9, 10, 14, 15, 17) did not describe the conduct of their recruitment processes at all.

b) Who chose not to participate and why?

Green *et al.* (2011) was the only study that described who declined to participate and why. A further four studies (5, 8, 15, 17) explicitly reported that everyone who was invited to participate agreed to do so.

Nijdam-Jones *et al.* (2015) recruited FSU participants who voluntarily responded to posters and a brief presentation at the hospital, so no one actively declined their invitation, although they do not report any considerations of why many FSUs may not have responded. Similarly, Walker *et al.* (2013) invited FSUs to participate at a ward community meeting, and they do not reflect in their report on those who did not voluntarily respond; furthermore, one FSU agreed to participate in the ethnographic observation phase of their study but then declined to subsequently being interviewed, and no reason for their refusal is given.

Frayn *et al.* (2016) offered possible reasons why some FSUs may not have participated in the recovery college that they studied, but these were general rather than specific about individuals. Olsson *et al.* (2014) and Skinner *et al.* (2014) both reported how many FSUs declined participation, but only gave the reasons why for FSUs who were unable to take part due to practical reasons (moving out of hospital, and having other commitments at the same time as study activities); for other FSUs who did not participate, no reasons were described. Adshead *et al.* (2015) reported that four FSUs refused to attend the therapeutic group that they studied, but did not describe their reasons for refusal. McKeown *et al.* (2016, p.236) ambiguously reported that "only small numbers of staff and service users refused invitations to participate", without specifying further who or why. Mezey *et al.* (2010, p.685) described that two FSU participants "changed their minds" prior to being interviewed, but no reasons why they did so were reported.

Four studies (2, 3, 9, 10) did not describe their recruitment at all, so these provided no details about who chose not to participate or why. Lastly, Cromar-Hayes and Chandley (2015) also did not describe who chose not to participate or why, but furthermore it is ambiguous whether their action research approach meant that participation in the study was essentially non-optional for their nursing staff participants.

c) Was selection bias discussed?

Six studies (1, 2, 5, 12, 13, 17) explicitly discussed the possibility of selection bias as part of their limitations, and these mostly reflected that any selection bias in their recruitment was inherent due to their topic focus. For example, FSUs who attended therapy groups became more socialised to reflecting on their experiences, a characteristic which in turn increased their likelihood of participating in reflective research interviews about the therapy groups.

Eight studies (3, 7, 8, 11, 14-16, 18) did not explicitly discuss selection bias, but based on other details reported about their recruitment, the potential for selection bias appears likely to be minimal and not giving rise to any particular issues.

Both studies by McKenna *et al.* (2014a, 2014b) used data from "purposively selected" samples, however they described no details about the bases for purposive sampling; although the nature of purposive sampling created possibilities for selection bias, they did not discuss this issue at all. The aforementioned ambiguity about whether Cromar-Hayes and Chandley's

(2015) action research was optional or not for nursing staff poses issues about selection bias that are not discussed, and any potential biases are unknown without details of who did and did not participate.

Frayn *et al.* (2016) did not discuss selection bias, but the voluntary nature of attendance at the recovery college they studied meant that those FSUs who attended and gave feedback were likely to be aligned with the recovery principles under investigation. Similarly, staff who were interviewed for the study were purposively "selected on the basis of long-term involvement with the [recovery college]" (p.31), which meant that they would likely have had a strong investment in it and may therefore have been biased to speak positively of it.

3.5.3 Data Collection

a) Was collection of data systematic and comprehensive? Are methods explicitly outlined and examples, such as interview questions, given?

Six studies (1, 5, 8, 13-15) explicitly described their methods of data collection and gave verbatim examples of interview questions used, demonstrating that their collection of data was systematic and comprehensive.

Although not entirely explicit, the data collection of nine further studies (2, 4, 9-12, 16-18) appeared to be mostly systematic and comprehensive. Four of these studies (9, 11, 16, 18) did not provide examples of specific questions used in their interviews and/or focus groups, but they did describe the nature of questions or topics that they used to elicit data. The same is true of Cromar-Hayes and Chandley (2015), although their report was less comprehensive as it did not describe who facilitated their focus groups. McKenna *et al.* (2014b) and Mezey *et al.* (2010) outlined their methods of data collection explicitly, except that neither provided examples of specific questions, and nor did they describe the nature of questions or topics. Ayres *et al.* (2015) used questionnaire measures to collect data, and whilst these are described comprehensively, the process by which they were administered is not described at all. Souter (2015) also used questionnaires and described these comprehensively, but did not provide any details about the conduct of interviews which were offered to participants as an alternative method of data collection.

The final three studies (3, 6, 7) did not provide enough detail about their data collection to judge whether it was systematic and comprehensive.

b) Are characteristics of the study group and setting clearly described?

Only three studies (1, 8, 17) clearly described both their study group and setting. Twelve studies (2-4, 6, 9-11, 13-16, 18) clearly described the study settings, but provided only minimal information about the study authors' affiliations and, in eight cases, also their professional roles. Conversely, Mezey *et al.* (2010) described their study group but did not describe the setting beyond that it was a medium secure unit. Green *et al.* (2011) also only described their study setting generally as a medium secure unit, but they also did not describe their study group except for author affiliations. Lastly, Ferrito *et al.* (2012) neither described their study group (except author affiliations) nor the setting, except generally that it was a secure forensic service.

c) When was data collection stopped and why?

Two studies (4, 13) clearly described the end of their data collection and justified why this was deemed reasonable: Cromar-Hayes and Chandley (2015) reported that they reached data saturation, and Nijdam-Jones *et al.* (2015) described factors that prospectively guided the sample size they used. Additionally, Chandley *et al.* (2014) explicitly described that their action research project was ongoing at the time of publishing their report about it, which is justified for this methodology. Laithwaite and Gumley (2007) reported reaching theoretical sufficiency, but they did not justify why they used this principle to end their data collection.

Eleven studies (1, 5, 7, 9-12, 14-16, 18) did not clearly describe when or justify why their data collection ended, although based on the sizes of their datasets with respect to the methodological approaches they used, the end of their data collection appears reasonable.

Three more studies (2, 6, 17) also did not explicitly discuss the end of their data collection, but in these cases it is not possible to judge whether this was reasonable within their study designs.

3.5.4 Role of Researchers

a) Do the researchers occupy dual roles (clinician and researcher?)

Only six studies (8, 11, 12, 16-18) discussed explicitly in their main text (i.e., excluding author affiliations) whether or not any of their researchers occupied dual roles as clinicians alongside their researcher roles. In two of these studies (8, 17) the primary researcher (who was the only one to have direct contact with participants) also held a clinical role in the study setting. In another two of these studies (12, 18), the converse was true - the primary researcher (again, the only one to have direct contact with participants) was independent of the study setting. The other two of these studies (11, 16) described that some of their researchers had clinical roles alongside their researcher role, but it is not possible to determine what effects this may have had because neither study sufficiently described which researchers were involved in the different aspects of each study (e.g., recruitment, data collection).

The remaining eleven studies (1, 2, 4-7, 9, 10, 13-15) did not explicitly discuss in their main text anything about the roles of their researchers.

b) Do the researcher(s) critically examine their own influence on the formulation of the research question, data collection, and interpretation?

Laithwaite and Gumley (2007) were the only reviewed study that critically examined the influence of its researchers on the conduct of the study - they explicitly described their engagement with methods of reflexivity which helped them achieve this.

All other seventeen studies (1-7, 9-18) reported no efforts in this vein at all.

3.5.5 Ethics

a) Is informed consent detailed?

Ten studies (5, 8-10, 12, 13, 15-18) explicitly stated that informed consent was given by participants. Of these, only Walker *et al.* (2013) comprehensively detailed (i) who sought participants' consent, (ii) that participants had mental capacity to give consent, and (iii) ethical considerations about coercion and participants' rights with respect to giving consent. Although some of the other studies did address some of these aspects, no others specified who sought participants' consent.

Two further studies (1, 14) described that participants gave consent, but it is not explicit that their consent was informed with respect to the specific research study.

The remaining six studies (2-4, 6, 7, 11) did not discuss participants' consent at all.

b) Is a discussion of anonymity and confidentiality presented? How were anonymity and confidentiality ensured?

Ayres *et al.* (2015) reported collecting data using anonymous questionnaires, which assured the anonymity of respondents. Skinner *et al.* (2014) also stated clearly how they ensured anonymity and confidentiality in their study, by anonymising data and keeping it in a locked filing cabinet.

Seven further studies (1, 5, 11, 12, 14, 17, 18) also explicitly referred to issues of confidentiality. Ferrito *et al.* (2012) described that they removed identifying details so that disclosed material would be anonymised, and they ascribed quotes to pseudonyms. Adshead *et al.* (2015) and Walker *et al.* (2013) explicitly stated that they used pseudonyms to ensure confidentiality. Three studies (11, 12, 14) reported that anonymity and confidentiality of participants' information was assured, but they did not detail how; they did all anonymise quotes used (ascribing them numbers, generic roles such as 'staff', or not ascribing them to any source at all), but this step was not explicitly described. Souter's (2015) only explicit reference to confidentiality was as a limitation of his study, that the anonymity of participants could possibly be compromised from the small sample (eight nurses).

Six studies (4, 8-10, 13, 15) did not discuss anonymity or confidentiality explicitly, but it is evident that they all took steps to ensure that reported quotes did not identify participants. Neither Green *et al.* (2011) nor Chandley *et al.* (2014) made explicit reference to issues of confidentiality, but they also did not present any quotes or other potentially identifiable material in their reports. Frayn *et al.* (2016) did not explicitly discuss anonymity or confidentiality, yet they ascribed people's names to extended accounts of three participants - it is unclear if these were the participants' real names or pseudonyms.

c) Was approval from an ethics committee received?

Ten studies (5, 8-15, 18) explicitly cited or described that they received approval from an ethics committee. Seven studies (1-4, 6, 7, 17) made no reference to ethical approval at all. Skinner *et al.* (2014) stated clearly that their study did not require ethical approval because it was an evaluation of a service.

3.6 Soundness of Interpretative Approach

a) Is process of analysis described in-depth?

Seven studies (5, 8, 12-16) explicitly described the processes of their analyses with enough detail for the analyses to be replicable. All seven of these studies also cited the specific analytic guidelines that they used.

Six more studies (1, 9-11, 17, 18) also cited the specific analytic guidelines used, but they only reported general details about the processes of their analyses, such that no reliable attempt at replication could be made on the basis of what they explicitly reported.

Three studies (2, 4, 7) did not describe their analytic processes beyond very generally naming the forms of analyses used (thematic analysis and content analysis), and these were not cited as being based on any specific analytic guidelines. Lastly, neither Chandley *et al.* (2014) nor Frayn *et al.* (2016) described any methods of analysis at all.

b) How were themes derived from the data? Were alternative explanations sought?

Six studies (5, 8, 12-14, 16) clearly described how they derived themes from the data, and sought alternative explanations in the process. Three of these studies (5, 8, 16) implicitly used inductive approaches to derive themes, and the other three (12-14) explicitly described combining inductive and deductive approaches.

Three further studies (9, 10, 15) clearly described how themes were derived from their data, but they provided no evidence of seeking alternative explanations. Of these, McKenna *et al.* (2014a) and Olsson and Schön (2016) explicitly described combining inductive and deductive approaches, whilst McKenna *et al.* (2014b) explicitly described using an exclusively inductive approach.

Cromar-Hayes and Chandley (2015) demonstrated evidence of seeking alternative explanations, but their description of how themes were derived from their data was too brief to be clear. Similarly, three other studies (1, 2, 18) only minimally described how themes were derived from their data, and did not appear to seek alternative explanations either.

Adshead *et al.* (2015) explicitly claimed to use a deductive approach, and Ayres *et al.* (2015) explicitly described using an inductive approach. The other two studies (4, 18) implicitly appeared to use inductive approaches.

The remaining five studies (3, 6, 7, 11, 17) did not describe at all how themes were derived from their data.

c) Are the interpretations clearly presented and adequately supported by the evidence? Were quotes used and on what basis were these chosen?

Thirteen studies (1, 4, 5, 9-18) presented their interpretations clearly and adequately supported these with evidence from their data. All of these studies used quotes as a form of supporting evidence, although only five (9-11, 15, 18) explicitly described the basis on which they selected quotes - typically to ‘illustrate’, ‘support’, or ‘exemplify’ themes.

Laithwaite and Gumley (2007) clearly described each of their themes in turn, but their attempt to bring these together into a grounded theory was so complex that their description of it became incoherent. They did not present their grounded theory in diagrammatic form (as is commonly done in grounded theory studies), yet doing so may have helped to improve the coherence of their presented interpretations.

Frayn *et al.* (2016) presented a range of their participants’ views as ‘illustrations’ of their findings. However, their findings were not necessarily interpretations; in line with their aim to report a case example, their findings were generally descriptive rather than analytical.

The interpretations of the remaining three studies (2, 3, 7) were either not clearly presented, or were not adequately supported with evidence. The data presented by Ayres *et al.* (2015) appeared to support the interpretations that the authors made, but this can only depend on the reader’s inference, without links being made explicit in their presentation of findings. Chandley *et al.*'s (2014) presentation of their interpretations is generally clear, but their supporting evidence appears to have been selected on an *a priori* basis in a manner that suggests bias, with quotes inserted haphazardly and not attributed to any sources. Green *et al.* (2011) provided no supporting evidence at all for their interpretations, and these were only briefly described.

d) Was trustworthiness of data checked? Was an audit trail or triangulation employed?

Twelve studies (4, 5, 8-16, 18) described methods of checking the trustworthiness of their data and analyses. In terms of audit trails, all of these twelve studies reported transcribing audio recordings of their interviews and/or focus groups, and only three studies (8, 16, 18) reported additional means: using memos, field notes, or reflective journals. Methods of triangulation reported were: discussing analyses within studies' research teams (9-12, 14-16), member checking with subsamples of study participants (4, 13), consultation either with independent researchers (5, 8, 16) or with FSU representatives (11), using supervision (8), and synthesising multiple methods of data collection (18). Skinner *et al.* (2014) explicitly stated that they deemed member checking to be unnecessary in their study due to the thoroughness of their data collection.

The remaining six studies (1-3, 6, 7, 17) did not describe or discuss any methods of checking the trustworthiness of their data or analyses.

e) Are findings presented with reference to existing theoretical and applied literature?

Fourteen studies (1, 3, 5, 7-16, 18) presented their findings with sufficient reference to previous theoretical and applied literature on topics of recovery in forensic mental health.

Two studies' reports of their findings (4, 17) became confused by shifts in their topic focus between the introduction and discussion. Cromar-Hayes and Chandley (2015) started with reference to recovery in generic and forensic mental health contexts but then framed their results primarily with reference to reflective practice in mental health nursing rather than recovery. Similarly, Souter (2015) introduced new topics (such as links between histories of abuse and personality disorders) in his discussion of his study's findings, which detracts from the initial focus on recovery in forensic mental health. Furthermore, Souter does not cite any other empirical research to justify his advocacy of the potential benefits of recovery-oriented approaches.

Frayn *et al.* (2016) referenced theoretical and empirical literature about recovery colleges as their topic of focus in their paper's introduction, but they discussed their own findings with minimal reference to any literature, and would have benefitted from doing so.

Ayres *et al.* (2015) made no reference to other empirical literature except for passing references to their own earlier work and citing the psychometric measures that they used.

f) Are limitations discussed?

Ten studies (1, 2, 5, 8-10, 12, 13, 16, 17) explicitly discussed their limitations with sufficient depth that they offered meaningful considerations for interpreting study findings.

Three further studies (14, 15, 18) did explicitly describe some of their limitations, but these were described so briefly that the considerations offered seemed to be tokenistic.

Frayn *et al.* (2016) only discussed limitations of the recovery college project that was the subject of their study, but they offered no consideration of limitations of their study itself. Green *et al.* (2011) did explicitly discuss general limitations of their mixed methods study, but none of these considerations were about the qualitative phase of the study.

The remaining three studies (3, 4, 11) did not discuss their limitations at all.

g) Is the manuscript well written and accessible?

Fifteen studies (1, 4-7, 9-18) were judged to be well written, and are accessible to their health sciences audience, as well as being accessible to lay audiences in some cases.

Laithwaite and Gumley (2007) articulated their introduction and methodology well, but their description of their findings and their discussion became convoluted and thus less accessible; this seemed to be due to their attempt to frame their interpretations in terms of multiple interacting theoretical issues.

Chandley *et al.* (2014) explicitly chose to use an unconventional structure for their report in an attempt to reflect the recursive nature of their action research methodology. Although well intended, this led to their omission of any explicit description of their data collection and their analysis, which ultimately makes it difficult for a reader to understand what happened in the study. Furthermore, the ostentatious language and writing style used is frequently inaccessible, and significant and sometimes controversial claims about issues in forensic mental health are made without referencing these with any evidence.

The introduction to Ayres *et al.*'s (2015) study does not follow a logical flow of related ideas, but instead moves abruptly from one subtopic to another, which precludes the possibility of a clear rationale for the study being set up.

4. Discussion

This review aimed to identify and summarise the qualitative research literature of recovery in forensic mental health contexts, and to critically appraise its methodological quality.

Eighteen studies were identified, which explored the perspectives of different stakeholders (mainly FSUs and forensic service staff) using a range of qualitative approaches. The findings of these studies generally indicated that recovery principles were meaningful and applicable in forensic services, although adaptations were often needed to help overcome specific challenges created by the complexities of forensic contexts.

The literature only investigated recovery in inpatient services, and so it is not known whether the findings are generalisable to community forensic contexts with outpatient FSUs. Whilst inpatients constitute the greatest proportion of FSU populations (and, correspondingly, they are apportioned the most resources) (Centre for Mental Health, 2011), the meaning of recovery principles for FSUs living in the community should also be specifically explored so that their needs can also be understood and supported. The imperative for this is highlighted by the high rates of rehospitalisation in forensic services, which may be partly attributable to insufficient aspects of community care (Chiringa *et al*., 2014).

Barriers and dilemmas to implementing recovery principles in forensic contexts were identified empirically in many of the reviewed studies, which reflected concerns that are commonly cited in the broader theoretical literature, such as the tension between managing risk and empowering FSUs (e.g., Drennan and Alred, 2012; Pouncey and Lukens, 2010). The pervasiveness of such challenges highlights the need for evidence-based policy guidance for implementing recovery in forensic contexts. Existing resources, such as the ImROC briefing paper *'Making recovery a reality in forensic settings'* (Drennan *et al*., 2014), provide a starting point, but should be formalised in policy to ensure that they are adopted by services.

This review's critical appraisal of the reviewed studies indicates variable levels of methodological quality. The use of qualitative approaches was judged to be appropriate in all eighteen studies, and the majority of studies framed their research questions and their findings in relation to other literature in the topic area. However, significant shortcomings were commonly identified in the 'transparency of procedures' appraisal domain, as follows.

The omissions and ambiguities of recruitment procedures in all studies except one makes it indeterminable whether recruitment was conducted in a manner that was ethically appropriate and scientifically credible. At worst, it is possible that participants could have been recruited through implicit or explicit forms of coercion by researchers or by other people involved in recruitment such as forensic service staff. Although the conjecture of such a scenario may seem extreme, such ethical considerations are especially important in research with vulnerable populations. FSUs are especially vulnerable to exploitation such as coercion, due multiply to the effects of impairments in their mental health on their capacity to make informed decisions, and their diminished legal rights (Arboleda-Flórez and Weisstub, 2013). These issues were the basis for Coffey's (2006, p.73) concern that “given the complexity of ethical issues with largely captive populations, there is a striking absence of discussion of ethical problems in forensic mental health research”. This concern clearly remains valid over a decade later given that the vast majority of reviewed studies (all of which were published in the intervening years) did not explicitly describe these essential and ethically sensitive aspects of their procedure. Further to the ethical issues raised by this, the omissions and ambiguities of recruitment procedures increases the possibility of selection bias, an issue of credibility and validity which was also not explicitly addressed in most studies.

A second significant shortcoming in the transparency of procedures was the absence in all but one study of any explicit examination of the influences that researchers had on the development, conduct and interpretations of the studies. Such critical self-awareness in research is known as reflexivity (Finlay and Gough, 2003), and its use is regarded as being especially important in qualitative research as a way to enhance transparency and reduce bias (Dev *et al*., 2009). The subjectivity of qualitative research is a common point of criticism for its scientific integrity, but as Finlay (2002, p.531) argues, “through the use of reflexivity, subjectivity in research can be transformed from a problem into an opportunity”.

Unfortunately, the absence of explicitly reported reflexivity in the majority of reviewed studies limits the rigour and credibility of their findings.

4.1 Implications for Future Research

In light of shortcomings identified in the reviewed studies, future qualitative studies of recovery in forensic mental health should explicitly report their procedures in full, especially aspects which may implicate ethical issues. Further to this, qualitative researchers should engage in and describe methods of reflexivity to enhance the integrity of their findings.

Research is needed to investigate recovery in community forensic contexts with outpatient FSUs, given that the existing literature was only conducted in inpatient services.

Building on the empirical foundation of the reviewed qualitative studies, future research in this field could use experimental or quasi-experimental research paradigms to systematically investigate the feasibility and effectiveness of implementing recovery principles in forensic mental healthcare.

4.2 Implications for Clinical Practice

Principles of recovery appear to be meaningful in inpatient forensic services, but often need to be adapted in order to address challenges that are specific to forensic contexts. The most commonly identified principle of recovery in the reviewed studies was ‘connectedness with others’, which forensic service staff (especially nurses and nursing assistants) can help FSUs to develop by proactively forming relationships with them. This also creates a means by which forensic service staff can try to foster FSUs’ hope for the future, and enhance FSUs’ sense of empowerment by facilitating a collaborative approach to their treatment.

Studies investigating the meaning and implementation of recovery principles in community contexts with outpatient FSUs were not identified by the present review. The generalisability of findings in the reviewed studies to community contexts can therefore not be guaranteed.

4.3 Strengths and Limitations of this Review

One strength of the present review is its inclusion of studies which explored the perspectives of all relevant stakeholders, extending beyond FSUs to forensic service staff and other non-staff carers of FSUs. Studies of these perspectives were excluded from the two earlier systematic reviews of this topic (Clarke *et al*., 2016; Shepherd *et al*., 2016) but their inclusion here offered important insights on the topic that were not identified by FSUs, which is deemed to justify the incurred reduction in sample homogeneity by including staff and non-staff carers.

This review's use of the RATS (Clark, 2003) critical appraisal tool is another strength, as its comprehensiveness facilitated the identification of strengths and limitations in the literature that may have been overlooked if a less comprehensive appraisal tool had been used.

A potential limitation of the present review was its stringent exclusion of studies that did not prospectively describe recovery in accordance with the conceptualisation adopted for this review (see Section 1.1). This selection criterion was employed in an attempt to maximise the homogeneity of reviewed studies and minimise the influence of subjectivity in study selection, both of which were arguably achieved. Yet, it is recognised that recovery is personally defined and thus inherently heterogeneous; the six studies excluded by this criterion may still have had relevance to the topic in its broader sense. Similarly, excluding grey literature served to increase the homogeneity of reviewed studies, but this was likely at the expense of potentially illuminating insights directly from the perspectives of those with lived experiences.

4.4 Conclusion

The qualitative research investigating recovery in forensic mental health is varied in quality. Strengths of this literature are the relevance of topics studied and the appropriateness of qualitative approaches used. Weaknesses in the reviewed studies were most commonly identified in the transparency of their procedures, which prompted uncertainty about ethical conduct and limited their scientific credibility.

Notwithstanding the variable methodological quality of the reviewed studies, the unequivocal conclusion of their collective findings is that recovery is meaningful and applicable in forensic mental healthcare if adaptations are made to address the particular challenges of forensic contexts.

Implications for practice:

- Principles of personal recovery are meaningful in inpatient forensic services.
- Forensic service staff (especially nurses and nursing assistants) can help forensic service users to feel connected with other people by proactively forming relationships with them. This can enhance their personal recovery.
- Facilitating a collaborative approach to forensic service users' treatment can increase their sense of empowerment, and give them hope for the future.
- Applying these principles of personal recovery in inpatient forensic services should be done with adjustments to ensure that safety and security are not compromised.
- The application of these implications to community contexts cannot be guaranteed because research into personal recovery in outpatient forensic services has not yet been published.

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Oxford Doctoral Course in Clinical Psychology

PAPER B

HOW DO FORENSIC SERVICE USERS MAKE SENSE OF BEING RECALLED TO HOSPITAL FROM CONDITIONAL DISCHARGE IN THE COMMUNITY? A GROUNDED THEORY STUDY.

OWEN PAUL RYE

A thesis submitted in partial fulfilment of the requirements of the degree of Doctor of Clinical Psychology, validated by the University of Oxford

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How do forensic service users make sense of being recalled to hospital from conditional discharge in the community? A grounded theory study.

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Abstract

Background: A high proportion of forensic mental health service users (FSUs) are recalled to secure hospitals from conditional discharge in the community. The limited research on recall to date has preliminarily identified why FSUs are recalled, but not how they make sense of the process. **Aims:** To develop a conceptual understanding of how FSUs make sense of the process of being recalled to hospital. **Methods:** A constructivist grounded theory approach was used. Semi-structured interviews were carried out with eleven FSUs from different levels of forensic service security who had been recalled varying numbers of times (range=1-5) across a wide timeframe before being interviewed (range=2 months-16 years, 2 months). **Results:** A theoretical model was constructed to illustrate the process of how FSUs make sense of being recalled. FSUs appraise being recalled on a continuum from negative to positive based on their experiences when conditionally discharged and their reflections on the circumstances of being recalled. The nature of their appraisal reciprocally influences their subsequent attitudes towards forensic services and their engagement with treatment. **Conclusions:** FSUs make sense of being recalled in a recursive process influenced by their perceptions of events before and during the recall itself, and their subsequent experiences.

Proposed journal: Criminal Behaviour and Mental Health (see Appendix E for submission guidelines)

1. Introduction

1.1 Forensic Mental Health Services

Forensic mental health services (hereafter simply ‘forensic services’) provide care and containment for people who are mentally unwell and have committed a criminal offence, or who are at high risk of committing a criminal offence (McInerny et al., 2004). Forensic services are designed to assess, treat, and manage the people in their care with the dual aim of improving their mental health and reducing their risk of committing further criminal offences (Sugarman et al., 2015).

In the UK, forensic services for adults comprise inpatient services (secure hospitals) and outpatient community services. Secure hospitals are graded into ‘high’, ‘medium’, and ‘low’ levels of security, as determined by the degree of physical, procedural and relational security that they provide (National Health Service Commissioning Board, 2013). Community forensic services are provided either by forensic community mental health teams or outreach liaison with generic community mental health teams by staff from secure hospitals (Coid et al., 2007).

Adult forensic mental health service users (FSUs) are a heterogeneous population (for population demographics, see Appendix F). Most FSUs are detained subject to sections of the Mental Health Act (MHA; 2007). FSUs who are judged to pose a risk of serious harm to others may additionally have restriction orders (MHA Section 37/41) imposed by the Ministry of Justice (MOJ) to limit their movement and discharge (Sarkar, 2010).

Definitive data about the full population size of FSUs in the UK is not available. However, the MOJ publishes an annual report about FSUs subject to restriction orders in England and Wales, which constitutes the majority of FSUs in the UK. The latest available figures from the end of 2016 identified a total of 7,193 of these FSUs across inpatient and outpatient settings (MOJ, 2017).

Providing secure care is very expensive: inpatient forensic services alone account for approximately 20% of public expenditure on all adult mental health care, despite FSUs representing a relatively small clinical population (Centre for Mental Health, 2011). The economic burden is only one measure of the multitude of costs entailed by forensic services and their users, which realistically reflects incalculable loss of personal and societal potential (Sugarman et al., 2015).

1.2 Trajectories through Forensic Services

The first point of entry to forensic services for all FSUs is admission to a secure hospital ward with the least restrictive level of security needed to manage them (MOJ, 2017). When FSUs' mental health improves and any risks that they pose decrease, they then progress to lower levels of inpatient security until they are sufficiently well and safe to be discharged to the community or, if they were transferred into secure hospital from prison and have a criminal sentence to serve out, transferred back to prison.

However, the trajectories of FSUs through services are rarely linear, and more often than not they are characterised by twists and turns, including transfers up and down levels of security (e.g., medium to low then back to medium), and back and forth between hospitals and the community (Centre for Mental Health, 2011). Explanations of this are multifactorial, but include fluctuations in FSUs' mental health and presenting risks, with FSUs being moved to services that are most able to care for them and manage them safely (Kennedy, 2002).

Research into the complex trajectories of FSUs through services often refers to the negative psychological consequences of long durations living in institutional settings, which have been conceptualised throughout various bodies of literature as 'institutionalisation'.

Approximately two-thirds of FSUs will spend at least two years in secure hospitals, and many FSUs may also have spent additional time serving a custodial sentence in prison (Rutherford et al., 2008). When living in institutional settings, people have less control over their environment and activities, reducing their opportunities for autonomy which has been associated with diminished self-efficacy and self-esteem (Wilson et al., 2011).

The eventual discharge of FSUs to the community therefore represents a substantial transition with many challenges, including the need for FSUs to take increased responsibility for meeting their daily living needs, and the potential for exposure to stressors that may impact on a person’s emotional wellbeing and thus increase their risk of (re)offending. In light of this, it seems unsurprising that both FSUs and forensic service staff express anxieties about community discharge, despite service pathways being designed to offer a model of stepped care and rehabilitation programmes to prepare FSUs for moving from an institutional setting into the community (Centre for Mental Health, 2011).

1.3 Recall to Secure Hospitals

The movement between hospitals and the community is frequently observed in FSUs subject to restriction orders (MHA Section 37/41). The discharge of these restricted FSUs requires the approval of either a Mental Health Review Tribunal (MHRT) or the Secretary of State for Justice. The vast majority (88%, n = 499 in 2016) of discharges of restricted FSUs to the community are not absolute discharges; instead, they are subject to conditions requiring FSUs' continued engagement with supervision and treatment provided by community services whilst there continues to be a substantial risk of harm to public safety or the health of the FSU (MOJ, 2017; Wrench et al., 2010). Conditionally discharged FSUs may also be directed to live in a place specified by the Secretary of State (Fennell, 2008). Discharge conditions are determined through comprehensive risk assessment, and can include attendance at clinical reviews, compliance with medication, abstention from substance misuse, and limits on consumption of alcohol.

During conditional discharge, if a restricted FSU’s mental health remains stable and their presenting risks are judged to be sufficiently low, then an MHRT or the MOJ usually agree to absolutely discharge them from the care and oversight of forensic services (MOJ, 2009). However, if their mental health deteriorates whilst they are conditionally discharged, or their presenting risks escalate to a level that is judged to be unmanageable in the community, then it is likely that the FSU will be recalled to a secure hospital for further containment and treatment (MOJ, 2009). Breaches of discharge conditions are not in themselves grounds for recall, but are considered to be ‘risk-related behaviours’ that may indicate actual or potential deterioration in an FSU’s mental health which may increase the risk of them engaging in offending behaviour. For further details about the process of recall, see Appendix G.

Each year, there are approximately half (51% in 2016) as many occasions of FSUs being recalled to a secure hospital each year as there are conditional discharges being granted (MOJ, 2017). In 2016, there were 255 incidents of conditionally discharged restricted FSUs being recalled to a secure hospital. This high rate of FSU recalls compares to only 80 conversions from conditional discharge to absolute discharge in the same calendar year (MOJ, 2017).

The high rates of recall incur financial costs of providing further inpatient care for FSUs, as well as increasing the total length of stay in hospitals for FSUs (Centre for Mental Health, 2011). Longer inpatient stays can lead to deleterious effects of institutionalisation, such as reduced self-efficacy and self-esteem as described earlier (see Section 1.2). Given this, reducing the incidence of recall would presumably be beneficial for forensic services and for individual FSUs. However, recall should not necessarily be judged as inherently negative or a failure; its utility should be considered on the basis of a more comprehensive understanding of its function as a clinical and legal process.

1.4 Research on Recall

There is currently no published research that has evaluated recall as a process in forensic service pathways, which makes it difficult to determine whether it is a helpful or unhelpful process for FSUs and for forensic services in terms of outcomes such as FSUs' mental health.

To consider the utility of recall in forensic services, it is necessary to understand what leads FSUs to be recalled to secure hospitals from conditional discharge in the community, what the clinical and legal outcomes of recall are, and to understand what the experience of being recalled is like for FSUs themselves.

A literature search identified only three studies to date which report explicitly on the recall of FSUs. As part of a broader study of outcomes for conditionally discharged FSUs, Riordan et al. (2006) identified that lack of social support, drug misuse and self-harm were all significant predictors of recall. O' Sullivan et al., (2013) interviewed five male FSUs who were 'dually diagnosed' (i.e., with comorbid paranoid schizophrenia and substance misuse) about their experiences, following their recall to a medium-secure ward. The authors used Interpretative Phenomenological Analysis (Smith et al., 2009) to identify factors leading to these FSUs' recall that included loss of and exclusion from social support networks, the disabling effects of substance misuse on developing an adaptive life in the community, and feeling helplessly at the mercy of systems. Aspirations of recovery, particularly meaningful occupation and social integration, were seen as factors that could have reduced the likelihood of substance relapse and subsequent recall if they had been fulfilled, but they were not.

Chiringa et al. (2014) interviewed six ‘dually diagnosed’ male FSUs who had been recalled to a medium-secure ward about their perceptions of why they had been recalled. The authors used a method of qualitative analysis informed by grounded theory (the form of which was unspecified) to identify that the participants felt they had not been given sufficient justification or explanation for their recall by professionals. The participants also perceived that standards of aftercare provided by community services were poor, that they felt lonely, and that their opportunities for independence were limited by excessive service surveillance.

Existing research on recall has thus begun to identify *what* factors can contribute to the recall of FSUs, as well as exploring the perceptions of a subpopulation of FSUs about their experiences of being recalled. However, the literature on recall is currently limited, so it would be premature to make conclusions about the clinical and legal utility of recall.

At this early stage of research into recall, it could be most helpful to pursue further qualitative investigation of FSUs’ views on recall in an attempt to profit from the rich understanding of the process that only those with lived experience of it can offer (Tapp et al., 2013; Coffey, 2006). The two previous qualitative studies of FSUs’ experiences of recall illuminated *what* FSUs’ perceptions of being recalled were, including *why* it happened (O’ Sullivan et al., 2013; Chiringa et al., 2014). It could be helpful to build on these findings by elevating the understanding of FSUs’ experiences of recall to a more conceptual level in terms of the psychological mechanisms involved in *how* FSUs make sense of the process of being recalled to a secure hospital from conditional discharge in the community.

1.5 Study Aims

This study aims to develop a conceptual understanding in the form of a theoretical model of the psychological mechanisms involved in how FSUs make sense of the process of being recalled to hospital. Using grounded theory, this study aimed to answer one question:

- How do FSUs make sense of the process of being recalled?

2. Method

2.1 Design

The study design used a modified version of constructivist grounded theory (Charmaz, 2014). As the research question focused on understanding the process of how FSUs make sense of being recalled, grounded theory was chosen as the most suitable approach because it provided a methodical framework to develop an explanatory theoretical model of the data that was rooted in the accounts of study participants (Charmaz, 2014). Further details on the rationale for choosing constructivist grounded theory are described in Appendix H.

2.2 Participant Selection

A purposive sampling strategy was used in an attempt to include participants from a range of settings; namely, inpatients from different levels of ward security (medium-secure, low-secure, and a pre-discharge unit[1]), and outpatients living in the community.

Inclusion and exclusion criteria were developed with the aim of recruiting a relatively homogenous sample. People were eligible to participate in the study if they:

- Were aged 18 years or older;

- Were a current service user of the forensic mental health service;

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[1] Pre-discharge units are designed to prepare FSUs for conditional or absolute discharge by bridging the gap between low-secure wards and supported accommodation in the community. They are kept locked, but FSUs residing in them are granted a set of keys so that they can come and go independently in accordance with their level of unescorted leave.

- Had been recalled to a secure hospital unit from conditional discharge in the community under Section 37/41 of the Mental Health Act (2007) on at least one occasion;
- Were able to speak and understand English;
- Did not have a diagnosed learning disability;
- Were judged by their clinical care team and the researcher not to present an unmanageable degree of risk to themselves or to others in an interview situation;
- Had mental capacity to give willing and informed consent to participate in the study in accordance with the Mental Capacity Act (2005).

2.3 Study Context

Participants were recruited from a forensic mental health service in the south of England. The service encompasses three counties in England, with three hospital sites for secure wards located in three highly populated, industrialised towns with ethnically, socioeconomically, and culturally diverse populations.

2.4 Ethical Considerations

Prior to the commencement of data collection, relevant approvals were obtained. Approval of the study was granted by the Oxford Doctoral Course in Clinical Psychology (Appendix I) following the development of a detailed dissertation proposal. Ethical approval was granted by the ‘South Central - Oxford B’ NHS Research Ethics Committee (Appendix J) and the Health Research Authority (Appendix K). Sponsorship and site approval (Appendix L) were granted by the NHS Trust that hosted the forensic service.

Key ethical considerations included that FSUs may have felt coerced to participate, the subject matter potentially being distressing for participants to talk about, any risks of harm which participants could pose to themselves or others (particularly the researcher), and the likely event that participants' responses may refer to criminal activity. Further details about these ethical considerations and how they were managed are described in Appendix M.

2.5 Recruitment

The purposive sampling strategy provided a basis to recruit participants from different levels of forensic service security in different phases, according to what was indicated by the concurrent and iterative data analysis process (see Section 2.7): first from low-secure wards, then from a pre-discharge unit, and then opening recruitment to FSUs in medium-secure wards and outpatient FSUs who were living in the community.

Potential participants were identified through eligibility screening of patient records by qualified clinical psychologists who worked in the forensic service. FSUs who met study inclusion criteria were approached by the identifying psychologist or another member of the FSU's usual care team to invite them to participate in the study, providing them with a brief verbal description, letter of invitation (Appendix N) and participant information sheet (Appendix O). Potential participants were given at least 24 hours to consider the information; if they were interested in participating, they provided written agreement for the researcher to meet with them directly (Appendix P), and if they were not interested in participating then they were not approached further about the study.

Across all settings of the forensic service sampled, 33 FSUs were identified as being eligible to participate. Twenty of these potential participants were approached by a member of staff from their usual care team, as described below. The other 13 eligible FSUs were not approached, either because clinicians from the FSUs' usual care team did not follow up on approaching eligible FSUs to invite them to participate (n = 6; 2 females, 4 males; 3 medium-secure, 3 community), or because the researcher was no longer seeking to recruit further participants from their forensic service setting due to the evolving needs of the purposive sampling strategy (n = 7: 1 female, 6 males; 3 low-secure, 4 community).

Nine of the twenty FSUs who were approached to take part in the study declined: all of these were male, five were on medium-secure wards, two were on low-secure wards, and two were outpatients in the community. Reasons for declining to participate were only given by three FSUs, all of whom were on medium-secure wards: one did not want to be audio recorded (which was an essential feature of taking part), one was concerned that their data would not be secure if they took part, and one was “not interested”.

The researcher met with the other eleven potential participants in person to discuss the study, introduced by a clinician familiar to the potential participant to help them feel at ease and reduce the possibility that the researcher was perceived with suspicion. The discussion followed the structure of the participant information sheet, outlining the details of the study and what participation would involve, giving an opportunity for the researcher to answer any questions. If potential participants wished to proceed with participation following the discussion, then the researcher sought and obtained their consent in writing (Appendix Q).

Eleven FSUs gave their written informed consent to participate in the study.

Participants all consented for a member of their care team to collect demographic information about them from their patient records, including details of their hospital admissions (Appendix R). This was then shared with the researcher.

2.6 Data Collection

Participants each engaged in one individual face-to-face semi-structured interview facilitated by the researcher, which was carried out directly after participants gave consent. Interviews took place at forensic service buildings, either in private rooms on wards, or in off-ward visiting rooms, depending on each participant’s current status (inpatient/outpatient, leave, risk). Interviews ranged in duration from 31 minutes to 67 minutes (mean = 52 minutes, SD = 10.17). All interviews were audio recorded on an Olympus DS-3500 Digital Voice Recorder.

The interviewers' questions were guided by a schedule of topics, questions and prompts (Appendix S). The first iteration of the interview schedule was developed provisionally by the researcher, guided by the principles of data collection and intensive interviewing in constructivist grounded theory (Charmaz, 2014). The researcher then discussed this version with two of their supervisors (SH and CCo) and consulted with a group of FSUs (none of whom participated in the study) in order to finalise it (for further details about the development of the original interview schedule, see Appendix T). The interview schedule included specific questions and prompts in the following topic areas: experiences of living in the community on conditional discharge, experiences of being recalled, how participants made sense of being recalled, how participants felt about being recalled (at the time and subsequently), what could have helped prevent participants from being recalled, and participants' views on forensic mental health services and other systems involved in the process of recall. In accordance with the theoretical sampling principles of grounded theory (Charmaz, 2014), the interview schedule was added to over the course of the study in an attempt to incorporate questions that could elicit data that was relevant to further developing the ongoing analytic process.

In order to orientate the interview conversations, all interviews started with the same question. Participants' responses guided other questions asked, including the order and form of topic areas and questions taken from the interview schedule, which was therefore used flexibly.

Participants were paid £10 in cash at the end of interviews, as reimbursement of their time and effort.

Interviews were transcribed in MS Word, removing identifying details such as names and places. Anonymised transcript data were imported into NVivo 11 computer software.

2.7 Analysis

The data were analysed following the methodological principles and procedure of constructivist grounded theory (Charmaz, 2014), the stages of which are described below.

The researcher's familiarity with the data is an important aspect of the analytical process, so the researcher listened again to the audio recording of each interview once before proceeding to code its respective transcript.

The coding process began with initial line-by-line coding of the transcripts through a close reading of the data, breaking it down into its smallest component parts and assigning each of these parts a short label, using gerunds (verb forms which function as nouns) as much as possible to capture action (see Appendix U for an example of initial line-by-line coding). As it became apparent that some initial codes related to others, these were provisionally grouped into 'focused codes'. As initial coding proceeded and more focused codes were formed, the method of coding moved from coding line-by-line to coding by 'incidents', which were sections of data that conveyed an overarching meaning, typically spanning several lines of text (Charmaz, 2014) (see Appendix V for an example of initial 'incident' coding). After initial coding had been completed, focused coding was carried out to draw together the remaining initial codes into meaningful groups that formed the foundations for tentative analytic categories. These categories formed the basis for the development of the theoretical model, and they were re-analysed and revised as necessary throughout the process until the theoretical model was completely constructed (refer to Appendix W for the finalised codes and categories derived from the data).

A method of ‘constant comparison’ (Charmaz, 2014; Appendix X) was employed throughout the analysis to compare all data, codes and categories to themselves and to each other. This included looking for similarities, differences and subtleties that aided the researcher in remaining open to making new insights about the data. The researcher specifically paused the coding process after interviews three, six, eight, and eleven to conduct more in-depth reviews of the data following the constant comparative method. After analysing data from 11 interviews, no novel concepts emerged and thus the analysis was considered to have reached theoretical sufficiency (Dey, 1999), whereby categories were well enough described to fit the data and further data collection would be unlikely to add to them.

The researcher wrote memos throughout the analysis to record their ongoing interpretations of the data and their ideas about the emerging theory (Charmaz, 2014) (summary versions of key memos are provided throughout the results to illustrate the ongoing process; see Appendix Y for a full example of a memo made during theory construction).

2.8 Reflexivity

Constructivist grounded theory recognises that researchers’ subjective beliefs about the social world are never fully dormant and therefore these influence the conduct of research, by way of reflexivity (Charmaz, 2008). Rather than attempting to suppress this influence, Charmaz (2014) advocates that researchers enhance their awareness of their own beliefs so that they are better able to recognise how these shape the research they conduct.

The researcher was a Trainee Clinical Psychologist who had never worked in the service from which participants were recruited, and they had no previous knowledge of the participants recruited for the study. The researcher did have prior experience of working clinically as an Assistant Psychologist in a different forensic mental health service.

The impact of the researcher's earlier experiences on their beliefs and potential biases was considered throughout the study using methods to enhance their reflexivity. A reflective journal was kept throughout the research to record the researcher's reflections and ideas so that they were prompted to consider how their own beliefs shaped the study's design, data collection and analysis (see Appendix Z for excerpts). Before commencing data collection, the researcher engaged in a bracketing interview facilitated by a peer who was also conducting qualitative research.

These methods of enhancing reflexivity elucidated the researcher's motivation to undertake the study as being primarily driven by working clinically in inpatient mental health services, where they perceived patients who had long stays in hospital to develop low self-efficacy and external loci of control which the researcher viewed as "institutionalisation". The researcher's impressions that FSUs were 'institutionalised' by forensic services thereby compounded their prior critical opinions that forensic services held a disproportionate amount of power to control the liberties and, ultimately, lives of FSUs to the point that FSUs could lose their personhood. Having interacted with FSUs on a personal level through therapeutic activities as an Assistant Psychologist, the researcher had experienced the humanity of FSUs first-hand, and they therefore wanted to ensure that agencies of greater instrumental power (i.e., those who design and deliver forensic services, including the government and the NHS) appreciated this too. Undertaking qualitative research using the perspectives of FSUs was the researcher's attempt to 'give voice' to this marginalised group of people, and thus to advocate for forensic services to be designed and delivered based upon the needs of FSUs themselves.

The bracketing interview also highlighted that it would be useful for the researcher to find out more about their supervisor's beliefs about recall of FSUs by interviewing them (see Appendix AA).

2.9 Credibility

To enhance credibility of the analytical procedure and constructed theory, the researcher's initial line-by-line coding of excerpts from three interview transcripts was reviewed by a colleague who was familiar with grounded theory methodology and coding. This generally validated the researcher's coding practices, and guided the researcher to label codes more succinctly in subsequent analyses. The researcher consulted with a grounded theory specialist regarding the naming and grouping of analytical categories, and the development of the theoretical model. This consultation process guided revisions of the categories and model until these were judged to adequately account for findings in the data.

3. Results

3.1 Participant characteristics

Eleven FSUs gave their written informed consent to participate in the study.

Characteristics of participants are summarised in Table 1 to help situate the sample. Participants were each assigned a participant number and a pseudonym to protect their confidentiality.

Participants were predominantly male (ten men, one woman), aged between 26 and 55 years old (mean = 38.91 years, standard deviation = 9.67 years). Eight were white British, one was black African, one was Pakistani, and one was white Irish.

Eight participants were currently inpatients: four on low-secure wards, three on medium-secure wards, and one on a pre-discharge unit. The remaining three participants were

Table 1.

Participant characteristics

P#	Pseudonym	Gender	Age	Ethnic group	Current level of security	Current psychiatric diagnoses (ICD-10) (primary listed first)	No. of recalls	Time elapsed[1] since: First FMH admission	First recall	Latest recall
1	Andrew	Male	49	White	Low	Schizoaffective disorder	1	16y 3m	0y 10m	0y 10m
2	Benjamin	Male	33	Black	Low	Schizoaffective disorder	1	10y 9m	5y 3m	5y 3m
3	Caleb	Male	37	Asian	Low	Paranoid schizophrenia	2	11y 2m	3y 3m	0y 10m
4	David	Male	55	White	PDU	Paranoid schizophrenia	4	20y 2m	12y 2m	4y 10m
5	Evan	Male	48	White	Community	Schizoaffective disorder	3	18y 2m	16y 2m	7y 0m
6	Francesca	Female	28	White	Medium	Emotionally unstable PD	1	10y 5m	0y 3m	0y 3m
7	Gavin	Male	33	White	Low	Schizoaffective disorder, dissocial PD	3	16y 6m	13y 8m	2y 6m
8	Henry	Male	41	White	Medium	Schizophrenia (unspecified)	1	14y 8m	0y 11m	0y 11m
9	Ian	Male	26	White	Medium	Dissocial PD, emotionally unstable PD, ADHD, Tourette's disorder	1	8y 8m	0y 2m	0y 2m
10	Jacob	Male	31	White	Community	Paranoid schizophrenia	5	13y 4m	4y 0m	0y 2m
11	Keith	Male	47	White	Community	Schizoaffective disorder, schizophrenia (unspecified)	1	11y 6m	5y 6m	5y 6m

[1] Up to time of data collection

Notes: ADHD = Attention-deficit hyperactivity disorder; FMH = Forensic mental healthcare service; ICD-10 = International Statistical Classification of Diseases and Related Health Problems 10th Revision (World Health Organization, 2016); P# = Participant number, PD = Personality disorder, PDU = Pre-discharge unit living in the community on conditional discharge. All eleven participants were currently under Section 37/41 of the Mental Health Act (2007), and the index offences that led participants to first be admitted to forensic services were categorised as ‘violent’ in all eleven cases. Psychiatric diagnoses given to participants (including comorbidities) were: schizoaffective disorder (n=5), paranoid schizophrenia (n=3), unspecified schizophrenia (n=2), emotionally unstable personality disorder (n=2), and dissocial personality disorder (n=2), Tourette’s syndrome (n=1), and attention-deficit hyperactivity disorder (n=1).

Participants had been recalled between one and five times (median = 1). The range of time since they were first recalled was between 2 months and 16 years 2 months (mean = 5 years 8 months), and the range of time that had elapsed since their latest recall up to point of interview was between 2 months and 7 years 0 months (mean = 2 years 5 months).

3.2 The ‘Making Sense of Being Recalled’ Model

3.2.1 Overview of the Model

Making sense of being recalled is a process that centrally involves appraising recall on a continuum from negative to positive, which is influenced by experiences before, during, and after the recall. In turn, the appraisal itself influences subsequent experiences and reflections that are related to being recalled. Crucially, the recursive nature of this process means appraisals of being recalled can change over time; such re-appraisal represents movement along the continuum. The process is represented by Figure 1.

Prior to being recalled, FSUs’ experiences of living in the community on conditional discharge range across two continua: ‘adaptation’ and ‘connectedness’. Those enjoying life in the community feel more connected with others, whereas those struggling feel disconnected. The extent of perceived adaptation and connectedness in the period directly before the event of recall influences appraisal of recall.

Following recall to a secure hospital, FSUs reflect on the circumstances of the event of recall and consider the extent to which they agree with explanations for their recall and if being recalled was an appropriate measure. Their level of agreement, along with their sense of agency in actions and decisions that led to their recall, contribute to where FSUs fall on the appraisal continuum.

Subsequent experiences with forensic services are shaped by FSUs' appraisal of being recalled, and their appraisal is reciprocally influenced by their experiences. Positive appraisals lead to positive attitudes about forensic services, which in turn reinforce positive appraisals; an equivalent feedback loop reinforces negative appraisals and attitudes.

FSUs who appraise their recall positively describe higher levels of engagement with treatment. This is driven not only by the positive appraisal itself, but also by personal goals and motivational factors in their lives. Engaging with treatment reinforces positive appraisals of being recalled, as well as strengthening positive attitudes about forensic services.

The elements involved in the process of making sense of being recalled are explained in further detail in the following sections. Quotes from participants (credited to pseudonyms, see Table 1) are used to illustrate the concepts of the model; the quotes used were selected as exemplars, and also to represent the perspectives of all eleven participants. Memos are also included to demonstrate the analytical process; these are written in the first person as a reflective account.

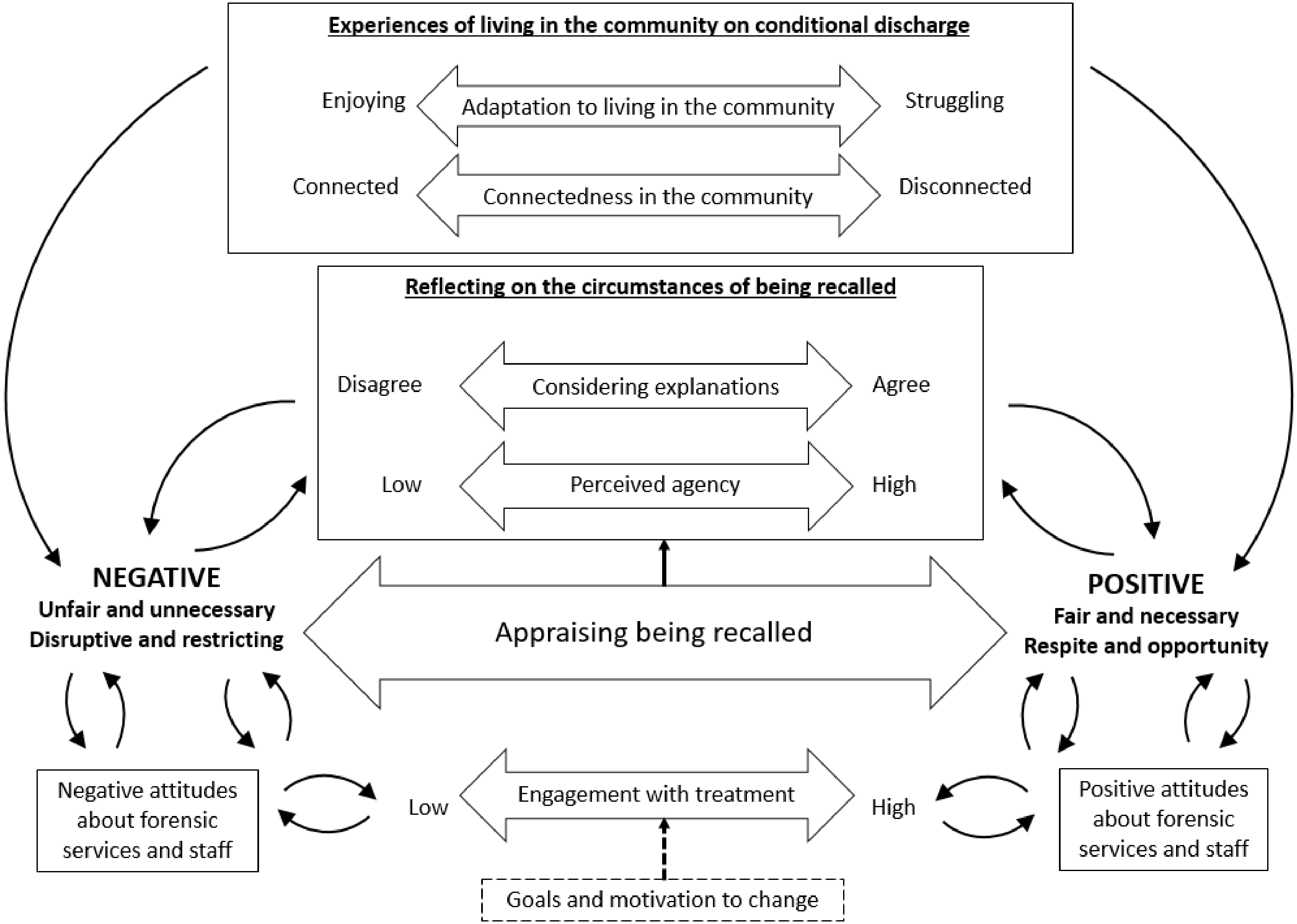

Figure 1. A theoretical model illustrating the process of 'making sense of being recalled' for forensic mental health service users

3.2.2 Experiences of Living in the Community on Conditional Discharge

Participants talked about their experiences of living in the community whilst they were conditionally discharged, often with a focus on the period of time leading up to when they were recalled. Factors contributing to how positively life in the community was experienced were related to participants' degree of adaptation and connectedness, along two continua respectively.

Most participants identified times when they were enjoying life in the community prior to the period leading up to their recall:

> *"It shows, y'know, how good I was, y'know, I was doing the first six, seven years in community before the problems I had which I got recalled for." (Caleb)*

Factors contributing to this included paid or voluntary work, and recreational activities that were personally meaningful to them:

> *"…those days I was um working with a, er, studio […] and I was doing recordings, so I was more into like my music and how I can deliver it…" (Benjamin)*

Being engaged in the community helped participants to feel connected with others:

> *"I did make a lot of good friends in [town], there's some really nice people there, you know; they care as well" (Keith)*

Experiences of feeling supported, whether through personal relationships or by professionals, further contributed to the degree of connectedness:

> *"Yeah, I had a whole team there - the help was there if I needed it" (Henry)*

In contrast to enjoying aspects of conditional discharge, many participants also described experiences of struggling to cope with stressors they encountered in the period leading up to when they were recalled:

> *"I had so much going on, with this, that, and the other […] and <oogh!> everything flew in the air!" (Andrew)*

Sources of stress varied, but included difficulties in relationships with family members or friends, and having insufficient financial support or losing money gambling.

Many participants who historically had issues taking illicit drugs felt frustrated that they were exposed to drugs, either through friends they had reunited with or in their local area:

> *"At odd times they'd come and knock and it was just getting to me, and it was frustrating me, annoying me, and all of that circle - I didn't, don't need that." (Caleb)*

Most of those participants relapsed into taking drugs, and two other participants described taking drugs to cope with the stress they were experiencing:

> *"I was so anxious it, it maybe was my way of dealing with it [...] coping with that at the time, sort of how I was feeling, so I think that's why I took the line of cocaine." (Ian)*

The change from being in hospital to the community also presented challenges:

> *"A lot of it was stress, some of it was-- you were going through things that you'd been sheltered from the whole time you were in here [hospital], so your emotions are a bit more different." (Francesca)*

Memo:

The code ‘struggling’ encapsulated many forms of difficulties, including issues in interactions with others. But the active nature of such interpersonal stress was distinct from the latent sense of loneliness and abandonment that permeated some participants’ accounts. Recognising this also prompted me to realise that some participants’ experiences of feeling ‘connected’ were not necessarily associated with ‘enjoying’. To reflect these differences, I split connectedness and adaptation into two separate theoretical codes in this category.

Several participants described feeling disconnected - isolated, and unsupported by others:

> *“I was in a house with all these people but we didn’t really socialise with each other, it’s more like you live in a room, and I had a television, and a bed, and stereo station and a sink and all that, and, er, you know, it was, it was a really nice room, but (sighs) I dunno (pause) I don’t know, I just felt, I started feeling lonely.” (Evan)*

Such difficulties with feeling disconnected in supported accommodation extended beyond the milieu to perceived shortcomings in the support provided:

> *“The care was pretty poor. There wasn’t-- the communication was really to a minimal with them and their staff” (Keith)*

Aftercare from the community forensic service was also perceived as insufficient by some:

> *“I would’ve rather they knew exactly what I was doing, rather than just coming to see me as if it was a tick box exercise.” (Francesca)*

Memo:

Although the majority of participants described difficulties just prior to the point when they were recalled, many of them had reflected that life in the community had been good earlier on during their conditional discharge - particularly participants who had been in the community for longer periods (up to seven years in two cases). A few participants felt that their life had been going well at the time when they were recalled. I needed to ensure that the change and variety of experiences in the community came across, which led me to adopt continua for the theoretical codes of 'adaptation' and 'connectedness'.

Most participants described degrees of struggling and feeling disconnected in the period leading up to their recall, signifying movement for participants along the 'adaptation' and 'connectedness' continua based on their experiences.

This change often happened gradually with a sense of inevitability:

> *"It was a sort of, a sort of steady downward slope sorta thing." (Andrew)*

Or, alternatively, it happened suddenly as an acute response to events:

> *"I had a massive argument with my wife [...] and, er, by this time (pause) I'd, I'd had enough - I was really, really, I'd just had enough, and, um, (pause) I wanted to kill myself." (David)*

Movement across the continua was bi-directional, meaning that adaptation could change from struggling in the earlier stages of conditional discharge to enjoyment at the time they were recalled:

> *"…towards, I don't know, like the end of, before I got recalled, I kind of found my own way - I got a job, and I was actually doing things, so all that support I thought I needed I didn't actually need…" (Francesca)*

3.2.3 Reflecting on the Circumstances of Being Recalled

Participants' accounts of the events that took place when they were recalled varied not only in terms of the content of *what* happened, but *how* each individual participant reflected on the circumstances of when they were recalled.

Memo:

A cornerstone of interviewing participants was me asking them about *what* led to them being recalled, to develop my understanding of *how* they made sense of it. They offered me explanations of what they perceived had prompted their recall, sometimes noting how their perceptions of precipitating events were different to the accounts of the agencies (forensic services and the Ministry of Justice) that were ultimately in charge of recalling them.

These parts of the interviews and data posed challenges to me. My interpretations of participants' explanations were susceptible to my own biases as a practising clinician with prior experiences of working with FSUs who had been recalled. Further still, participants' explanations were likely to have been influenced by the accounts of professionals if the recall was subsequently discussed between them.

I had intentionally decided to not collect data from participants' clinical records as an aspect of the study's design that could help me to remain open and curious about participants' views, which I endeavoured to understand on their terms here.

A plethora of explanations for being recalled were given by participants, frequently including reference to taking drugs, becoming mentally ill, breaching discharge conditions, and receiving insufficient support from forensic services. Other less frequently cited factors that participants identified included interpersonal conflict, being evicted from accommodation, gambling, and in one case re-offending (*"theft of a motor vehicle"* - Ian). In many cases, participants identified multiple factors with interacting effects:

> *"I got recalled for-- indirectly though ketamine use, um, which I think was down to me losing contact with my son, and I think I was using it for escapism more than anything. [...] I was thinking the worst. His mother, being a scorned woman, didn't, er, comfort me by saying don't worry, he's with us, he's okay, everything - she'd say things like your, your paranoia is unfounded, which I felt was quite, made me worry even more" (Keith)*

Memo:

Each account was unique. Whilst there may have been common factors identified to explain why they had been recalled, the circumstances of each participant on each occasion of being recalled varied greatly. In most respects, the content of *what* participants told me (their explanations) was incidental to the process that I was investigating of *how* they made sense of it. After initially coding these data in terms of 'explanations' for recall, I then began to recognise patterns in the ways that participants reflected on the circumstances, and re-coded data accordingly.

In considering explanations for being recalled (either their own, or what they perceived as the account of agencies), participants were engaged in a reflective process that contributed to their opinions of how much they agreed with being recalled.

Some participants' explanations indicated their agreement with being recalled, usually referring to their recognition that they were experiencing difficulties in the community:

> *"Well I can understand why [forensic staff] thought that it was needed, 'cos like I said before, even I didn't feel I was right." (Andrew)*

Disagreement with being recalled resulted from differences in perception between themselves and the agencies involved. Participants either disagreed with agencies about whether alleged events that prompted their recall actually took place, or they disagreed with being rehospitalised as the outcome of precipitating events:

> *"…they said I was coming back here, and then I was like asking could I read the warrant, and apparently my self-harm had gone up, and there was suspicion that I wasn't taking my medication (pause) but, um, (pause) it didn't add up." (Francesca)*

> *"…drugs shouldn't be a reason for someone to be in a long time. […] it doesn't necessarily need to come in back into hospital for it…" (Gavin)*

Memo:

The other pattern I perceived when I was re-coding participants' accounts of their circumstances when they were recalled was how they described varying degrees of agency in being part of the decisions and action that led to their recall. Some had actually asked staff to be rehospitalised, whereas others had been told by staff that they were going to be recalled without having any opportunity to discuss it first.

In terms of their perceived role in the decisions and actions that led to their recall, some participants described having a high degree of agency:

> *"I wanted a total cut out from where I was in, so I asked for help in a, in, in a way, say look can you take me to hospital and let me sort my head out." (Caleb)*

However, many participants described having a low level of agency in the process:

> *"Well the doctor and the teams decide to bring you back in, um, but I think, yeah, if it was down to me I probably would've just stayed out there." (Jacob)*

3.2.4 Appraising Being Recalled

Participants made an appraisal of their recall based on a combination of what their experiences on conditional discharge in the community had been like prior to being recalled, and through reflecting on the circumstances of being recalled.

Participants who were higher towards the disconnected and struggling ends of the continua tended to appraise being recalled to hospital positively. For these participants, coming back into hospital was perceived as fair and necessary, providing respite from difficulties in the community, and offering the chance to engage with support:

> *"I think some of the times I needed to be recalled so I could get off of the drugs, 'cos if I stayed in the community then, um, probably just would've got worse, and worse, really, yeah." (Jacob)*

> *"…this time right now, y'know, the benefits to get out of the system and the hospital is, er, is important for me to utilise all the, er, opportunity I get here…" (Caleb)*

Similarly, those participants who agreed more with their recall, and especially those who had a higher degree of agency in the process, appraised recall positively:

> *"so I, er, ended up, um (pause) asking them if they could put me in hospital, be good to help me…" (David)*

Conversely, negative appraisal was more likely among participants who had been enjoying their lives in the community and had felt connected with others at the time of being recalled. They perceived being recalled as unfair and unnecessary, disruptive to their lives, and restricting:

> *"…it's torn my family apart, hasn't it, really?" (Ian)*

> *"…you're only supposed to do that amount of time, (pause) sort of, detained, in a way, if you deserve it really, I think." (Gavin)*

Furthermore, participants who expressed disagreement with being recalled also appraised recall negatively, particularly if they had been actively opposed to it at the time:

> *"Well, the second time that I-- I was just pissed off about that drug dealer, and I, I'm sure I took the medication. But then, you know, I got recalled - it was all, it just happened all of a sudden, I wasn't expecting to get recalled or nothing, I didn't think I wanted to get recalled." (Evan)*

Memo:

My interviews with participants were inherently retrospective, and I realised that their accounts comprised a mixture of information/perceptions that they may have held *at the time* when they were recalled, and information/perceptions that had subsequently been subsumed into their accounts through hindsight, introspection, and discussing the recall with other people such as clinicians and solicitors. Furthermore, participants' perspectives on being recalled may have changed in light of their subsequent experiences - not least the events/time in hospital after being recalled.

By purposively sampling participants from different levels of security, I had the opportunity to speak with participants who had a wide range of experiences post-recall - some over months, some over many years. At points during data analysis I found myself at a loss for how to account for such heterogeneity. But ultimately, this is what illuminated a core principle of my developing theory: making sense of being recalled is a recursive process of experience, reflection, and appraisal.

Appraisal was therefore a continuum in itself, subject to change of re-appraisal. Being continuous also accommodated for appraisals that indicated ambivalence.

Participants' appraisals were not static; they were dynamic, open to revision in light of subsequent experiences, the passage of time, and further reflection on precipitating factors:

> *"I was guns blazing [...] that's changed over time. [...] I was past caring, so I probably did need to be put in a -- so I could become to care for myself again" (Keith)*

> *"Well, it might have been a positive, because a) I was, was feeling lonely, so I was in a place of safety and with people, and b) I got away from the drug dealing shithead, who, who, who was – you know, I think a lot of people who were living there at the time were under stress because of what was going on" (Evan)*

Some participants expressed ambivalence about being recalled, endorsing both positive and negative aspects of being recalled:

> *"At the end of the day I was taking too much on, and I needed to slow down a little bit, get the right medication to, y'know, get my brain balanced, get more coordination, and stuff like that. And being here has helped me to a*

> *degree where I hopefully will be charged--discharged from here. […] And I haven't broken any laws, haven't broken any recolations (sic) or nothing, and it's a situation I'm still in now. I still to be up, still at loggerheads with the Home Office that's 'sposed to treat me. Okay fair enough, in the past, yes, there probably was a problem with me, but that's not me now." (Andrew)*

3.2.5 Attitudes towards Forensic Services and Staff after Being Recalled

Participants' appraisals of being recalled reciprocally influenced their attitudes about forensic services, staff, and systems (particularly the MOJ): positive appraisals reinforced positive attitudes, and negative appraisals reinforced negative attitudes.

Participants who held negative attitudes expressed feeling powerless in respect to forensic services, and that continuing to be detained after their recall was a form of persecution:

> *"Other people are always in charge when you're under section, cos it's not like you've just got a doctor to please, or everyone else to please, it's some person sitting in some office in the government innit (sic), that you never even meet." (Francesca)*

> *"All I can say is the reasons they put me-- that's when they're-- when it comes to the point like, because of my beliefs, I have to be in hospital, that's where it's all wrong." (Benjamin)*

Positive attitudes about forensic services indicated how participants felt supported by staff:

> *"…from my point of view, um (pause) I think there's a good system here, um, and the team are there for, y'know, for them to help you…" (David)*

3.2.6 Engagement with Treatment

Appraising recall positively, as well as having positive attitudes about forensic services was associated with participants' level of engagement with treatment after being recalled. Higher degrees of engagement included participating in rehabilitative activities such as occupational and psychological therapies, and were often driven by personal goals and motivational factors in their lives that were oriented towards a better future for themselves through personal change:

> *"…when I got recalled now, it's a different story, I'm being totally honest now, and, and er I wanna change my ways and I want a different lifestyle, y'know, I got, I got motivation like my daughter, family, y'know all that plays a part but (1 second inaudible), the point is that I'm, I'm cooperating more than I was before, and that makes a lot of difference, you see?" (Caleb)*

Some inpatient participants described lower degrees of engagement, even suggesting that they were simply 'going through the motions' of hospital processes and anticipating their discharge to the community again without meaningfully engaging in rehabilitative treatment:

> *"All I understood of that I was in hospital and I have to be discharged, and, er, I just have to play the game, follow myself through until I get out." (Benjamin)*

> *"And I know I can come off meds and be fine, y'know, but I just take them to (pause) think the doctor knows best, and does he really? Not necessarily, y'know?" (Gavin)*

Participants' engagement was observed to reciprocally influence their appraisal of recall and their attitudes towards staff:

> *"I'm getting' all the help I need this time, I'm talkin' about it, and boy have I been through a lot, I've been through, I've been absolute hell, I was, er, in my opinion I was a walking zombie for all that time, and like there's nothin' I can really say now - I'm in the system, I'm, I'm going through the system, I'm talking with [psychologist] which is (pause) alright, so beneficial and all that, like, to sit down and talk about it and, type of thing, everything I been through and that, but, um, (long pause) yeah um, I'm just really gutted that all this weren't sorted out years and years ago on the first time, really, er, yeah." (Henry)*

4. Discussion

4.1 Summary of Findings

This study aimed to develop an understanding of how FSUs make sense of the process of being recalled to a secure hospital from conditional discharge in the community. The developed theoretical model illustrates that making sense of being recalled is a recursive process for FSUs, revolving around their appraisal of how negative or positive they perceive their recall to be.

FSUs' appraisals of being recalled were variably influenced by:

- Their perceived adaptation and connectedness with others in the community prior to being recalled;
- Reflecting on the circumstances of being recalled, including their sense of agency in the process and considering explanations of why they were recalled;
- Their attitudes about forensic services, staff, and systems;
- Their engagement with change after being recalled.

These findings build on previous qualitative research with 'dually diagnosed' male FSUs who had been recalled to medium-secure units, including their understanding of why they were recalled (O' Sullivan et al., 2013; Chiringa et al., 2014). Experiences of disempowerment, unfairness, and inadequate support in the community that were described as major themes in these earlier studies were also identified in the accounts of some FSUs in the present study. However, through the broader inclusion of FSUs from different levels of security, whose various and sometimes multiple recalls took place over a wider range of time, the present study demonstrates how FSUs' perceptions of being recalled may be amenable to change over time and in light of subsequent experiences.

The finding that recall is appraised positively and negatively by FSUs is similar to findings in generic mental health contexts that psychiatric patients also perceive involuntary hospitalisations in terms of positive and negative aspects (Katsakou et al., 2007).

4.2 Procedural Justice

Recall was perceived positively by FSUs who agreed that it was necessary in the circumstances, and negatively by FSUs who disagreed with explanations for why it happened, especially those who also felt that they had little involvement in the process. This key finding resonates with the theory of procedural justice, which posits that individuals' perceptions of fairness when interacting with authority figures are based more on the qualities of the interaction than its outcome (Lind et al., 1988). Specifically, that individuals who feel that their 'voice' is heard during decision-making situations, and who feel that they were treated with dignity and respect by authority figures, are more likely to perceive clinical and legal processes as being fair and just. This consequently leads them to feel more positively about the outcome of decisions about them, and higher perceptions of procedural justice are theorised to "facilitate subsequent therapeutic process" (Tyler, 1992, p.439). Support for the theory has been described at length in criminological literature, and it also has been measured empirically in 'mental health courts' in the USA, where individuals who have criminally offended and are presenting with mental health issues are considered for diversion to receive care instead of being imprisoned (Canada et al., 2014; Kopelovich et al., 2013).

The concept of procedural justice is surprisingly absent in mental health research conducted in the UK, but its manifestation in this study's theoretical model of how FSUs make sense of recall indicates that it is relevant to clinical practice in forensic services.

Further to the intrinsic value of enhancing procedural justice, its association with improving mental health (Kopelovich et al., 2013) and reducing the likelihood of reoffending

(Wales et al., 2010) supports the hypothesis that it can enhance therapeutic engagement. This is also provisionally supported by the present study's finding that FSUs who appraised their recall positively were typically more engaged with rehabilitative treatment following their recall. This suggests that there would likely be clinical and legal utility in working to enhance FSUs' sense of procedural justice during the events of their recall, which would include ensuring that their perspectives are heard by professionals when decisions about recall are being made, and to ensure that they are treated with dignity and respect throughout the process of recall.

4.3 Engagement Following Recall

Whilst the notion of enhancing procedural justice offers a potentially promising mechanism for improving the experience and outcomes of recall, it is important to recognise that its application in the formal judicial settings of mental health courts is not equivalent to the various circumstances in which recall takes place in the UK. In its extremes, recall of FSUs may be carried out as an acute response to crises such as suicide attempts or violent reoffending. These situations place pressure on professionals to ensure the safety of FSUs, themselves, and the public, and can understandably lead them to prioritise actions that manage immediate risks over FSUs' care (Riordan et al., 2005). Therefore, the circumstances of recall may limit or even jeopardise the potential for conferring a sense of procedural justice for FSUs at the first opportunity.

However, although the factual events of recall are fixed, FSUs' appraisal of their recall was found to be dynamic, influenced by their attitudes about and engagement with forensic services subsequent to being recalled. Therefore, there may be opportunities for improving FSUs' appraisals of their recall at a later stage.

In addition to established forms of treatment and rehabilitation facilitated by forensic services, it could be helpful for forensic service staff to engage specifically with FSUs about their experiences of being recalled. Further to Chiringa et al.,'s (2014) finding that FSUs often did not feel that the reasons for their recall were explained or justified to them, there are likely to be opportunities post-recall for staff to retroactively enhance FSUs' sense of procedural justice, such as in clinical reviews or therapy sessions. In the first instance, clinicians involved in the recall of an FSU should discuss the reasons for their recall with them as soon as is reasonably practicable - whilst this may not be possible at the time in acute situations, it should remain a priority for clinicians to facilitate for the benefit of FSUs (Jones, 2015).

Notably, no FSUs in the present study explicitly described forensic service staff discussing the recall with them subsequent to the event. To date there has been no research into the perceptions of forensic service staff about recall, although evidence in this study that some FSUs disagreed with staff's explanations for their recall suggests that there may be incongruity between the lived experience of recall for FSUs and the way it is seen or approached by staff. Reconciling this could be facilitated by forensic service staff attempting to collaboratively support FSUs in the process of making sense of being recalled, which could help to foster positive attitudes and increase engagement among FSUs who appraise their recall negatively.

Support for this assertion is evident in the literature on personal recovery in forensic services, wherein collaborative treatment practices by forensic service staff with FSUs has been found to empower FSUs and increase their engagement with rehabilitative treatment (Gudjonsson et al., 2011; Ayres et al., 2015). The merits of staff fostering relationships with FSUs that are perceived as being caring and supportive is highlighted by yet more research in generic mental health contexts of involuntarily hospitalised patients (Hughes et al., 2009).

4.4 Strengths and Limitations

A key strength of the present study was its broader sampling strategy relative to previous qualitative studies of recalled FSUs. Interviewing FSUs from different levels of security, including those who were again conditionally discharged and living in the community, was pivotal to discovering that making sense of recall involved the recursive influence of experiences subsequent to the recall events themselves. The sampling strategy also meant that the present study stood to be more representative of the range of FSUs in forensic services, rather than being tied to one level of security, a diagnostic group, or gender.

Notwithstanding these merits of the sampling strategy, it is possible that the sample was biased. Firstly, the recruitment procedure may have been biased by clinicians in the forensic service not following up on approaching FSUs who had been identified as eligible. Data about this were not systematically recorded, but the researcher had noted that some clinicians expressed apprehension to invite FSUs who were “unsettled” (i.e., mentally ill) to participate, which may have led to the exclusion of such FSUs from the study, even though FSUs’ current mental state was not set as a study eligibility criteria. Secondly, the FSUs who did participate may have been those who were motivated to express strong views on being recalled, whilst those who declined to take part may have been ambivalent about their recall. This could offer some explanation for why the middle range of the model’s appraisal continuum was underrepresented in the data.

Theoretical sampling of the collected data did not identify much evidence for ambivalence, and theoretical sampling through further recruitment was not possible due to constraints on time and resources and the inherent challenges of engaging this population in research which could also account for the high declination rate. Nonetheless, FSUs’ appraisals of recall were conceptualised as a continuum on the basis of evidence that they appeared to be influenced by subsequent experiences. This evidence was, however, limited to the interpretation of FSUs' retrospective accounts in a cross-sectional research design because time constraints meant that longitudinal follow-up was not feasible.

4.5 Reviewing the Researcher's Reflexivity

The researcher engaged in methods to enhance their reflexivity throughout the study, as described earlier (see Section 2.8). The impact of the researcher's beliefs had been continuously considered throughout data collection, analysis, and reporting, as illustrated by a sample of memos that were reported throughout the study results (Section 3.2).

In line with the constructivist grounded theory approach used, the researcher's prior beliefs about the research topic and context were deemed to interact with the perspectives of participants to generate a co-constructed account of the phenomenon of recall. This included the researcher revising their initially critical stance about the power of forensic services in light of interviewing some participants who expressed positive opinions about the function of forensic services to detain FSUs in order to provide 'respite' and 'opportunity' to recover.

Overall, the researcher judged that the findings of the study were a representative account of the experiences and opinions of the FSUs who participated, and that the researcher's influences on the conduct of the study were explicit through their reflexivity.

4.6 Clinical Implications

As a recursive process, making sense of being recalled continues throughout FSUs' subsequent treatment with forensic services: during their stay in a secure hospital, and into further occasions on conditional discharge in the community. FSUs' attitudes towards and engagement with forensic services post-recall is influenced by whether they appraise their recall negatively or positively. It is important for forensic staff to recognise if FSUs appraise their recall negatively in order that they may intervene accordingly. Engaging FSUs more actively in their treatment by working collaboratively with them can help to increase their positive attitudes towards forensic services. This in turn could facilitate increased positivity in FSUs' appraisals about being recalled, which may reciprocally reinforce their engagement, and therefore potentially improve recovery rates for FSUs.

4.7 Implications for Future Research

The recall of FSUs to secure hospitals is an under-researched topic area, and further investigation into it would help to develop understanding of it as a clinical and legal process.

The concept of procedural justice (Lind et al., 1988) was perceived to have manifested in the theoretical model developed in the present study. Further research examining its relevance to the experiences of recalled FSUs would help to elucidate if the proposed process of appraising recall is comparable to the mechanisms of procedural justice.

The present study and previous qualitative explorations of FSUs' lived experiences of being recalled has highlighted that their perceptions and explanations of recall may differ from the views of forensic service staff, who are key agents in the recall process. A qualitative exploration of staff's perceptions of recall might illuminate how their accounts compare to FSUs.

The cross-sectional design of the present study limited the interpretation of changes in FSUs' appraisals of their recall over time to inference based on retrospective accounts. Further research to investigate the proposed mechanism of dynamic appraisal longitudinally is vital in order to assess its conceptual validity.

The research literature on involuntary admissions in generic mental health contexts demonstrated relevance to the interpretation of the present study's findings, indicating that there appear to be parallel psychological processes involved. A newly published study in that literature has developed and validated a questionnaire to measure psychiatric patients' attitudes towards involuntarily hospitalisation (Gabriel, 2017). If the validity of this tool in forensic services was demonstrated through empirical study then this could provide a quantitative tool to assess FSUs' attitudes towards being recalled.

4.8 Conclusions

This study explored the lived experiences of FSUs in a topic area which has had limited attention in research to date: recall to a secure hospital from conditional discharge in the community. The findings proposed a grounded theory model of how FSUs make sense of their recall by appraising it on a continuum from negative to positive. The negative impact of negative appraisals on FSUs' engagement with treatment is important for clinicians to recognise; through collaboratively supporting FSUs in the process of making sense of being recalled, clinicians may be able to increase the treatment engagement of this group of FSUs.

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Appendices

Appendix A

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Notes/Endnotes	Notes or Endnotes should be used only if absolutely necessary and must be identified in the text by consecutive numbers, enclosed in square brackets and listed at the end of the article.
Figures	All Figures (charts, diagrams, line drawings, web pages/screenshots, and photographic images) should be submitted in electronic form. All Figures should be of high quality, legible and numbered consecutively with arabic numerals. Graphics may be supplied in colour to facilitate their appearance on the online database. • Figures created in MS Word, MS PowerPoint, MS Excel, Illustrator should be supplied in their native formats. Electronic figures created in other applications should be copied from the origination software and pasted into a blank MS Word document or saved and imported into an MS Word document or alternatively create a .pdf file from the origination software. • Figures which cannot be supplied as above are acceptable in the standard image formats which are: .pdf, .ai, and .eps. If you are unable to supply graphics in these formats then please ensure they are .tif, .jpeg, or .bmp at a resolution of at least 300dpi and at least 10cm wide. • To prepare web pages/screenshots simultaneously press the "Alt" and "Print screen" keys on the keyboard, open a blank Microsoft Word document and simultaneously press "Ctrl" and "V" to paste the image. (Capture all the contents/windows on the computer screen to paste into MS Word, by simultaneously pressing "Ctrl" and "Print screen".) • Photographic images should be submitted electronically and of high quality. They should be saved as .tif or .jpeg files at a resolution of at least 300dpi and at least 10cm wide. Digital camera settings should be set at the highest resolution/quality possible.
Tables	Tables should be typed and included in a separate file to the main body of the article. The position of each table should be clearly labelled in the

	body text of article with corresponding labels being clearly shown in the separate file. Ensure that any superscripts or asterisks are shown next to the relevant items and have corresponding explanations displayed as footnotes to the table, figure or plate.
References	References to other publications must be in **Harvard** style and carefully checked for completeness, accuracy and consistency. This is very important in an electronic environment because it enables your readers to exploit the Reference Linking facility on the database and link back to the works you have cited through CrossRef. You should cite publications in the text: (Adams, 2006) using the first named author's name or (Adams and Brown, 2006) citing both names of two, or (Adams *et al.*, 2006), when there are three or more authors. At the end of the paper a reference list in alphabetical order should be supplied:
For books	Surname, Initials (year), *Title of Book*, Publisher, Place of publication. e.g. Harrow, R. (2005), *No Place to Hide*, Simon & Schuster, New York, NY.
For book chapters	Surname, Initials (year), "Chapter title", Editor's Surname, Initials, *Title of Book*, Publisher, Place of publication, pages. e.g. Calabrese, F.A. (2005), "The early pathways: theory to practice – a continuum", in Stankosky, M. (Ed.), *Creating the Discipline of Knowledge Management*, Elsevier, New York, NY, pp. 15-20.
For journals	Surname, Initials (year), "Title of article", *Journal Name*, volume issue, pages. e.g. Capizzi, M.T. and Ferguson, R. (2005), "Loyalty trends for the twenty-first century", *Journal of Consumer Marketing*, Vol. 22 No. 2, pp. 72-80.
For published conference proceedings	Surname, Initials (year of publication), "Title of paper", in Surname, Initials (Ed.), *Title of published proceeding which may include place and date(s) held*, Publisher, Place of publication, Page numbers. e.g. Jakkilinki, R., Georgievski, M. and Sharda, N. (2007), "Connecting destinations with an ontology-based e-tourism planner", in *Information and communication technologies in tourism 2007 proceedings of the international conference in Ljubljana, Slovenia, 2007*, Springer-Verlag, Vienna, pp. 12-32.
For unpublished conference proceedings	Surname, Initials (year), "Title of paper", paper presented at Name of Conference, date of conference, place of conference, available at: URL if freely available on the internet (accessed date). e.g. Aumueller, D. (2005), "Semantic authoring and retrieval within a wiki", paper presented at the European Semantic Web Conference

	(ESWC), 29 May-1 June, Heraklion, Crete, available at: http://dbs.uni-leipzig.de/file/aumueller05wiksar.pdf (accessed 20 February 2007).
For working papers	Surname, Initials (year), "Title of article", working paper [number if available], Institution or organization, Place of organization, date. e.g. Moizer, P. (2003), "How published academic research can inform policy decisions: the case of mandatory rotation of audit appointments", working paper, Leeds University Business School, University of Leeds, Leeds, 28 March.
For encyclopedia entries (with no author or editor)	*Title of Encyclopedia* (year) "Title of entry", volume, edition, Title of Encyclopedia, Publisher, Place of publication, pages. e.g. *Encyclopaedia Britannica* (1926) "Psychology of culture contact", Vol. 1, 13th ed., Encyclopaedia Britannica, London and New York, NY, pp. 765-71. (For authored entries please refer to book chapter guidelines above)
For newspaper articles (authored)	Surname, Initials (year), "Article title", *Newspaper*, date, pages. e.g. Smith, A. (2008), "Money for old rope", *Daily News*, 21 January, pp. 1, 3-4.
For newspaper articles (non-authored)	*Newspaper* (year), "Article title", date, pages. e.g. *Daily News* (2008), "Small change", 2 February, p. 7.
For archival or other unpublished sources	Surname, Initials, (year), "Title of document", Unpublished Manuscript, collection name, inventory record, name of archive, location of archive. e.g. Litman, S. (1902), "Mechanism & Technique of Commerce", Unpublished Manuscript, Simon Litman Papers, Record series 9/5/29 Box 3, University of Illinois Archives, Urbana-Champaign, IL.
For electronic sources	If available online, the full URL should be supplied at the end of the reference, as well as a date that the resource was accessed. e.g. Castle, B. (2005), "Introduction to web services for remote portlets", available at: http://www-128.ibm.com/developerworks/library/ws-wsrp/ (accessed 12 November 2007). Standalone URLs, i.e. without an author or date, should be included either within parentheses within the main text, or preferably set as a note (roman numeral within square brackets within text followed by the full URL address at the end of the paper).

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Do you publish open access articles?	For questions about open access, please visit the Open Access section of the website.
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Appendix B

Full record of databases searched and search terms used

Line	Database[2]	Search Term
1	AMED, BNI, CINAHL, Medline, PsycINFO	recover*.ti,ab
2	AMED, BNI, CINAHL, Medline, PsycINFO	forensic.ti,ab
3	AMED, BNI, CINAHL, Medline, PsycINFO	offend. ti,ab
4	AMED, BNI, CINAHL, Medline, PsycINFO	offence*.ti,ab
5	AMED, BNI, CINAHL, Medline, PsycINFO	secur*.ti,ab
6	AMED, BNI, CINAHL, Medline, PsycINFO	convict*.ti,ab
7	AMED, BNI, CINAHL, Medline, PsycINFO	“special hospital*”.ti,ab
8	AMED, BNI, CINAHL, Medline, PsycINFO	2 OR 3 OR 4 OR 5 OR 6 OR 7
9	AMED, BNI, CINAHL, Medline, PsycINFO	qualitative.ti,ab
10	AMED, BNI, CINAHL, Medline, PsycINFO	phenomenolog*.ti,ab
11	AMED, BNI, CINAHL, Medline, PsycINFO	“grounded theory”.ti,ab
12	AMED, BNI, CINAHL, Medline, PsycINFO	interview*.ti,ab
13	AMED, BNI, CINAHL, Medline, PsycINFO	observation*.ti,ab
14	AMED, BNI, CINAHL, Medline, PsycINFO	“action research”.ti,ab
15	AMED, BNI, CINAHL, Medline, PsycINFO	“focus group”.ti,ab
16	AMED, BNI, CINAHL, Medline, PsycINFO	“content analy*”.ti,ab
17	AMED, BNI, CINAHL, Medline, PsycINFO	“thematic analy*”.ti,ab
18	AMED, BNI, CINAHL, Medline, PsycINFO	“discourse analy*”.ti,ab
19	AMED, BNI, CINAHL, Medline, PsycINFO	“conversation analy*”.ti,ab
20	AMED, BNI, CINAHL, Medline, PsycINFO	“narrative analy*”.ti,ab
21	AMED, BNI, CINAHL, Medline, PsycINFO	ethnomethodology*.ti,ab
22	AMED, BNI, CINAHL, Medline, PsycINFO	“Q methodology*”.ti,ab
23	AMED, BNI, CINAHL, Medline, PsycINFO	“mixed method*”.ti,ab
24	AMED, BNI, CINAHL, Medline, PsycINFO	9 OR 10 OR 11 OR 12 OR 13 OR 14 OR 15 OR 16 OR 17 OR 18 OR 19 OR 20 OR 21 OR 22 OR 23
25	AMED, BNI, CINAHL, Medline, PsycINFO	1 AND 8 AND 24

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[2] Searched individually

Notes. AMED = Allied and Complementary Medicine Database, BNI = British Nursing Index, CINAHL = Cumulative Index of Nursing and Allied Health Literature

Appendix C

Data extraction form

Citation
Location and setting (e.g., high-secure/community, NHS/private)
Research aims
Clearly outlined research aims? YES/NO **Clearly defined research question(s)?** YES/NO
Design/Method
Qualitative methodology: **Data collection method(s):**
Participants
N = **Service user demographics** **Demographics – Gender:** **Demographics – Ages (mean and range):** **Demographics – Ethnicity:** **Demographics – Mental health diagnosis/es:** **Demographics – index offence:** **Staff demographics** **Demographics – Gender:** **Demographics – Ages (mean and range):** **Demographics – Ethnicity:** **Demographics – Profession:** **Demographics – any other:** **Carer demographics** **Demographics – Gender:** **Demographics – Ages (mean and range):** **Demographics – Ethnicity:** **Demographics – Profession:** **Demographics – any other:** **Perspectives explored (e.g., service user, carer, professional):** **Inclusion/Exclusion criteria stated?** YES/NO

Appendix D

Critical appraisal tool (Clark, 2003)

Guide to peer reviewing qualitative manuscripts: RATS		
R	**Relevance of study question**	
	Is it important for medicine or public health? Is it linked to existing knowledge base (literature, theory, practice)?	Is the research question explicitly stated? Is the research question justified?
A	**Appropriateness of qualitative method**	
	Is qualitative methodology the best approach for the study aims? Is the study design justified?	Why was a particular method (for example, interviews) chosen?
T	**Transparency of procedures**	
	Sampling	
	Are criteria for selecting the study explained and justified?	Why were these participants selected as the most appropriate to provide access to type of knowledge sought by study?
	Recruitment	
	How and by whom was recruitment conducted? Was selection bias discussed?	Who chose not to participate and why?
	Data collection	
	Was collection of data systematic and comprehensive? Are characteristics of study group and setting clearly described? When was data collection stopped and why?	Are methods explicitly outlined and examples, such as interview questions, given?
	Role of researchers	
	Do the researcher(s) critically examine their own influence on the formulation of the research question, data collection, and interpretation?	Do the researchers occupy dual roles (clinician and researcher)?

(Continued)

Guide to peer reviewing qualitative manuscripts: RATS (Continued)		
	Ethics	
	Is informed consent detailed?	
	Is a discussion of anonymity and confidentiality presented?	How were anonymity and confidentiality ensured?
	Was approval from ethics committee received?	
S	**Soundness of interpretive approach**	
	Analysis	
	Is process of analysis described in-depth?	Were negative or deviant cases analysed?
	How were themes derived from the data? Were alternative explanations sought?	Were quotes used and on what basis were they chosen?
	Was trustworthiness of data checked?	Was an audit trail or triangulation employed?
	Are findings presented with reference to existing theoretical and applied literature?	
	Are limitations discussed?	
	Is the manuscript well written and accessible?	

Appendix E

Submission guidelines for Criminal Behaviour and Mental Health

Author Guidelines

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Author Guidelines

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Previous users can Check for existing account. New users should Create a new account.

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- Correspondence is welcomed

Title and Abstract Optimisation Information. As more research is read online, the electronic version of articles becomes ever more important. In a move to improve search engine rankings for individual articles and increase readership and future citations to Criminal Behaviour and Mental Health at the same time please visit **Optimizing Your Abstract for Search Engines** for guidelines on the preparation of keywords and descriptive titles.

Manuscript style. The language of the journal is (British) English. All submissions must have a title, be printed on one side of A4 paper with numbered pages, be double-line spaced and have a 3cm wide margin all around. Illustrations and tables must be printed on separate sheets, and not incorporated into the text.

- The **title** page must list the full title, short title, names and affiliations of all authors. Give the full address, including e-mail, telephone and fax, of the author, who is to check the proofs.
- Include the name(s) of any **sponsor(s)** of the research contained in the paper, along with **grant number(s)** .
- The article will be sent for peer review without the above identifying details.
- **Substantive research articles** should not exceed **3000** words for the main body of the text and contain no more than **4 tables or figures** . A structured **abstract** should be supplied and must not exceed **200** words. It should be subdivided into the following headings: background, aims/hypotheses, methods, results, conclusions/implications for (clinical) practice.
- **Brief Reports** are particularly welcome. They should not exceed **1000** words for the main body of the text, contain only **1 table and/or figure** , references should be limited to 20 and an abstract not exceeding 150 words should be supplied.

Reference style. References should be arranged alphabetically. Where reference is made to more than one work by the same author, published in the same year, identify each citation in the text as follows: (Collins, 1998a), (Collins, 1998b). Where multiple authors are listed in the reference, please cite in the text as ‘Maxwell et al. (1999)’. All references must be complete and accurate. Where possible the DOI for the reference should be included at the end of the reference. Online citations should include date of access. References should be listed in the following style:

Website : The Geriatric Website (1999) http://www.wiley.com/oap/ [1 April 1999]

Paper in a journal : Thierry, KL, Spence MJ (2004). A real-life event enhances the accuracy of preschoolers' recall. Applied Cognitive Psychology 18: 297-309. DOI: 10.1002/acp.965

Book : Hare RD, Schalling D (1978). Psychopathic Behaviour: Approaches to Research. New York: Wiley.

Chapter in a book : Oucho JO, Gould WT, Smith FK, Brown PL, Jones RH (1993). Internal migration, urbanization and population distribution. In Foote KA, Hill KH, Martin LG (eds) Demographic Change in Sub-Saharan Africa. Washington DC: National Academy Press pp. 255-296.

Personal communications and unpublished data should not be listed in the reference section but should be given in full in the text.

Illustrations . Supply each illustration on a separate sheet, with the lead author's name and the figure number (in Arabic numerals), with the top of the figure indicated, on the reverse. Line artwork must be high-quality laser output (not photocopies). Tints are not acceptable; lettering must be of a reasonable size that would still be clearly legible upon reduction, and consistent within each figure and set of figures. Supply artwork at the intended size for printing.

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Appendix F

Population demographics of adult forensic mental health service users (FSUs)

Common psychiatric diagnoses among FSUs are psychotic disorders (80% prevalence in high security; Walsh et al., 2002) and personality disorders (upwards of 65%; Blackburn et al., 2003). Mood disorders are less common but still prevalent (18%; Coid et al., 2001). It is important to appreciate that the majority of FSUs experience comorbid mental health and personality problems (Coid et al., 2001). Another significant problem for many FSUs is substance misuse (up to 90%; Oddie et al., 2009), with links often identified between substance misuse and incidents of offending by FSUs (Chiringa et al., 2014).

Offending behaviours that lead to conviction and admission into forensic services (known as an FSU's 'index offence') include violence against the person (57%), sexual offences (12%), and robbery (5%) (Ministry of Justice, 2017).

Approximately 87% of FSUs are male and 88% of those are aged between 21 and 59 years old, with very similar age demographics found for females (Ministry of Justice, 2017).

Demographic data on FSUs' ethnicities were not found in an online search of sources.

Other demographic variables that are judged to influence mental health and offending include socioeconomic class, employment opportunities, level of education, quality of upbringing by caregivers, and exposure to criminality during youth (Clark, 2008).

References for Appendix F

Blackburn, R, Logan, C, Donnelly, J, Renwick, S (2003). Personality disorders, psychopathy and other mental disorders: Co-morbidity among patients at English and Scottish high-security hospitals. Journal of Forensic Psychiatry & Psychology 14: 111–137. DOI: 10.1080/1478994031000077925

Chiringa, J, Robinson, JE, Clancy, C (2014). Reasons for recall following conditional discharge: explanations given by male patients suffering from dual diagnosis in a London Forensic Unit. Journal of Psychiatric and Mental Health Nursing 21: 336–44. DOI:10.1111/jpm.12083

Clark D (2008). Non-custodial sentences and mentally disordered offenders. In Soothill K, Rogers P, Dolan M (eds) Handbook of Forensic Mental Health. Padstow, UK: Willan Publishing pp. 144-174.

Coid, J, Kahtan, N, Gault, S, Cook, A, Jarman, B (2001). Medium secure forensic psychiatry services: Comparison of seven English health regions. The British Journal of Psychiatry 178: 55–61. DOI:10.1192/bjp.178.1.55

Ministry of Justice (2017) https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-october-to-december-2016 [19 July 2017]

Oddie, S, Davies, J (2009). A multi-method evaluation of a substance misuse program in a medium secure forensic mental health unit. Journal of Addictions Nursing 20: 132-141. DOI: 10.1080/10884600903078944

Walsh, E, Leese, M, Taylor, P, Johnston, I, Burns, T, Reed, F, Higgit, A, Murray, R (2002). Psychosis in high-security and general psychiatric services: Report from the UK700 and Special Hospitals' Treatment Resistant Schizophrenia groups. The British Journal of Psychiatry 180: 351–357. DOI: 10.1192/bjp.180.4.351

Appendix G

Details about the process of recall

The order for recall of a conditionally discharged FSU can be made by the Secretary of State for Justice or by the Responsible Clinician, and there must be evidence of a deterioration in the FSU’s mental health that warrants their containment. Services are required to inform FSUs that they are being recalled at the time that this happens, and then must give the FSU a further explanation of the reasons for their recall as soon as is reasonably practicable (Jones, 2015).

Recall is classified distinctly from readmission, the latter of which describes when a former FSU is admitted to forensic services again, having had a period of absolute discharge from forensic services separating the episodes of care. In instances of recall, FSUs will have been continuously open to forensic services as they transition back to hospital from the community.

References for Appendix G

Jones R (2015). Mental Health Act Manual 18th Ed. London, UK: Sweet & Maxwell.

Appendix H

The rationale for adopting a constructivist grounded theory approach

Qualitative research methods offer systematic approaches to investigate phenomena from the perspectives of people who have lived experience of it, and the value of including forensic mental health service users' (FSUs) perspectives has been recognised to enhance ecological validity of research findings in this field (Coffey, 2006; Tapp et al., 2013). Grounded theory is a qualitative research methodology that seeks to construct theoretical models of social processes rooted in the accounts of individuals (Tweed et al., 2012), and it was therefore judged to be well-suited to provide a framework for the development of an inductive theoretical explanation of how FSUs make sense of the process of being recalled.

Other qualitative research approaches were differentially considered for the study before the adoption of grounded theory was finalised. These are described, including reasons why there were not adopted for the study. Interpretative Phenomenological Analysis (IPA; Smith et al., 2009) aims to capture and understand a group of people's individual subjective experiences in depth, but its outcomes are broadly thematic and categorical rather than conceptual and theoretical. Similarly, discourse analysis (Potter et al., 1987) focuses closely on the language used by individuals when describing their own experiences of a particular phenomenon, but was not conceptually or theoretically driven either. Thematic analysis (Braun et al., 2006) codes data in a way that is comparable to grounded theory methods, looking to identify themes in the data. However, the procedures and aims of thematic analysis with respect to data collection and interpretation are not as rigorous or extensive as those of grounded theory, and crucially thematic analysis does not provide a framework with which to develop emergent themes further into concepts or a theoretical model that could explain and predict the interaction between relevant factors for the phenomenon being studied.

Therefore, a grounded theory approach was adopted for this study. Specifically, Charmaz's (2014) constructivist version of grounded theory was selected. This was chosen primarily because the researcher shares its epistemological assumptions that meaning is actively co-constructed through the interactions between people, rather than latent meaning 'emerging' from data as in the positivist and post-positivist versions of grounded theory expounded by Glaser (1982) and Strauss and Corbin (1998), respectively.

On reflection upon following completion of the study, the data generated in this study were indeed deemed to be co-constructed by the researcher and participants through the dynamic process of the face-to-face interviews, which were the primary source of data collection. This process itself was influenced by individual attributes of the researcher and participants, such as their values, social position, and behaviour, as was considered throughout the process by the researcher's engagement in methods to enhance reflexivity.

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Braun, V, Clarke, V (2006). Using thematic analysis in psychology. Qualitative Research in Psychology 3: 77-101. DOI: 10.1191/1478088706qp063oa

Charmaz KC (2014). Constructing Grounded Theory 2nd Ed., London, UK: Sage Publications.

Coffey, M (2006). Researching service user views in forensic mental health: A literature review. Journal of Forensic Psychiatry & Psychology 17: 73–107. DOI: 10.1080/14789940500431544

Glaser B (1992). Basics of Grounded Theory Analysis: Emergence vs. Forcing. Mill Valley, CA: The Sociology Press.

Potter J, Wetherell M (1987). Discourse and Social Psychology. London, UK: Sage Publications.

Smith JA, Flowers P, Larkin M (2009). Interpretative Phenomenological Analysis: Theory, Method and Research. London, UK: Sage.

Strauss A, Corbin J (1998). Basics of Qualitative Research: Techniques and Procedures for Developing Grounded Theory 2nd Ed., Newbury Park, CA: Sage Publications.

Tapp, J, Warren F, Fife-Schaw, C, Perkins, D, Moore, E (2013). What do the experts by experience tell us about “what works” in high secure forensic inpatient hospital services? The Journal of Forensic Psychiatry & Psychology 24: 160–178. DOI: 10.1080/14789949.2012.760642

Tweed A, Charmaz K (2012). Grounded theory methods for mental health practitioners. In Harper D, Thompson AR (eds) Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners. Chichester, UK: John Wiley & Sons pp. 131–146.

Appendix I

Study proposal approval letter from the Oxford Doctoral Course in Clinical Psychology

Oxford Health NHS
NHS Foundation Trust

The Oxford Institute of Clinical Psychology Training

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Oxford Doctoral Course in Clinical Psychology
An NHS Course validated by the University of Oxford

Isis Education Centre, Warneford Hospital, Oxford OX3 7JX
Tel: +44(0)1865 226431
Website: www.oxicpt.co.uk

5th July, 2016

Owen Rye
Trainee Clinical Psychologist
Oxford Doctoral Course in Clinical Psychology
Isis Education Centre
Warneford Hospital

Dear Owen,

Thank you very much for the revisions received to your dissertation proposal. You now have full approval from the Course for your research.

We wish you all the very best with your studies.

Yours sincerely,

Myra

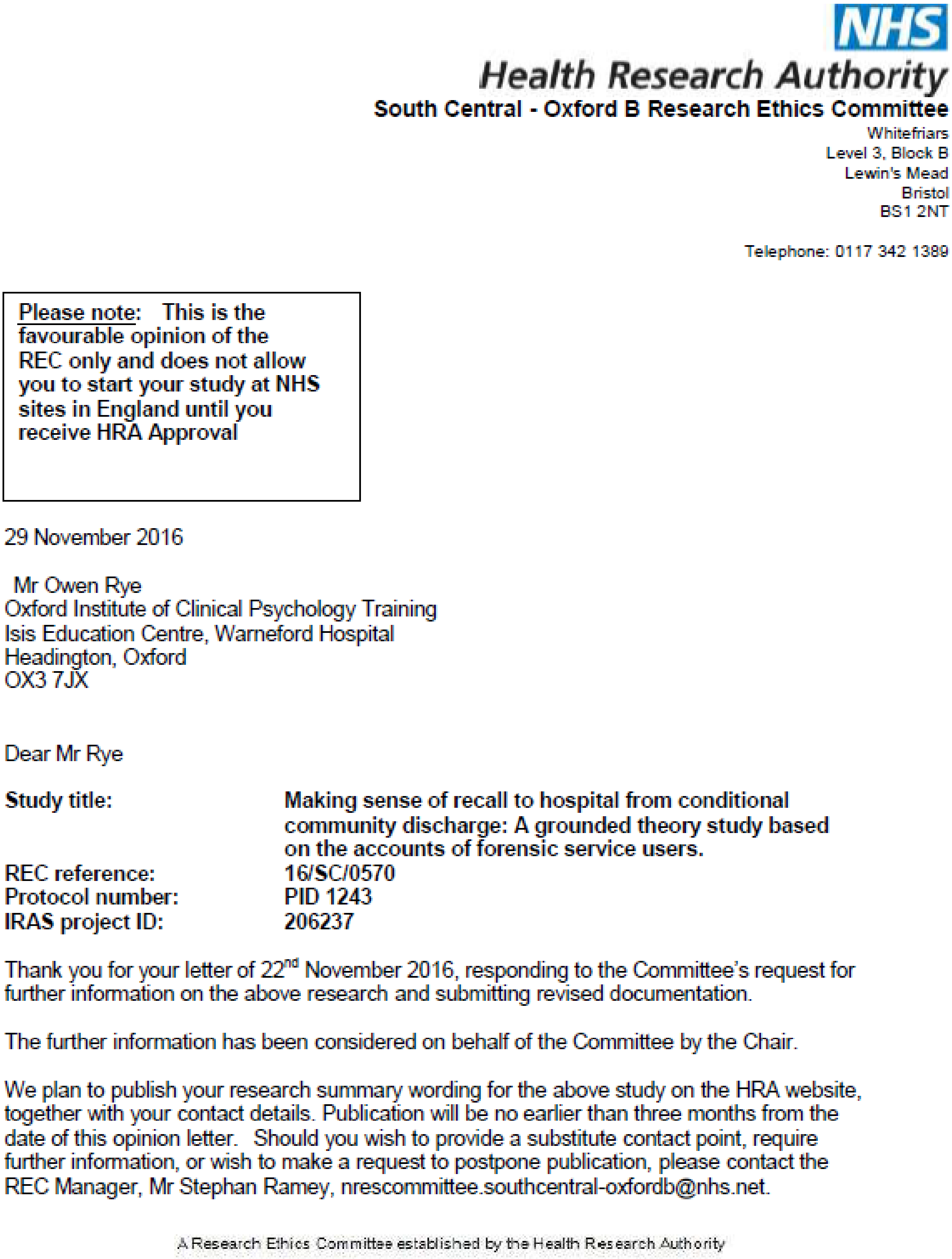
Dr Myra Cooper
Chair, Research Sub-Committee

c.c. Olivia Hewitt
Charlotte Couldrey
Clare Churchman

oryedissapp

Appendix J

Favourable opinion letter from South Central - Oxford B Research Ethics Committee



NHS
Health Research Authority
South Central - Oxford B Research Ethics Committee
Whitefriars
Level 3, Block B
Lewin's Mead
Bristol
BS1 2NT

Telephone: 0117 342 1389

Please note: This is the favourable opinion of the REC only and does not allow you to start your study at NHS sites in England until you receive HRA Approval

29 November 2016

Mr Owen Rye
Oxford Institute of Clinical Psychology Training
Isis Education Centre, Warneford Hospital
Headington, Oxford
OX3 7JX

Dear Mr Rye

Study title:	**Making sense of recall to hospital from conditional community discharge: A grounded theory study based on the accounts of forensic service users.**
REC reference:	**16/SC/0570**
Protocol number:	**PID 1243**
IRAS project ID:	**206237**

Thank you for your letter of 22nd November 2016, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact the REC Manager, Mr Stephan Ramey, nrescommittee.southcentral-oxfordb@nhs.net.

A Research Ethics Committee established by the Health Research Authority

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the study, which you can make available to host organisations to facilitate their permission for the study. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for NHS permission for research is available in the Integrated Research Application System, www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
GP/consultant information sheets or letters [PIS for HCPs]	2	19 November 2016
GP/consultant information sheets or letters [PIS for HCPs - tracked changes]	2	19 November 2016
Interview schedules or topic guides for participants [Interview Schedule/Topic Guide]	2	20 November 2016
Interview schedules or topic guides for participants [Interview Schedule/Topic Guide - tracked changes]	2	20 November 2016
IRAS Application Form [IRAS_Form_06102016]		06 October 2016
IRAS Checklist XML [Checklist_22112016]		22 November 2016
Letters of invitation to participant [Letter of Invitation]	2	19 November 2016
Letters of invitation to participant [Letter of Invitation - tracked changes]	2	19 November 2016
Letters of invitation to participant [Invitation Reply Slip - Inpatient version]	1	20 November 2016
Letters of invitation to participant [Invitation Reply Slip - Outpatient version]	1	20 November 2016
Non-validated questionnaire [Pro forma for participant demographic	2	20 November 2016

information]		
Non-validated questionnaire [Pro forma for participant demographic information - tracked changes]	2	20 November 2016
Other [Research protocol or project proposal - tracked changes]	2	20 November 2016
Other [Response to REC Cover Letter]	1	21 November 2016
Participant consent form [Consent Form]	2	19 November 2016
Participant consent form [Consent Form - tracked changes]	2	19 November 2016
Participant consent form [Consent Form for Follow-Up]	2	19 November 2016
Participant consent form [Consent Form for Follow-Up - tracked changes]	2	19 November 2016
Participant information sheet (PIS) [PIS]	2	19 November 2016
Participant information sheet (PIS) [PIS - tracked changes]	2	19 November 2016
Participant information sheet (PIS) [PIS for Follow-Up]	2	19 November 2016
Participant information sheet (PIS) [PIS for Follow-Up - Tracked Changes]	2	19 November 2016
Referee's report or other scientific critique report [Academic course approval letter]	1	05 July 2016
Research protocol or project proposal [Protocol]	2	20 November 2016
Summary CV for Chief Investigator (CI) [Summary CV for CI]	1	21 August 2016
Summary CV for student [Summary CV for student]	1	21 August 2016
Summary CV for supervisor (student research) [Summary CV for supervisor 1]	1	22 August 2016
Summary CV for supervisor (student research) [Summary CV for supervisor 2]	1	16 August 2016

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at
http://www.hra.nhs.uk/hra-training/

16/SC/0570 **Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

Mr Chris Foy
Chair

Copy to: *Victoria Rush*
Ms Victoria Rush, Oxford Health NHS Foundation Trust

Appendix K

Letter of study approval by Health Research Authority

NHS
Health Research Authority

Mr Owen Rye
Oxford Institute of Clinical Psychology Training
Isis Education Centre, Warneford Hospital
Headington, Oxford
OX3 7JX

Email: hra.approval@nhs.net

06 December 2016

Dear Mr Rye,

Letter of HRA Approval

Study title:	**Making sense of recall to hospital from conditional community discharge: A grounded theory study based on the accounts of forensic service users.**
IRAS project ID:	**206237**
Protocol number:	**PID 1243**
REC reference:	**16/SC/0570**
Sponsor	**Organization not set**

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

Participation of NHS Organisations in England

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

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

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

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

Page **1** of **8**

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

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

After HRA Approval

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

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

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

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

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

Scope

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

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

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

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please email the HRA at hra.approval@nhs.net. Additionally, one of our staff would be happy to call and discuss your experience of HRA Approval.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **206237**. Please quote this on all correspondence.

Yours sincerely

Rekha Keshvara
Assessor

Email: hra.approval@nhs.net

Copy to: Victoria Rush, Oxford Health NHS Foundation Trust

Appendix A - List of Documents

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

Document	*Version*	*Date*
GP/consultant information sheets or letters [PIS for HCPs]	2	19 November 2016
GP/consultant information sheets or letters [PIS for HCPs - tracked changes]	2	19 November 2016
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Summary CV for student [Summary CV for student]	1	21 August 2016
Summary CV for supervisor (student research) [Summary CV for supervisor 1]	1	22 August 2016
Summary CV for supervisor (student research) [Summary CV for supervisor 2]	1	16 August 2016

Appendix B - Summary of HRA Assessment

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

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

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

Name: Victoria Rush
Tel: 01865902401
Email: research@oxfordhealth.nhs.uk

HRA assessment criteria

Section	HRA Assessment Criteria	Compliant with Standards	Comments
1.1	IRAS application completed correctly	Yes	No comments
2.1	Participant information/consent documents and consent process	Yes	No comments
3.1	Protocol assessment	Yes	No comments
4.1	Allocation of responsibilities and rights are agreed and documented	Yes	This is a non-commercial single site study taking place in the NHS where the single NHS organisation is also the study sponsor. Therefore no study agreements are required.
4.2	Insurance/indemnity arrangements assessed	Yes	Where applicable, independent contractors (e.g. General Practitioners) should ensure that the professional indemnity provided by their medical defence organisation covers the

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

Participating NHS Organisations in England

This provides detail on the types of participating NHS organisations in the study and a statement as to whether the activities at all organisations are the same or different.

This is a non-commercial single site study taking place in the NHS where that single NHS organisation is also the study sponsor. Therefore there is only one site type involved in the research.

If this study is subsequently extended to other NHS organisation(s) in England, an amendment should be submitted to the HRA, with a Statement of Activities and Schedule of Events for the newly participating NHS organisation(s) in England.

The Chief Investigator or sponsor should share relevant study documents with participating NHS organisations in England in order to put arrangements in place to deliver the study. The documents should be sent to both the local study team, where applicable, and the office providing the research management function at the participating organisation. For NIHR CRN Portfolio studies, the Local LCRN contact should also be copied into this correspondence. For further guidance on working with participating NHS organisations please see the HRA website.

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

Confirmation of Capacity and Capability

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

This is a single site study sponsored by the site. The R&D office will confirm to the CI when the study can start.

Principal Investigator Suitability

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

A Principal Investigator to be allocated at the participating NHS site.

GCP training is not a generic training expectation, in line with the HRA statement on training expectations.

HR Good Practice Resource Pack Expectations

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

It is expected that all study activities will be undertaken by local staff employed by the participating NHS organisation. Therefore no honorary research contracts or letters of access are expected for this study.

Other Information to Aid Study Set-up

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

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

Appendix L

Letter confirming capacity and capability of sponsoring NHS Trust to host study

Oxford Health NHS
NHS Foundation Trust
Caring, Safe and Excellent

Professor John Geddes
Director of R&D
Warneford Hospital
Oxford
OX3 7JX
Tel: 01865 226451

26th January 2017

Our Ref: OHFT PID 1243/GBR

Owen Rye
Trainee Clinical Psychologist
The Oxford Institute of Clinical Psychology Training
Isis Education Centre
Warneford Hospital
Oxford
OX3 7JX

Dear Owen

RE:	**CONFIRMATION OF CAPACITY AND CAPABILITY (GREEN LIGHT)**
Study Title:	**Making sense of recall to hospital from conditional community discharge: A grounded theory study based on the accounts of forensic service users**
IRAS Project ID:	**206237**

I am pleased to confirm that Oxford Health NHS Foundation Trust (OHFT) has the capacity and capability to undertake the above named research study, as described in your Protocol (version 2, 20 November 2016). This confirmation is dependent on formal approval from the HRA, which includes a favourable ethical opinion from a National Research Ethics Service Committee. The HRA approved documents should be provided to us, and where appropriate, all localised patient facing documents.

Oxford Health NHS Foundation Trust agrees to start this study on **26 January 2017**, as previously discussed with **Gordon Riddell**. This confirmation of capacity and capability is dependent on you commencing the study within 3 months from the date of this letter. If the study does not commence by **25 April 2017** then please notify the R&D office as the Trust position may have changed and this confirmation of capacity and capability may need to be reassessed.

Recruitment
NHS Trusts are required to meet and report on performance standards set against national recruitment targets, one of which is first participant recruited to a study. I can confirm that your first participant target recruitment date is **31 March 2017**. In addition to this, a study is expected to recruit its target sample size within a pre-specified recruitment period. In the Protocol you state that the Trust's involvement in your study will end on **22 September 2017** and that a target recruitment **range of 7 – 15 (but no higher than 20)** participants is required. If you feel that you may not meet these targets please notify the R&D department immediately.

Access to NHS for Research Purposes
Completion of a Research Passport Application may be required for researchers who do not hold a substantive or honorary contract with an NHS organisation. Research activity should not take place at this site until either a Letter of Access or Honorary Research Contract has been issued for individuals where this applies. Please contact the R&D office to check if this is required.

Governance & Compliance
It is the Trust's expectation that the study will comply with all applicable and relevant laws, such as the Data Protection Act (1998), the Human Tissue Act (2004), the Mental Capacity Act (2005) and adheres to the Research Governance Framework (RGF), the principles of (ICH) Good Clinical Practice (GCP) and the NHS Confidentiality Code of Practice (Nov 2003) and if applicable the Clinical Trial regulations.

Please note that the Trust, as host organisation, is required to monitor research to ensure compliance with the RGF and other legal and/or regulatory requirements and you may be asked to provide access to authorised individuals from the R&D office for monitoring or audit purposes.

In working with the Trust there is an expectation that the following are provided to the R&D office in a timely manner;

- date of first participant recruited
- ongoing recruitment figures
- copy of reports to the HRA/REC
- any substantial or non-substantial changes relevant to the OHFT
- final report on completion of the study
- any publications arising from the study
- immediate notification of changes in involvement of key site personnel

If you wish to discuss this further, please do not hesitate to contact the R&D Office.

Kind regards

Professor John Geddes
Director of R&D

Cc: (by e-mail)

Supervisor: clare.churchman@oxfordhealth.nhs.uk

Appendix M

Further discussion of ethical considerations and how they were managed in the study

Consideration was given to the possibility that people may have felt coerced to participate, the subject matter potentially being distressing for participants to talk about, any risks of harm which participants could pose to themselves or others (particularly the researcher), and the likely event that participants' responses may refer to criminal activity.

An extended discussion of these considerations is presented below, including description of the steps that were actually taken to ensure good ethical conduct throughout study procedures.

Potential or perceived coercion

It is widely recognised that forensic service users (FSUs) are disempowered within forensic services, especially inpatient settings due to necessary methods of containment and restrictions limiting their autonomy. The FSUs of interest in this study were also subject to the Mental Health Act and restriction orders imposed by the Ministry of Justice. As such, they were potentially vulnerable to being coerced into activities that may reflect well on their rehabilitative progress but which they might not otherwise participate in. Participating in research is a prime example of something which FSUs could be coerced into. Concerted efforts were therefore made during the recruitment and consent phases for clinicians involved in recruitment and for the researcher to emphasise to potential FSU participants that participation was entirely voluntary and would have no effect, good or bad, on their treatment or legal rights. This was stated explicitly on the printed information sheet and consent form.

In an attempt to further minimise issues of coercion during interviews, participants were reminded regularly that their participation was voluntary, that they could decline to answer questions or censor their responses in the interview without giving any reason.

Potential for emotional distress

During interviews, participants were asked about their personal experiences of recall to secure hospitals, which in some cases led to the discussion of emotionally sensitive subject matter that was upsetting to the participant. The researcher sought to express sympathy to the participants during the interview whilst maintaining a boundary as an outside researcher and not a member of their clinical care team. At the start of all interviews, the researcher told participants that they could take a break(s) during the interview if they wished, and the researcher also reminded participants about this during the interview if they appeared to be distressed. The researcher ‘checked in’ with participants approximately thirty minutes into interviews to see if they were okay to continue, in addition to asking them this at other times if they presented as distressed in any way. Participants were offered a short debrief at the end of interviews by the researcher, who also reminded them to seek support from clinical staff or other people of their choosing if they felt distressed following the interview.

Potential for disclosures of criminal activity or of future risks towards self or others

Given the clinical population and topic of interest, it was likely that participants might describe criminal activity that they had carried out in the past. It was also possible that participants might make disclosures that indicated future risks towards others or towards themselves. An essential point of informed consent was that participants agreed to the researcher giving a debrief to a qualified clinician from their care team immediately after the interview, detailing any indications of risks and any references to criminal activity so that appropriate clinical and legal action could be taken if any such disclosures were not previously documented or known about by the clinical care team. The researcher stated this clearly during the consent process, at the start of the interview, and following any such disclosure that these would be fed back to a qualified clinician from the participant’s care team after the interview. By ensuring that participants were aware of this process, they were able to make informed choices as to what they discussed during interviews and what they did not, and indeed several participants were observed by the researcher to censor themselves from making disclosures that were likely to implicate historic criminal activity.

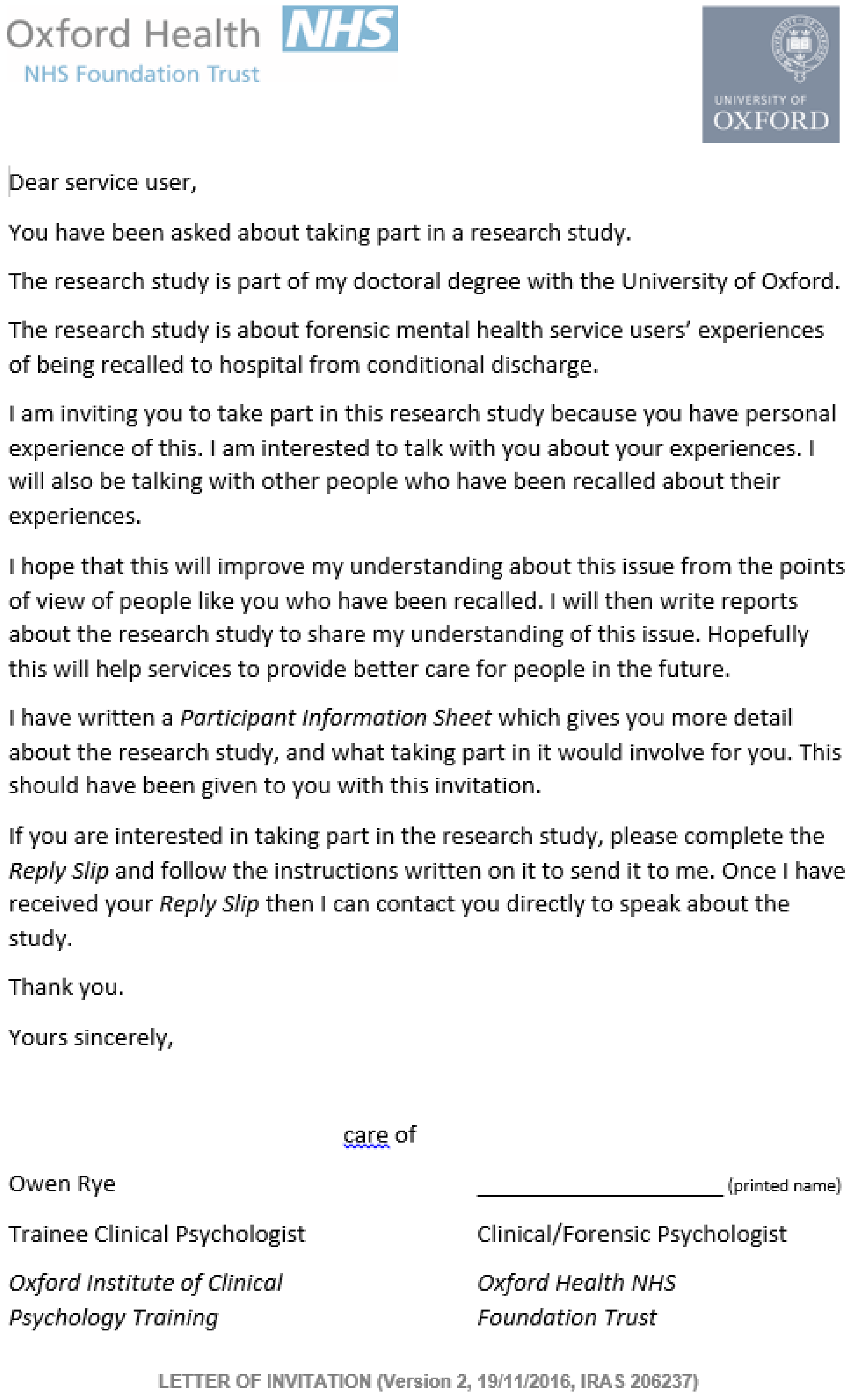
Potential for aggressive behaviour towards the researcher

As described in the study results, all of the study's participants had historically committed violent index offences, which was the original reason for the admission to forensic services. It was also likely that participants may have additional histories of behaving aggressively towards others. It was therefore possible that they may become aggressive towards the researcher during the researcher's contact with them (particularly during individual interviews), so to help prevent harm coming to the researcher or other people involved in the research process, the study's procedure put a range of safeguards in place.

Participants were only recruited if their clinical care team and the researcher judged that the participant would not present a risk to others or to themselves during study procedures, particularly the interview situation. To ensure the researcher's safety, all study procedures were conducted in forensic service buildings, and the researcher was inducted as necessary into relevant security procedures, including use of a personal alarm which the researcher wore for interviews on secure wards; arrangements were also made by clinical staff to be readily available if the researcher was at risk.

Appendix N

Letter of invitation



Oxford Health NHS
NHS Foundation Trust

UNIVERSITY OF
OXFORD

Dear service user,

You have been asked about taking part in a research study.

The research study is part of my doctoral degree with the University of Oxford.

The research study is about forensic mental health service users' experiences of being recalled to hospital from conditional discharge.

I am inviting you to take part in this research study because you have personal experience of this. I am interested to talk with you about your experiences. I will also be talking with other people who have been recalled about their experiences.

I hope that this will improve my understanding about this issue from the points of view of people like you who have been recalled. I will then write reports about the research study to share my understanding of this issue. Hopefully this will help services to provide better care for people in the future.

I have written a *Participant Information Sheet* which gives you more detail about the research study, and what taking part in it would involve for you. This should have been given to you with this invitation.

If you are interested in taking part in the research study, please complete the *Reply Slip* and follow the instructions written on it to send it to me. Once I have received your *Reply Slip* then I can contact you directly to speak about the study.

Thank you.

Yours sincerely,

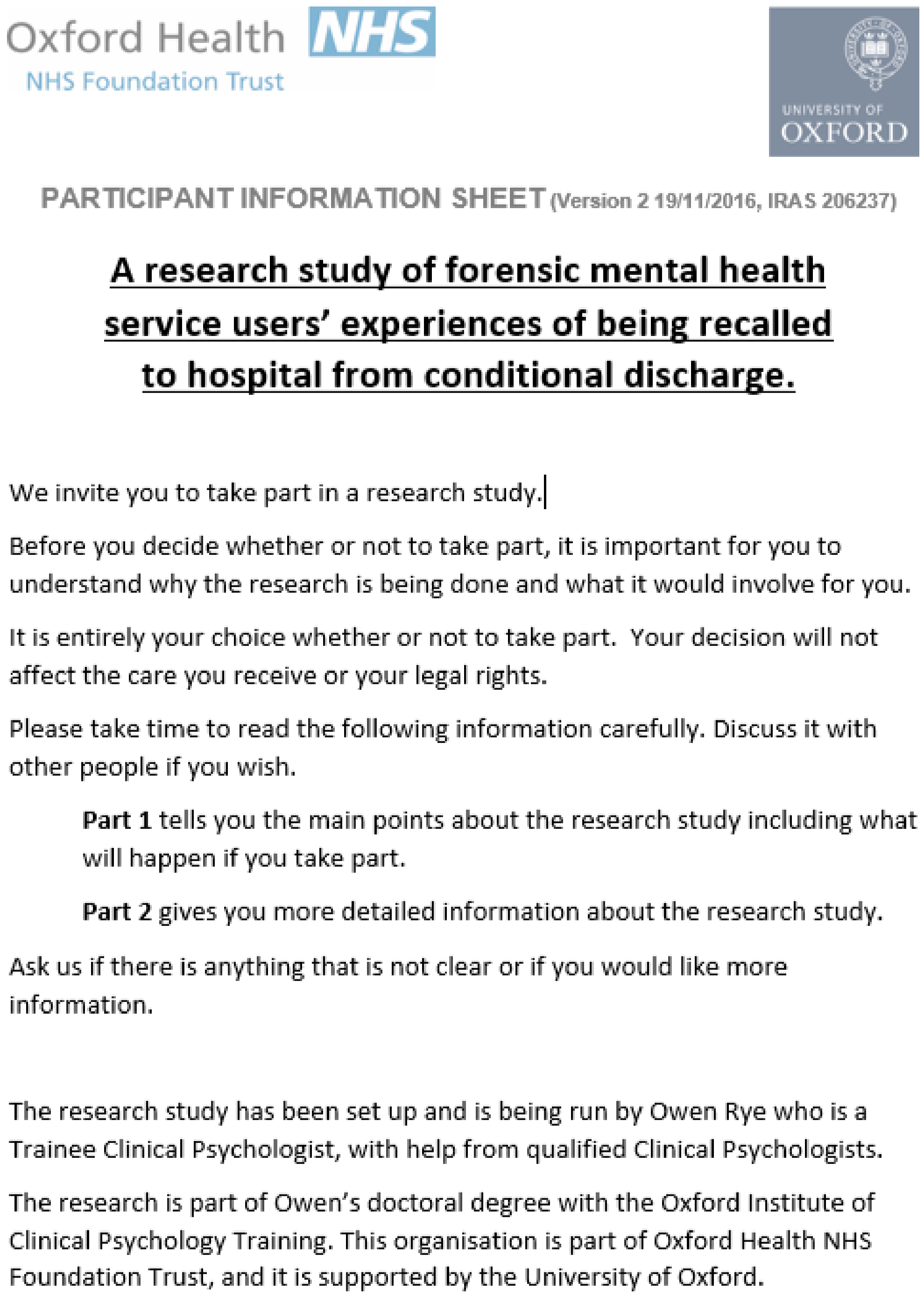
care of

Owen Rye	______________________ (printed name)
Trainee Clinical Psychologist	Clinical/Forensic Psychologist
Oxford Institute of Clinical Psychology Training	*Oxford Health NHS Foundation Trust*

LETTER OF INVITATION (Version 2, 19/11/2016, IRAS 206237)

Appendix O

Participant information sheet



Oxford Health NHS
NHS Foundation Trust

UNIVERSITY OF OXFORD

PARTICIPANT INFORMATION SHEET (Version 2 19/11/2016, IRAS 206237)

A research study of forensic mental health service users' experiences of being recalled to hospital from conditional discharge.

We invite you to take part in a research study.

Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it would involve for you.

It is entirely your choice whether or not to take part. Your decision will not affect the care you receive or your legal rights.

Please take time to read the following information carefully. Discuss it with other people if you wish.

Part 1 tells you the main points about the research study including what will happen if you take part.

Part 2 gives you more detailed information about the research study.

Ask us if there is anything that is not clear or if you would like more information.

The research study has been set up and is being run by Owen Rye who is a Trainee Clinical Psychologist, with help from qualified Clinical Psychologists.

The research is part of Owen's doctoral degree with the Oxford Institute of Clinical Psychology Training. This organisation is part of Oxford Health NHS Foundation Trust, and it is supported by the University of Oxford.

Part 1

Why is this research being done?

Many people who have lived in the community on conditional discharge are brought back (recalled) to hospital.

We want to understand more about this issue from the points of view of people who have been recalled.

We hope that this will help services to provide better care for people who are conditionally discharged so that they are less likely to be recalled to hospital. And when people do still need to be recalled to hospital, we hope that the research will help services to carry out recall in a better way.

Why have I been invited to take part in the study?

We have invited you to take part in the study because you have personal experience of being recalled to hospital from conditional discharge.

We are interested in your personal experiences of being recalled to hospital.

What does taking part in the study involve?

If you choose to take part in the study, you would be interviewed by a researcher about your own experiences of being recalled to hospital.

The interview would only involve talking. You would not have to fill out any questionnaires.

The interview would take about 1 hour, and definitely not longer than 1 ½ hours.

The interview would take place at the forensic mental health service building where you receive your usual care.

If you currently live in the community and had to travel to attend the interview, you would be paid money back towards the cost of your journey (up to £15) if you provide receipts for public transport or mileage for car journeys.

If you choose to take part in the study, we would also like to collect some background information about you – your age, gender, ethnicity, your mental health diagnosis, your current legal status, the category of your index offence, and your psychiatric admission history.

We would get this information from a staff member from your care team. They would collect it from your patient record. As researchers, we would not have direct access to your patient record.

Later on, we might also carry out shorter ‘follow-up’ interviews with some people who take part in the study. This will be up to six months after their first interview. This is optional (an extra choice), so you could still take part in the first interview without agreeing to take part in a ‘follow-up’ interview later on.

Are there any benefits for me if I take part?

If you choose to take part, you would be helping us to understand more about the issue of being recalled to hospital from conditional discharge.

This could help to improve care for other people like yourself in the future. But it is unlikely that taking part in the study would benefit you directly.

We know that taking part would take up some of your time. And we appreciate that you would be talking about your personal experiences in the interview. Because of this, we offer a payment of £10 to people who take part in the study. This would be paid to you after completing the interview (a minimum of 30 minutes).

Are there any disadvantages or risks to me if I take part?

If you take part, the interview would involve talking about your personal experiences of being recalled to hospital from conditional discharge. You might find it upsetting to talk about these experiences.

If you take part, we would collect information about you for the study. We would make every effort to keep information about you safe and confidential. However, there is always some risk that this information about you could be lost, stolen, or accessed by people who should not access it.

If I decide that I would like to take part then what happens next?

If you would like to take part in the study, please tell the psychologist who talked to you about the study and gave you this information sheet. If they are not available, you could tell another member of staff in your care team and they can let the psychologist know that you would like to take part.

The psychologist will then contact the lead researcher who will arrange to meet with you. The researcher will talk with you about the study to make sure that you have all the information you need to decide to take part, including answering any questions you may have. If you still want to take part, then the researcher will ask you to record your consent in writing on a consent form. You will be given a copy of your consent form to keep. When you have given written consent to take part, then the researcher will arrange to interview you.

Part 2

What would happen to the information about me collected for the study?

The interview would be audio recorded so that we could listen to it again.

We would then make a written version of the interview called a transcript.

The transcript and background information about you would *not* include details that could identify you personally such as your name or date of birth.

Any information that could identify you personally would be kept separate from the interview audio recording, transcript and background information.

Only we (the researchers) would be able to link together these separate parts of information, using a code that will also be kept safe.

When we write our reports about the study, we would like to quote small parts of what you say in the interview to help us explain what the study results were. If we quote something you said, we will link it with a false name (known as a 'pseudonym') rather than your own name, and any quotes would not include personal details.

We will store all information collected on paper securely in an NHS building.

We will store all digital forms of information securely on NHS computers.

When the study finishes, we have to keep the data for some time before it can be destroyed. Any information that could identify you personally will be kept for one year and then destroyed. Other information about you that has been collected for the study will be kept for five years and then destroyed.

The sponsor of this study is Oxford Health NHS Foundation Trust. The Trust's Research & Development Department might look at the information collected for this study to check that the study was carried out properly.

We want to make sure that this study is carried out to a high level of quality. To help us check the quality of the study, we might ask other researchers to look at or listen to some of the information we collect for the study. These other researchers will either be employed by Oxford Health NHS Foundation Trust or the University of Oxford. They will also respect your confidentiality, and they will not have access to information that could identify you personally.

We might also ask NHS administrators, who will either be employed by Oxford Health NHS Foundation Trust or Oxford University Hospitals NHS Foundation Trust, to help us make the written versions of the interviews (transcripts). These NHS administrators would only have access to the interview audio recording and the transcript that they write. So they would not have access to information that identifies you personally except for what is said during the interview. They will also respect your confidentiality.

Will staff from my care team know about my participation in the study?

We (the researchers) will need to have contact with staff from your care team so that we can arrange to meet with you about taking part in the research.

We will tell your named nurse/care co-ordinator, your psychologist, and your responsible medical officer (psychiatry doctor) if you decide to take part in the study. We will also give them a brief information sheet about the study.

But we will not tell staff from your care team about what you say or do as part of the study *unless* it indicates any risks towards yourself or risks towards other people. This includes if you talk about thoughts or plans of suicide, hurting yourself, or hurting other people. This also includes criminal activity that you have engaged in in the past or are thinking about engaging in in the future. We will need to tell staff from your care team about any of these risks to make sure that you and other people can be kept safe, and to make sure that any criminal activity is already known about. If you talk about criminal activity that you have engaged in that your care team does not already know about, then they may have to follow criminal reporting procedures and pass this information on to the police who may take further action. It is important for you to remember that we only want to interview you for research purposes, and so it will always be your choice what you do or do not say in the interview. We (the researchers) will not pressure you to talk about anything you do not want to, and we will let you know if anything you do talk about has to be reported by us to your care team.

What support is available if I feel upset due to taking part in the study?

We hope that taking part in the study will not be upsetting for you. Although the interview would involve talking about your personal experiences of being recalled to hospital from conditional discharge, which you might find upsetting. If you became upset during the interview, then the researcher interviewing you will ask if you would prefer to stop the interview – this will be your choice. If you became upset after the interview, then you should speak to a member of staff from your care team about this – before finishing the interview, the researcher interviewing you will make sure that you have someone you can speak to, and that you would be able to contact them if you needed to.

What will happen to the results of the study?

We will write about the results in our reports of the research study.

The lead researcher will write one report as part of their doctoral degree.

Another similar report will be written to be published in a scientific journal.

No personal information of you or other people who take part will be written in the reports. However, we would include some quotes from interviews – as explained earlier, these would be linked with false names (pseudonyms) and any quotes would not include any personal details.

We would be happy to provide you with a summary of the results if you wish. This might not be ready until a year after you take part in the study, and we would need to confirm your address at that time with your current care team.

What if I feel unhappy about something to do with the study?

If you had a concern about any aspect of this study, you should ask to speak to the researchers who will do their best to address your concern. The best person to speak to would be the lead researcher, Owen Rye. He does not have a direct telephone line, but if you telephone his office on 01865 226431 then you can ask the administrator who answers if Owen can telephone you back. Owen will aim to telephone you back within 24 hours of your telephone call.

If you were still unhappy and wished to complain formally, you could do this by contacting the Patient Advice & Liaison Service (PALS) using the details below.

Telephone: 0800 328 7971

E-mail address: PALS@oxfordhealth.nhs.uk

Postal address – Oxfordshire office: Patient Advice and Liaison Service, Oxford Health NHS Foundation Trust, Warneford Hospital, Warneford Lane, Headington, Oxford, OX3 7JX.

Postal address – Buckinghamshire office: Patient Advice and Liaison Service, The Whiteleaf Centre, Oxford Health NHS Foundation Trust, Bierton Road, Aylesbury, HP20 1EG.

In the event that something goes wrong and you are harmed during the research and this is due to someone's negligence then you may have grounds for a legal action for compensation against Oxford Health NHS Foundation Trust, but you may have to pay your legal costs. The normal National Health Service complaints mechanisms would still be available to you.

What if I agree to take part but later on I change my mind?

It is entirely your choice whether or not to take part in the research study. If you chose to take part then you would be free to change your mind later on and withdraw from the study. This would not affect the care you receive or your legal rights.

If you withdrew before the interview, then you would not have to do the interview and we would not collect any background information about you.

If you took part and completed the interview, you would be able to change your mind about us using your information for up to seven days afterwards – if you withdrew from the study before the end of these seven days then we would destroy all the information we collected about you for the study. But after seven days, the information we collected about you (including what you said in the interview) would be included in our results. If you did wish to withdraw after those seven days, then we would not contact you any further, but we would keep and use information we had collected about you already.

If you took part and completed the interview, but later you lost your mental capacity (the ability to make informed decisions) then we would not contact you any further, but we would keep and use information we had collected about you already.

Who is organising and funding the study?

The research study has been set up and is being run by Owen Rye who is a Trainee Clinical Psychologist, with help from qualified Clinical Psychologists.

The research is part of Owen's doctoral degree with the Oxford Institute of Clinical Psychology Training. This organisation is part of Oxford Health NHS Foundation Trust, and it is supported by the University of Oxford.

The qualified Clinical Psychologists who are helping Owen Rye with the study include Dr Clare Churchman and Dr Charlotte Couldrey who work for Oxford Health NHS Foundation Trust's forensic mental health service. Clare and Charlotte are only involved in setting up the study, identifying people who could take part, and supervising Owen. Owen will be the only researcher carrying out interviews. This is to help us avoid any conflict of interests for people who have Clare or Charlotte in their clinical care team.

The research is funded by the Oxford Institute of Clinical Psychology Training.

Have patients been involved in designing the study?

We consulted a small group of forensic mental health service users about the aims of the research, the design of the study, and the types of questions we will ask in the interviews. They generally approved of what we had planned, and we also made some changes based on their helpful feedback.

Who has reviewed the study?

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

Further information and contact details

Thank you for taking the time to read through all the information.

If you have any questions or would like further information about the study you should ask to speak to the researchers who will do their best to help you. To get in contact with the researchers, please tell the psychologist who talked to you about the study and gave you this information sheet. If they are not available, you could tell another member of staff in your care team and they can let the psychologist know.

The psychologist will then contact the lead researcher (Owen Rye) who will arrange to meet with you to answer any questions you have and give you further information about the study.

Thank you for taking the time to read through this information sheet and for considering taking part in the study.

Appendix P

Participant reply slip - inpatient and outpatient versions

Oxford Health NHS
NHS Foundation Trust

UNIVERSITY OF OXFORD

RESEARCH STUDY REPLY SLIP **(Inpatient Version 1, 20/11/2016, IRAS 206237)**

Title of Project: A research study of forensic mental health service users' experiences of being recalled to hospital from conditional discharge.

I understand that I have been invited to take part in a research study.

I have received the *Letter of Invitation* and *Participant Information Sheet*.

I am interested in taking part in the research study and/or would like more information about it.

I understand that the lead researcher (Owen Rye) will meet me in person to talk about my interest in taking part in the study, and to answer any questions I may have about it.

I understand that it will still be my choice to take part in the study or not take part. Meeting with the lead researcher to talk about the study does *not* mean that I have to take part.

I agree that a member of staff from my care team can send this reply slip on my behalf to the lead researcher.

If you understand the above information and agree to all of it, please complete your details below so the lead researcher can arrange to meet you:

Name: ____

Ward: ____

Signature: ____

Date: ________________________

Instruction for a staff member to return this reply slip on behalf of service user named above

Please scan and e-mail this reply slip to the lead researcher – owen.rye@oxfordhealth.nhs.uk

Oxford Health NHS
NHS Foundation Trust

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OXFORD

RESEARCH STUDY REPLY SLIP (Outpatient Version 1, 20/11/2016, IRAS 206237)

Title of Project: A research study of forensic mental health service users' experiences of being recalled to hospital from conditional discharge.

I understand that I have been invited to take part in a research study.

I have received the *Letter of Invitation* and *Participant Information Sheet*.

I am interested in taking part in the research study and/or would like more information about it.

I understand that the lead researcher (Owen Rye) will telephone me to talk about my interest in taking part in the study, and to answer any questions I may have about it.

I understand that it will still be my choice to take part in the study or not take part. Meeting with the lead researcher to talk about the study does *not* mean that I have to take part.

If you understand the above information and agree to all of it, please complete your details below so the lead researcher can telephone you:

Name: ____

Telephone number: ______________________________________

Signature: ____

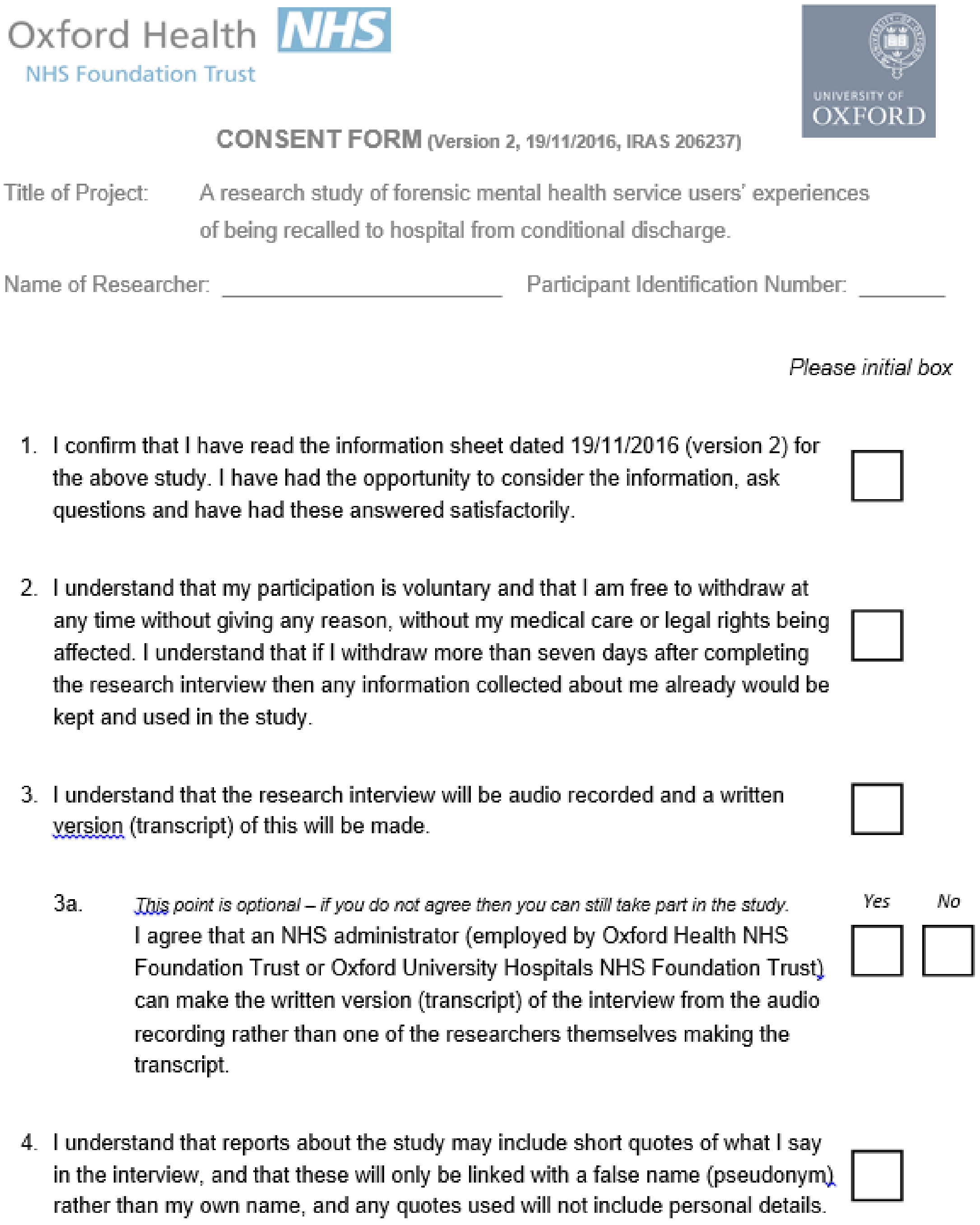
Date: ___________________________

<u>Instruction to return this reply slip to the lead researcher</u>

Please post this reply slip to the lead researcher in the stamped and addressed envelope (Owen Rye, Isis Education Centre, Warneford Hospital, Headington, Oxford, OX3 7JX)

Appendix Q

Consent form



Oxford Health NHS
NHS Foundation Trust

UNIVERSITY OF OXFORD

CONSENT FORM (Version 2, 19/11/2016, IRAS 206237)

Title of Project: A research study of forensic mental health service users' experiences of being recalled to hospital from conditional discharge.

Name of Researcher: ______________________ Participant Identification Number: _______

Please initial box

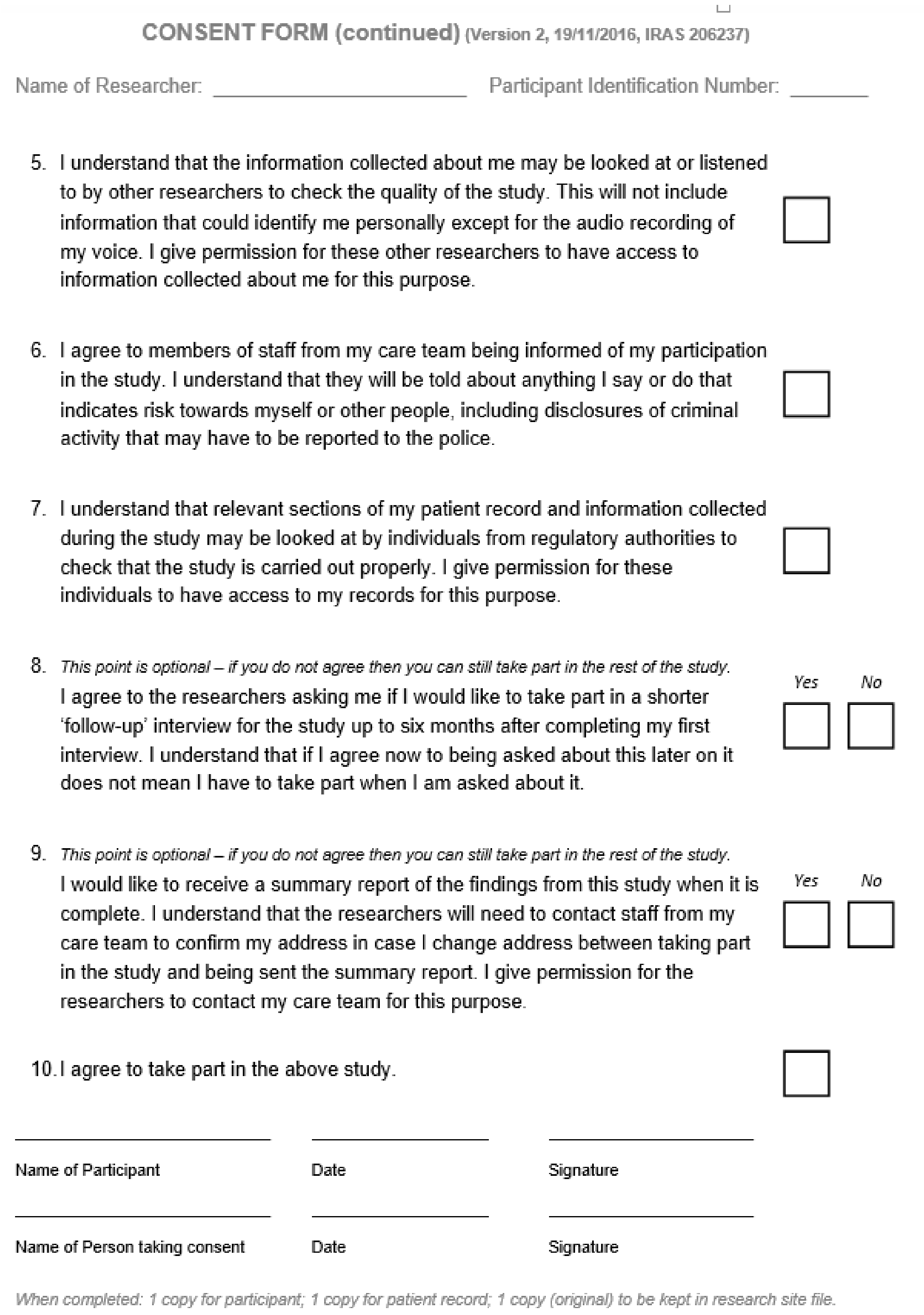
1. I confirm that I have read the information sheet dated 19/11/2016 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. I understand that if I withdraw more than seven days after completing the research interview then any information collected about me already would be kept and used in the study. ☐

3. I understand that the research interview will be audio recorded and a written version (transcript) of this will be made. ☐

3a. *This point is optional – if you do not agree then you can still take part in the study.* I agree that an NHS administrator (employed by Oxford Health NHS Foundation Trust or Oxford University Hospitals NHS Foundation Trust) can make the written version (transcript) of the interview from the audio recording rather than one of the researchers themselves making the transcript. *Yes* ☐ *No* ☐

4. I understand that reports about the study may include short quotes of what I say in the interview, and that these will only be linked with a false name (pseudonym) rather than my own name, and any quotes used will not include personal details. ☐



CONSENT FORM (continued) (Version 2, 19/11/2016, IRAS 206237)

Name of Researcher: ______________________ Participant Identification Number: _______

5. I understand that the information collected about me may be looked at or listened to by other researchers to check the quality of the study. This will not include information that could identify me personally except for the audio recording of my voice. I give permission for these other researchers to have access to information collected about me for this purpose. ☐

6. I agree to members of staff from my care team being informed of my participation in the study. I understand that they will be told about anything I say or do that indicates risk towards myself or other people, including disclosures of criminal activity that may have to be reported to the police. ☐

7. I understand that relevant sections of my patient record and information collected during the study may be looked at by individuals from regulatory authorities to check that the study is carried out properly. I give permission for these individuals to have access to my records for this purpose. ☐

8. *This point is optional – if you do not agree then you can still take part in the rest of the study.*
   I agree to the researchers asking me if I would like to take part in a shorter 'follow-up' interview for the study up to six months after completing my first interview. I understand that if I agree now to being asked about this later on it does not mean I have to take part when I am asked about it. *Yes* ☐ *No* ☐

9. *This point is optional – if you do not agree then you can still take part in the rest of the study.*
   I would like to receive a summary report of the findings from this study when it is complete. I understand that the researchers will need to contact staff from my care team to confirm my address in case I change address between taking part in the study and being sent the summary report. I give permission for the researchers to contact my care team for this purpose. *Yes* ☐ *No* ☐

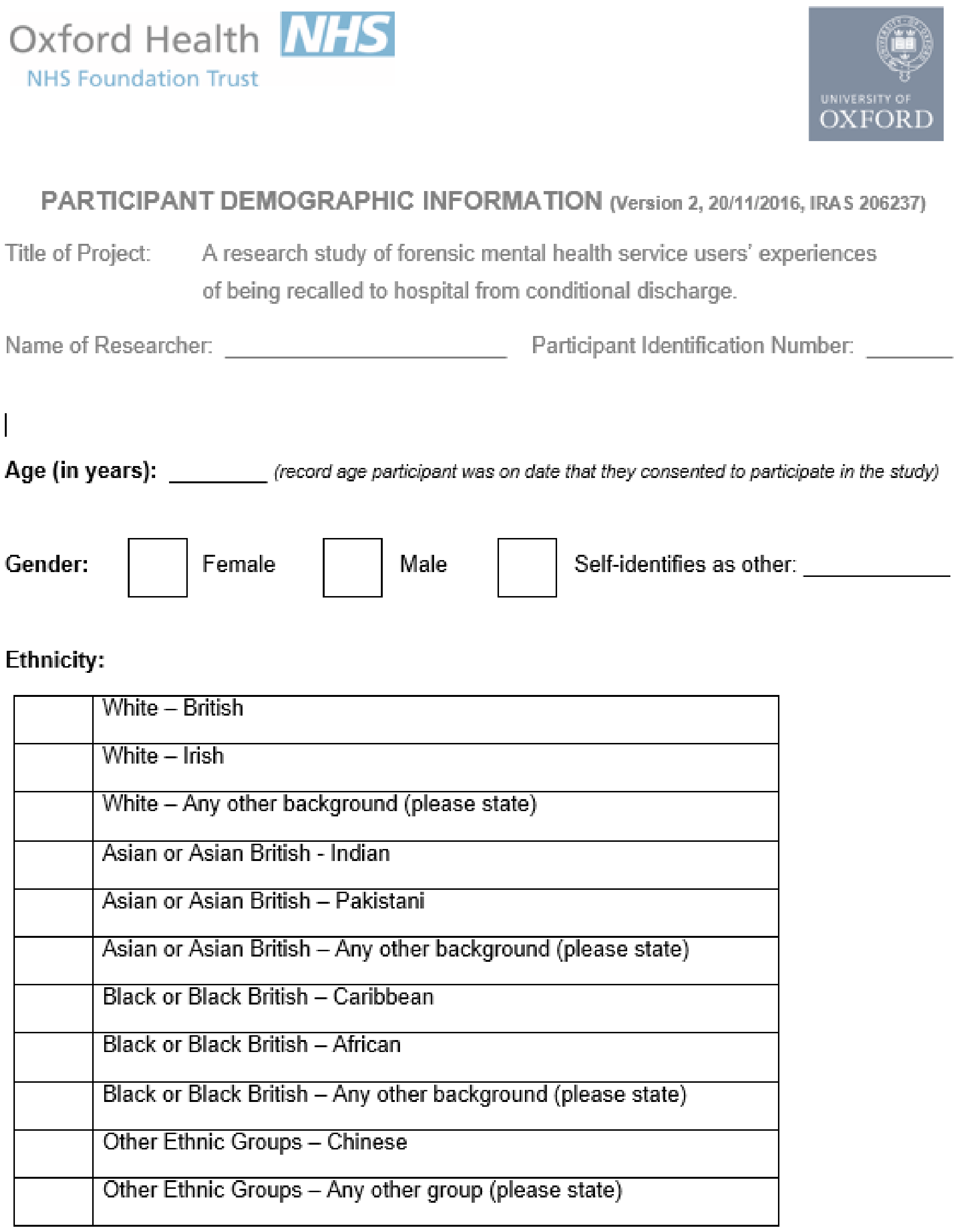
10. I agree to take part in the above study. ☐

______________________	________________	__________________
Name of Participant	Date	Signature
______________________	________________	__________________
Name of Person taking consent	Date	Signature

When completed: 1 copy for participant; 1 copy for patient record; 1 copy (original) to be kept in research site file.

Appendix R

Participant demographic information form



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OXFORD

PARTICIPANT DEMOGRAPHIC INFORMATION **(Version 2, 20/11/2016, IRAS 206237)**

Title of Project: A research study of forensic mental health service users' experiences of being recalled to hospital from conditional discharge.

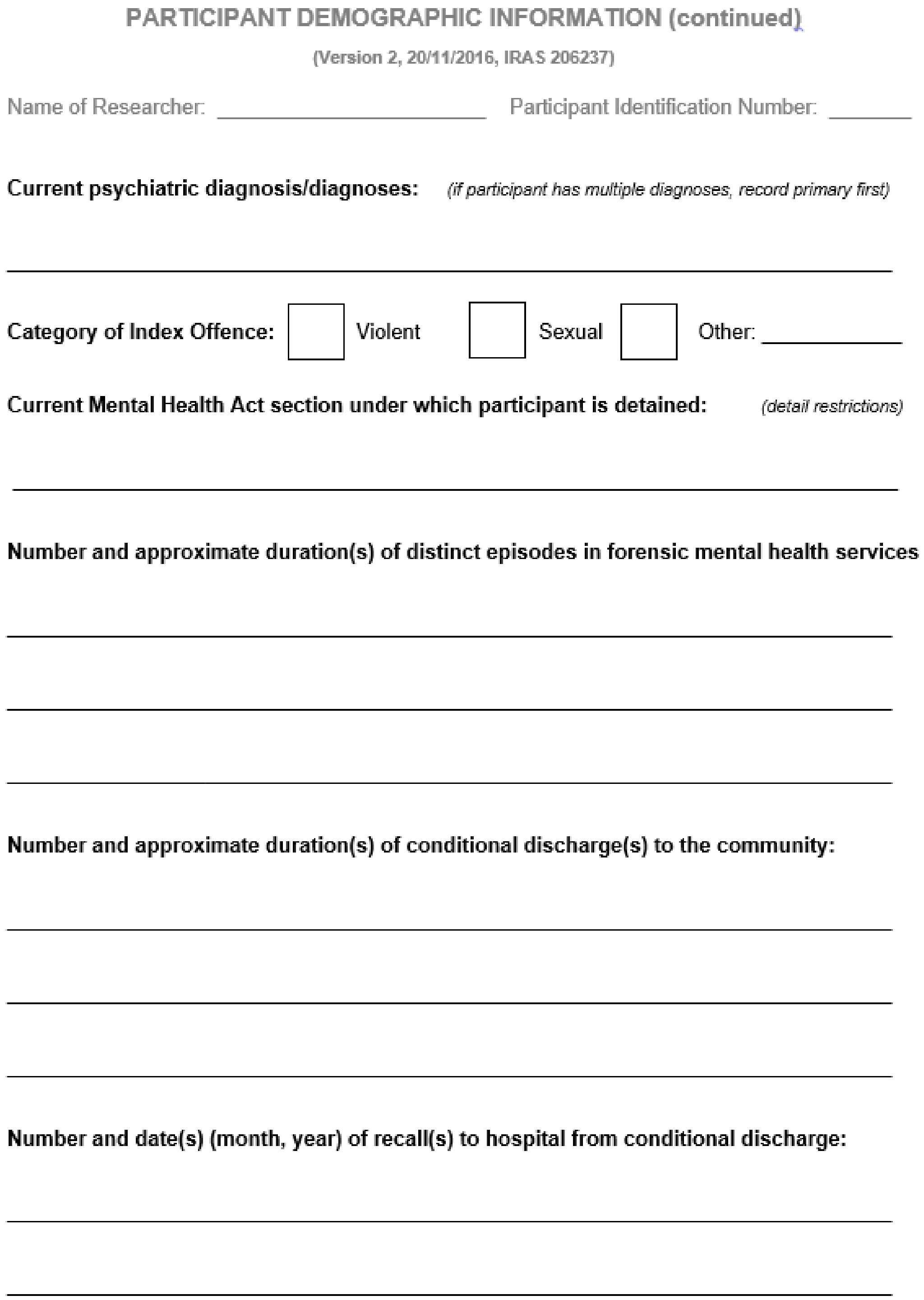
Name of Researcher: ______________________ Participant Identification Number: _______

Age (in years): ________ *(record age participant was on date that they consented to participate in the study)*

Gender: ☐ Female ☐ Male ☐ Self-identifies as other: ____________

Ethnicity:

	White – British
	White – Irish
	White – Any other background (please state)
	Asian or Asian British - Indian
	Asian or Asian British – Pakistani
	Asian or Asian British – Any other background (please state)
	Black or Black British – Caribbean
	Black or Black British – African
	Black or Black British – Any other background (please state)
	Other Ethnic Groups – Chinese
	Other Ethnic Groups – Any other group (please state)



PARTICIPANT DEMOGRAPHIC INFORMATION (continued)

(Version 2, 20/11/2016, IRAS 206237)

Name of Researcher: ______________________ Participant Identification Number: _______

Current psychiatric diagnosis/diagnoses: *(if participant has multiple diagnoses, record primary first)*

____

Category of Index Offence: ☐ Violent ☐ Sexual ☐ Other: ___________

Current Mental Health Act section under which participant is detained: *(detail restrictions)*

____

Number and approximate duration(s) of distinct episodes in forensic mental health services

____

____

____

Number and approximate duration(s) of conditional discharge(s) to the community:

____

____

____

Number and date(s) (month, year) of recall(s) to hospital from conditional discharge:

____

____

Appendix S

Interview schedule - original version, with additional questions added through study

ORIGINAL VERSION

INITIAL OPEN-ENDED QUESTIONS

1. As you know, I'm interested in your experience of being recalled to a secure hospital from conditional community discharge. So that I know a bit about the background to you being recalled, could you start by telling me about when you were conditionally discharged from hospital?

   - What reasons were there for you being conditionally discharged?
   - What were the conditions of your discharge?

2. Now can you tell me about your experience of being recalled?

3. Could you describe the events that led up to you being recalled?

   - What happened before?
   - What happened next?

4. Why do you think you were recalled?

   - If you remember, what were you thinking/doing around that time?
   - What professionals were involved? When was that? How were they involved?
   - Other than professionals, was anyone else involved (friends/family)? When? How?

INTERMEDIATE QUESTIONS

5. Is there something you think could have helped prevent you from being recalled?

   - Is there something you would have liked to do but didn't/couldn't?
   - Is there something that other people could have done that could have helped?

6. How, if at all, have your thoughts and feelings about being recalled changed since it happened?

   - Can you tell me something positive about being recalled?
   - Can you tell me something negative about being recalled?

7. As you look back on being recalled, are there any other events that stand out in your mind? Could you describe [each event]/it?

- How did [each event]/it affect what happened?

ENDING QUESTIONS

8. After having these experiences, what advice would you give to someone who has just been conditionally discharged to the community?

9. Is there something else you think I should know to understand this better?

10. Is there anything you think it would be helpful for me to ask people in future interviews?

11. Is there anything you would like to ask me?

ADDITIONAL QUESTIONS ADDED TO THE SCHEDULE THROUGH THE STUDY

- Can you tell me (more) about your views on the services, staff and systems that are involved in recall? *[Added after interview 4 following contrasted views expressed by first four participants]*
- How supported by others did you feel when you were living in the community? *[Added after interview 6 following suggestion of participant 6 to ask this directly]*
- What procedures do you think there should be to benefit patients in the process of recall? *[Added after interview 7 on suggestion of participant 7 to ask this directly]*

Appendix T

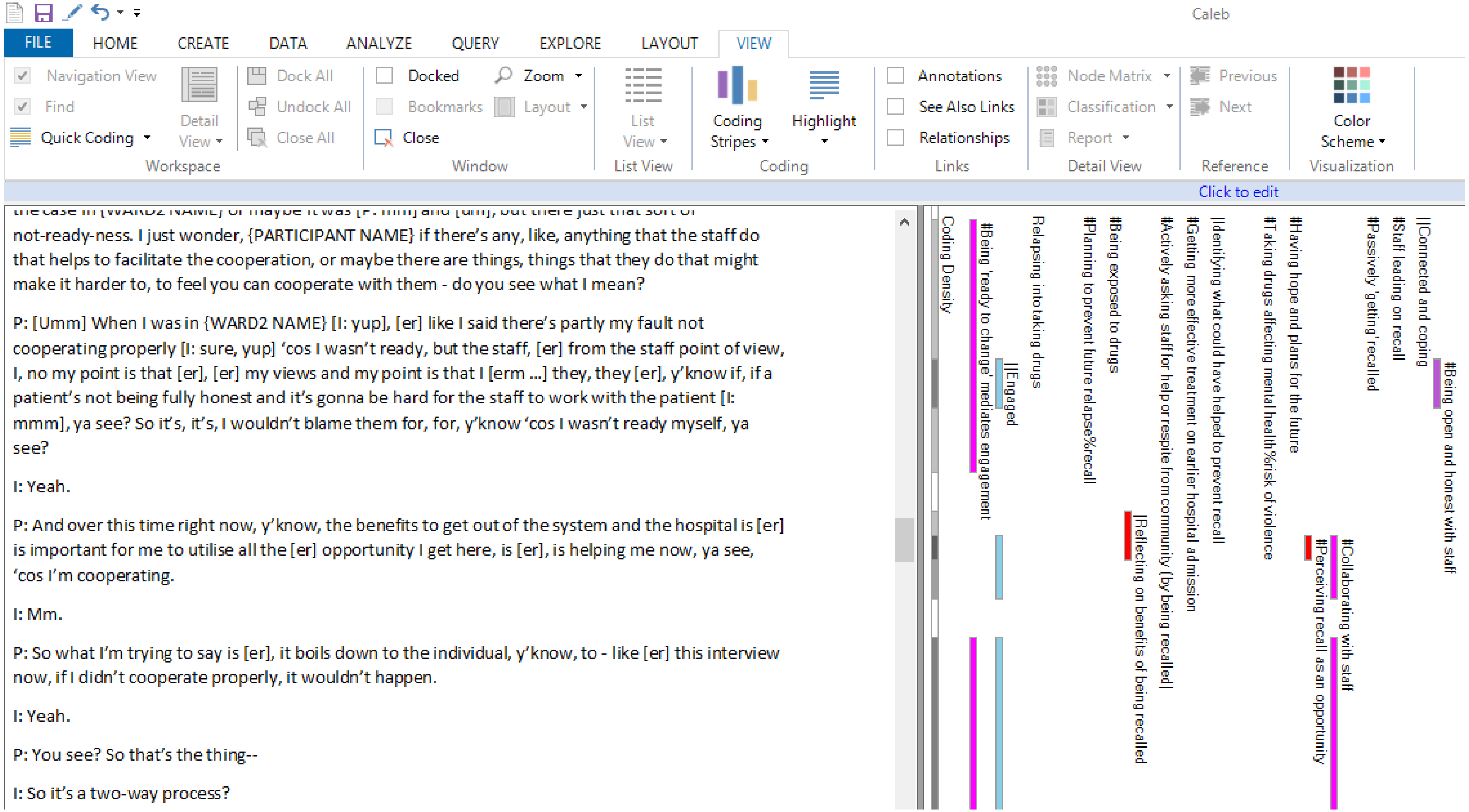
Development of interview schedule

The original interview schedule was prepared in advance of interviews, developed by the researcher in collaboration with two of their research supervisors (SH and CCo), guided by the principles of grounded theory methodology which was supported by consultation with a grounded theory specialist (KC). The researcher and two of their research supervisors (SH and CCo) also consulted with a group of local forensic service users about a draft version of the interview schedule to discuss the suitability of its language, the acceptability of topic areas and questions, and to take other suggestions of possible topics. The group generally approved of the interview schedule, making only a few suggestions to simplify the language and change the order of some interview questions.

The interview questions were deliberately designed to be open-ended and unstructured to help minimise researcher bias and mitigate the use or effect of leading questions, whilst aiming to encourage participants' to respond with rich descriptions of their experiences.

Appendix U

Example of initial line-by-line coding of interview transcript data



not-ready-ness. I just wonder, {PARTICIPANT NAME} if there's any, like, anything that the staff do that helps to facilitate the cooperation, or maybe there are things, things that they do that might make it harder to, to feel you can cooperate with them - do you see what I mean?

P: [Umm] When I was in {WARD2 NAME} [I: yup], [er] like I said there's partly my fault not cooperating properly [I: sure, yup] 'cos I wasn't ready, but the staff, [er] from the staff point of view, I, no my point is that [er], [er] my views and my point is that I [erm ...] they, they [er], y'know if, if a patient's not being fully honest and it's gonna be hard for the staff to work with the patient [I: mmm], ya see? So it's, it's, I wouldn't blame them for, for, y'know 'cos I wasn't ready myself, ya see?

I: Yeah.

P: And over this time right now, y'know, the benefits to get out of the system and the hospital is [er] is important for me to utilise all the [er] opportunity I get here, is [er], is helping me now, ya see, 'cos I'm cooperating.

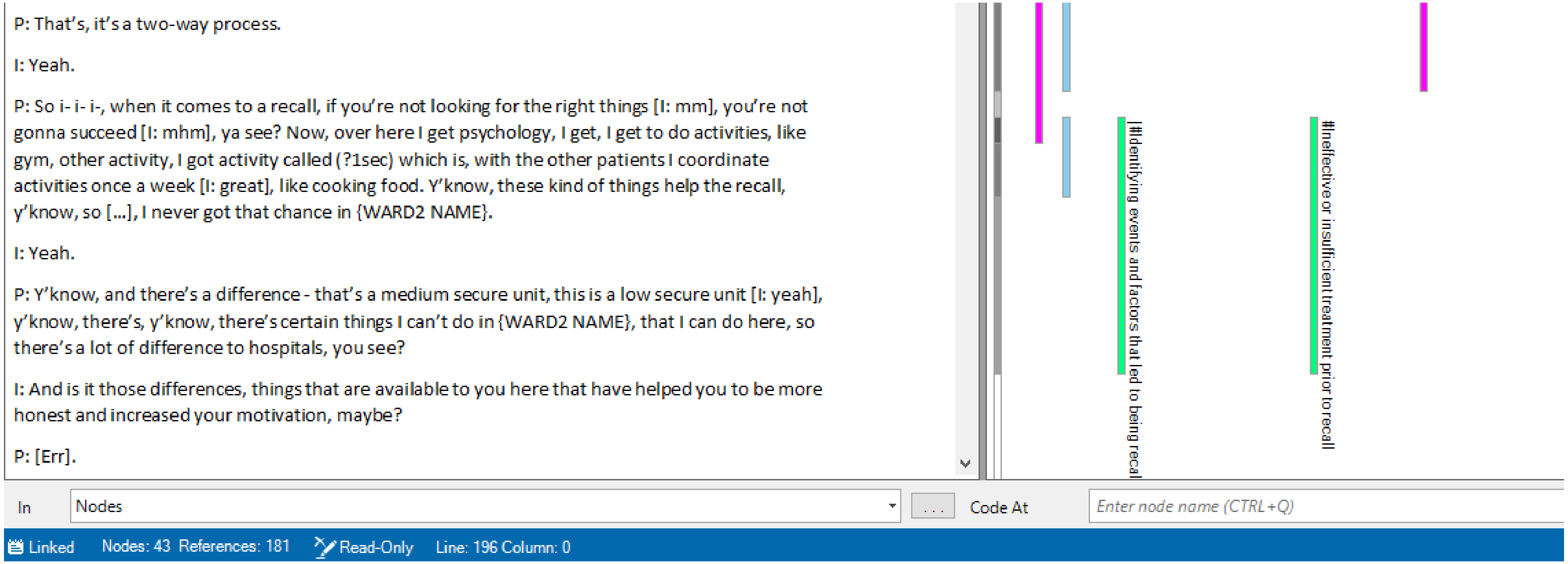
I: Mm.

P: So what I'm trying to say is [er], it boils down to the individual, y'know, to - like [er] this interview now, if I didn't cooperate properly, it wouldn't happen.

I: Yeah.

P: You see? So that's the thing--

I: So it's a two-way process?



P: That's, it's a two-way process.

I: Yeah.

P: So i- i- i-, when it comes to a recall, if you're not looking for the right things [I: mm], you're not gonna succeed [I: mhm], ya see? Now, over here I get psychology, I get, I get to do activities, like gym, other activity, I got activity called (?1sec) which is, with the other patients I coordinate activities once a week [I: great], like cooking food. Y'know, these kind of things help the recall, y'know, so [...], I never got that chance in {WARD2 NAME}.

I: Yeah.

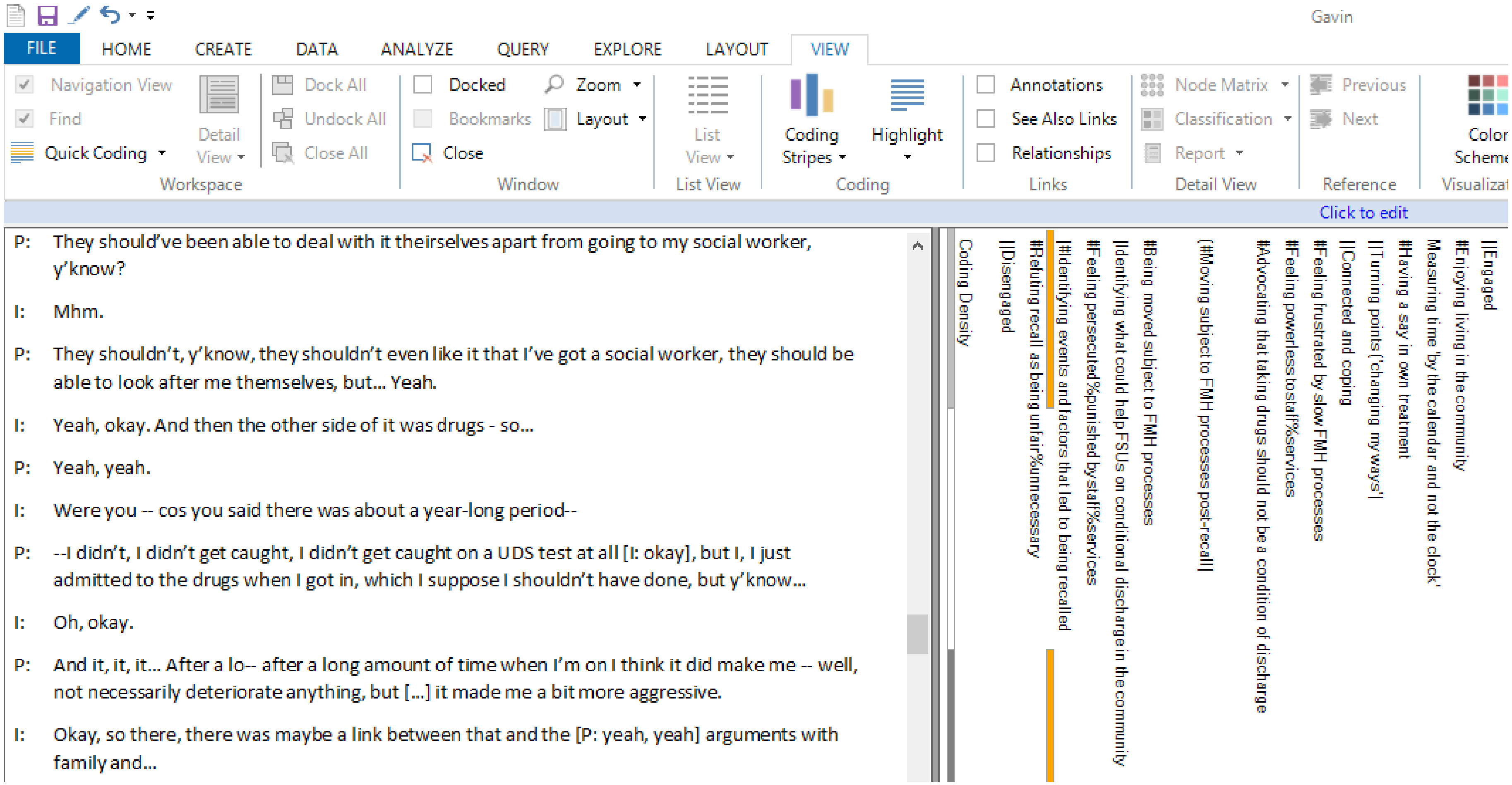
P: Y'know, and there's a difference - that's a medium secure unit, this is a low secure unit [I: yeah], y'know, there's, y'know, there's certain things I can't do in {WARD2 NAME}, that I can do here, so there's a lot of difference to hospitals, you see?

I: And is it those differences, things that are available to you here that have helped you to be more honest and increased your motivation, maybe?

P: [Err].

Appendix V

Example of initial 'incident' coding of interview transcript data



P: They should've been able to deal with it theirselves apart from going to my social worker, y'know?

I: Mhm.

P: They shouldn't, y'know, they shouldn't even like it that I've got a social worker, they should be able to look after me themselves, but... Yeah.

I: Yeah, okay. And then the other side of it was drugs - so...

P: Yeah, yeah.

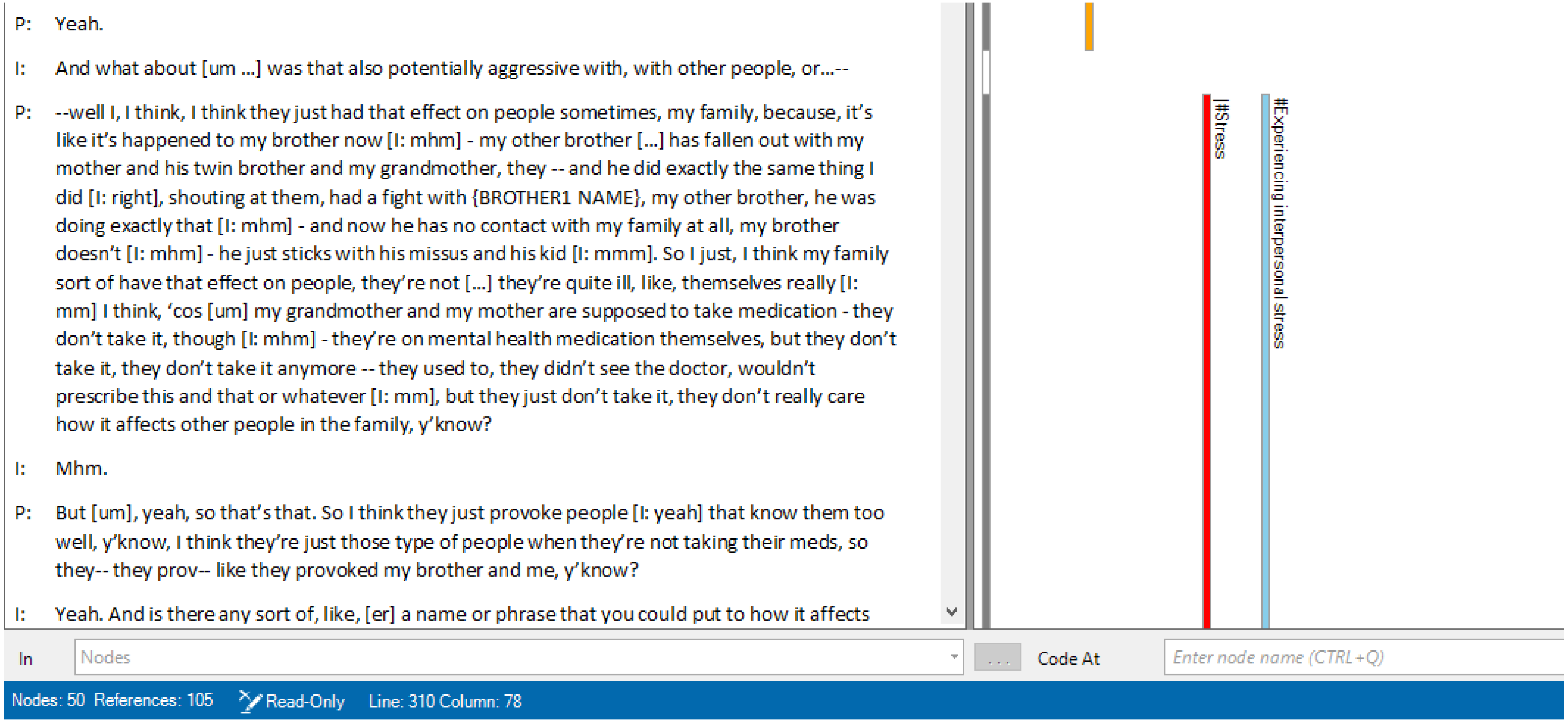
I: Were you -- cos you said there was about a year-long period--

P: --I didn't, I didn't get caught, I didn't get caught on a UDS test at all [I: okay], but I, I just admitted to the drugs when I got in, which I suppose I shouldn't have done, but y'know...

I: Oh, okay.

P: And it, it, it... After a lo-- after a long amount of time when I'm on I think it did make me -- well, not necessarily deteriorate anything, but [...] it made me a bit more aggressive.

I: Okay, so there, there was maybe a link between that and the [P: yeah, yeah] arguments with family and...



P: Yeah.

I: And what about [um ...] was that also potentially aggressive with, with other people, or...--

P: --well I, I think, I think they just had that effect on people sometimes, my family, because, it's like it's happened to my brother now [I: mhm] - my other brother [...] has fallen out with my mother and his twin brother and my grandmother, they -- and he did exactly the same thing I did [I: right], shouting at them, had a fight with {BROTHER1 NAME}, my other brother, he was doing exactly that [I: mhm] - and now he has no contact with my family at all, my brother doesn't [I: mhm] - he just sticks with his missus and his kid [I: mmm]. So I just, I think my family sort of have that effect on people, they're not [...] they're quite ill, like, themselves really [I: mm] I think, 'cos [um] my grandmother and my mother are supposed to take medication - they don't take it, though [I: mhm] - they're on mental health medication themselves, but they don't take it, they don't take it anymore -- they used to, they didn't see the doctor, wouldn't prescribe this and that or whatever [I: mm], but they just don't take it, they don't really care how it affects other people in the family, y'know?

I: Mhm.

P: But [um], yeah, so that's that. So I think they just provoke people [I: yeah] that know them too well, y'know, I think they're just those type of people when they're not taking their meds, so they-- they prov-- like they provoked my brother and me, y'know?

I: Yeah. And is there any sort of, like, [er] a name or phrase that you could put to how it affects

Appendix W

List of finalised codes and categories developed through analysis

Key to analytical nesting:

- Theoretical codes
    - Categories
        - Focused codes
            - Initial codes (remaining after merges into focused codes)

1. Experiences of living in the community on conditional discharge

- Connectedness in the community
    - Connected
        - Connecting with others/community
            - Forming/resuming romantic relationships
            - Making friends
            - Reconnecting with family
        - Doing meaningful things/being active with others
        - Feeling supported by others
            - Being supported by staff/services
        - Being supported by non-staff
    - Disconnected
        - Feeling alone/isolated
        - Feeling unsupported by staff/services
        - Not having structure/doing meaningful activities
- Adaptation to living in the community
    - Enjoying
        - Coping in the community
        - Enjoying living in the community
        - Pursuing interests
        - Recreational activities
        - Working (paid/voluntary)
    - Struggling
        - Being exposed to drugs
            - Relapsing into taking drugs
        - Stress
            - Experiencing interpersonal stress
            - Identifying stress of community living situation
            - Struggling financially/mismanaging money
            - Struggling to cope

2. Reflecting on the circumstances of being recalled

- Considering explanations
    - Agree
        - Recognising need to be recalled

    - Disagree
        - Refuting recall as being unfair/unnecessary
        - Resisting/opposing recall process
    - Identifying perceived reasons for recall
        - Becoming unwell
        - Being evicted
        - Breaching discharge conditions
        - Gambling
        - Ineffective or insufficient treatment
        - Interpersonal conflict
        - Other reasons
        - Taking illicit drugs
- Perceived agency
    - High
        - Actively asking staff for help or respite from community
        - Feeling informed about process by staff
        - Feeling involved in decisions
        - Taking self to hospital before could be taken in by staff/services
    - Low
        - Being ‘brought’ in/‘getting’ recalled
        - Being excluded or not included in decisions
        - Feeling powerless when recalled
        - Recall not explained by professionals
        - Staff leading on recall process

3. Appraising being recalled

- Positive
    - Fair and necessary
        - Recognising need to be recalled
    - Respite and opportunity
        - Hospital as place of safety
        - Identifying benefits of being recalled
        - Perceiving recall as opportunity to change
- Negative
    - Unfair and unnecessary
        - Asserting innocence/minimising own actions
        - Refuting recall as being unfair/unnecessary
    - Disruptive and restricting
        - Anticipating that may have progressed in community
        - Being back in hospital is restrictive
        - Being recalled disrupts community life
        - Thinking of time ‘lost’ to recall

4. Attitudes about forensic services and staff

    - Positive
        - Feeling understood by staff
        - Praising staff/services

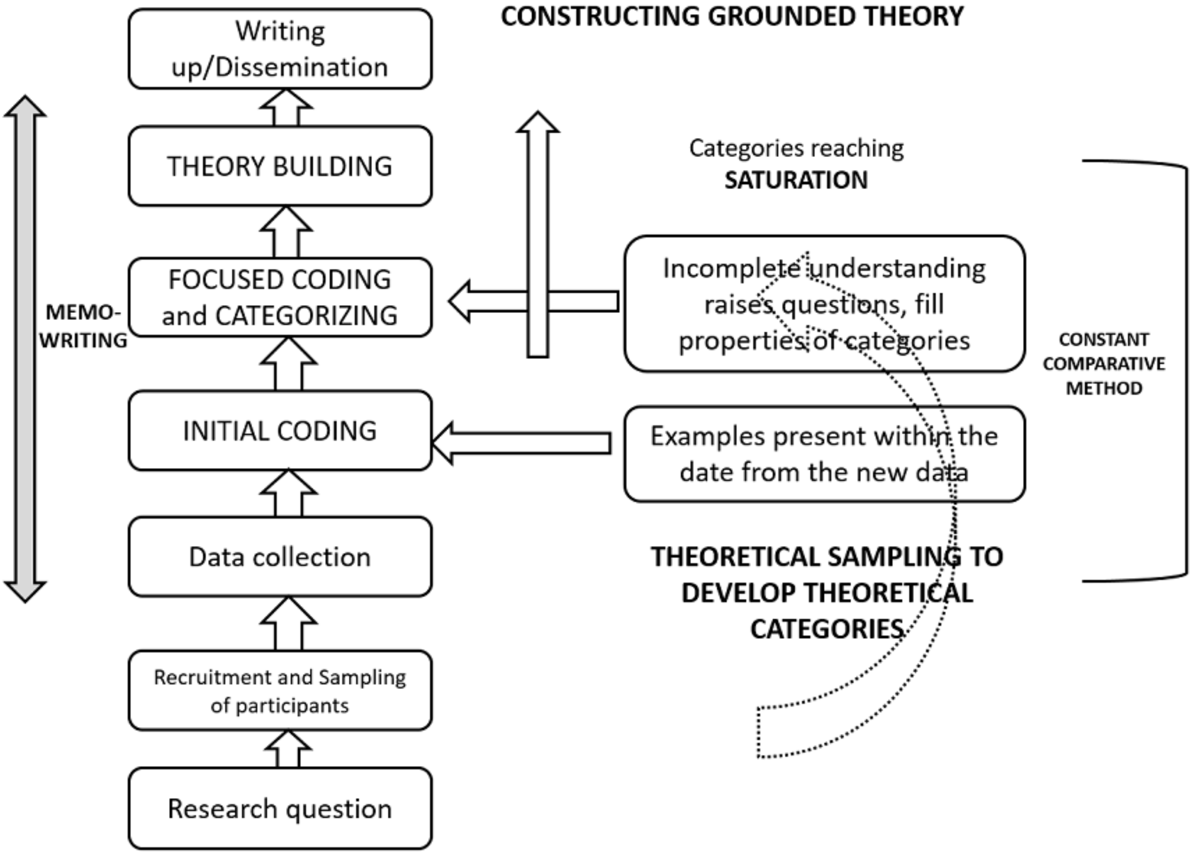
- Negative
    - Feeling persecuted/punished
    - Feeling powerless
    - Feeling unsupported by staff/services
    - Losing trust in staff due to recall

5. Engagement with treatment

- Goals and motivations to change
    - Being ‘ready to change’ (turning point?)
    - Being motivated to change/stay well
    - Having hope and plans for the future
- High
    - Being honest and open with staff
    - Collaborating with staff
    - Getting/staying ‘clean’ from drugs and drink
    - Participating in rehabilitative activities/therapies
    - Planning to prevent future relapse/recall
- Low
    - Going through the motions (‘playing the game’)
    - Opposing staff/services

Appendix X

Diagram of the ‘constant comparison’ method used in grounded theory



Based on Charmaz (2014, p.18).

Appendix Y

Example of full memo, written following first draft of emerging theoretical model

- In searching for clearer threads that ran through my data (rather than fragmented into chunks of time or events), I felt that it would surely help me to think back to the overall narratives of my participants to get a sense of what story they were telling me about their experiences. Earlier on during focused coding I'd made a post-it note of my perception of whether they regarded that being recalled was positive or negative. Some were clearly negative about it, some were clearly positive, but there were a few who I couldn't decide about.
- Reflecting on this note now (it was in clear sight on my PC monitor), it struck me: participants hadn't typically appraised their experiences in explicit evaluative terms like 'positive' and 'negative'. No. *Making sense* of being recalled is not necessarily a judgment - it's a process, and within it is a process of reconciling the event that has happened (i.e., being recalled is a matter of objective fact) with their experience of other events before and after the recall (i.e., subjective experiences of being in hospital, being in the community, their earlier life, etc etc). And reconciling events within the self-narrative of one's life is not necessarily about seeing events as 'positive' or 'negative' - it's more about accepting them or rejecting them. I'm not so set on the word 'rejecting', but I'm trying to capture something about a defiant denial, which perhaps forecloses the harmonious integration of events into their self-narrative and instead creates discord - i.e., I disagree with the fact I was recalled, and yet here I am in hospital.
- So there I had it - a breakthrough, rooted completely in the data of my participants and my analyses of it so far.
- But it still didn't account for everybody - those few participants who didn't fit into my positive/negative dichotomy also didn't fit into the accepting/rejecting one. And here was where the problem presented by own emerging ideas led me to see a solution:
  - Why should they fit into one or the other? Real life is rarely ever black and white (the conclusion of almost every psychological model I can imagine: 'it's a bit of both'), and nor are the experiences that my participants shared with me. How had I been so heavy handed as to categorise my participants into a blunt either/or dichotomy? It's not a dichotomy - it's a spectrum, a continuum - with accepting at one end and rejecting at the other. And voila! What has that simple reconceptualisation created? A space on which to place those few other participants who I couldn't fit into the dichotomy. And in being a continuum it's inherently all-inclusive - whether they hate that they were recalled, whether they embraced the opportunity it gave them to 'change their ways', whether they were ambivalent - all ranges of experience can and do fit somewhere on that spectrum. And what makes it work even more is that it can be constantly updated in light of new experiences - individual FSUs might start in one place on the continuum and then (perhaps with further inpatient treatment or a 'turning point') they might move along it to another place on the spectrum.
- With the continuum established, suddenly everything started falling into place around it. The component parts from the earlier sequential model retained their general sequence, but with this appraisal continuum process (accepting/rejecting) forming the keystone. A whirlwind twenty minutes later and I had my first full draft model.

Appendix Z

Excerpts from the researcher's reflective diary

The following excerpts from the researcher's reflective diary were selected following completion of the project to represent their thoughts at different stages in the research process.

General reflections on the topic and project

April 2015 - initial brainstorming of topic and method ideas and contacting potential supervisors

- Feeling drawn to using a qualitative method. Currently working on service-related project that evaluates service user engagement in adult psychology service, using thematic analysis - I like the process of methodically analysing data that has been directly drawn from lived experiences.

- Quite keen to pursue project that explores matters of recovery and/or institutionalisation in mental health services, probably inpatient settings - largely influenced by earlier assistant psychologist jobs.

- Had contact with a couple of potential supervisors in forensic and generic mental health services, weighing them up but leaning towards forensic because more familiar from assistant job.

August 2015 - first proposal draft

- Working on clear idea for paper A of reviewing FSUs' experiences of recovery in forensic contexts.

- Paper B I'm not settled on yet, but I keep being drawn towards reading about personality disorders, and my previous experiences of working with many female FSUs diagnosed as emotionally unstable makes me keen to explore this. But also still keen to pursue those notions of institutionalisation.

- End up writing my proposal combining both ideas for paper B - a qualitative exploration (gone with grounded theory for now) of personality factors in readmission to forensic units.

January 2016 - focusing on recall

- Met with a group of FSUs on medium secure unit yesterday to consult with them about the general acceptability of my project investigating FSUs' experiences of being recalled/readmitted/transferred in secure hospitals, and asking their opinions on my draft interview schedule. Very good feedback about researching FSUs' perspectives - seems they're keen to be heard! Encouraging for recruitment. Also generally good feedback on my interview questions, just some wording changes.

- Today presented ideas for papers A and B at course research seminar. Feedback on A good though integrative review likely to be far too ambitious - was advised to strip back to systematic review. Feedback on B was quite a reality check - trying to understand the different aspects of FSUs' experiences of recall, and readmission, AND transfers between wards/hospitals is way too big for the scale of this project, more fitting of a PhD. Need to pick one and focus on doing that well.

April 2016 - finalising proposal

- Feedback on earlier proposal drafts for paper B is that it's too service-oriented, almost like a big service-related project, which is not acceptable for thesis level. Recommended to tap into psychological processes more, and now developing proposal more with reference to existing literature from related areas - e.g., service users' experiences of generic mental health readmissions and involuntary hospitalisations, relapse prevention.

September 2016 - ethics application submitted!

- Finally sent off ethics application after multiple revisions to study documentation in order to ensure it was consistent with itself, and more thoroughly and explicitly describing the measures that I will employ in study procedures to ensure good ethical conduct given that FSUs are a vulnerable population.

January 2017 - full approval!

- At last have full approval to start recruitment. Going to be tight in the time that's left until submission in July, but my supervisor is optimistic that I'll be able to get a good number and range of participants.

Data collection reflections

Participant 2 - reflections recorded after completing interview [same format used for all participants]

- TOPICS/THEMES
  - Drug use quickly emerged as quite a centrally relevant aspect of the participant's recall/difficulties.
  - Evident that the participant felt he had a different (superior?) perspective than his clinical team, although not actually clear whether he disagreed about being recalled/needing to be in hospital.
- PARTICIPANT

    - Participant very talkative and tangential, expressed lots of idiosyncratic ideas (e.g., aspiration to become a 'king president') which likely attributable to delusional features of his diagnosed schizoaffective disorder. Quite ‘grandiose/narcissistic’ too.
    - Nonetheless, he did respond directly to interview questions and offer relevant responses about the topic - these were often just obscured within his broader opinions and experiences.
- PROCESS (CONDUCT OF INTERVIEW, ENGAGEMENT)
    - Participant very eager to be interviewed - again perhaps attributable to grandiosity/narcissism.
    - I think I did a good job at containing his overenthusiasm in order to refocus us on interview topics.
    - I did so with clear and direct reference to the interview schedule as a guide and anchor.
    - At times I indulged the participant's tangents and idiosyncrasies, with the intention of keeping him engaged in the interview process. And I don’t think this was too much to detract from the focus on the research topics.
    - I think that sometimes I used more closed questions (than open-ended) in order to more directly elicit information from the participant, and also to clarify his sprawling narratives.
    - I found the participant's idiosyncratic nature to be fascinating in some ways, and irritating in others - but I think that I managed to control my own reactions sufficiently to conduct an objective interview with him.

Analytical reflections

After coding transcript 4

> Coding this interview has bolstered my confidence in the staged coding analysis process - some of my line-by-line codes fit naturally into prior line-by-line codes (from P01-P03) or into the focused codes I developed in a round of focused coding after P03. The completely new codes have added new insights, but are not in as much contrast from the 3 prior interviews as the first 3 all were from each other. So it helps me feel more promise that the data might start to fall into place together as it goes on…

After focused coding round 2 (which followed initial coding P06)

- Finally finished second round of focused coding, took a long time, but I think this might have been the pivotal step in bringing together what key categories are emerging to interrogate further, including…

○ The passive/active dynamic identified when coding P04

○ Turning points? - A recurring theme is 'changing my ways' and the potential of recouping (resetting) while in hospital from being recalled. Also may well include breaking a cycle of drug taking, P03 + P05 especially.

○ Turning points are potentially mediated by FSUs' honest and engagement/collaboration with staff/services?

    - Reasons/causes for recall - very varied, including excessive drug use, deterioration in mental state, potential risk to others/self.

Remember to stay close to research question of how FSUs make sense of recall - not objectively why they were recalled, but what their experience was. It might not even make sense at all, which in itself is a useful finding.

[Further into analysis as it progressed into constructing the theoretical model, analytical reflections were recorded in the form of memos]

Appendix AA

Bracketing interview with research supervisor

As a further method of reflexivity, the researcher held a conversation with their research supervisor in the style of a bracketing interview, in an attempt to identify any beliefs or potential biases the supervisor held which could influence the conduct of the study. The supervisor was working clinically in the service at the time the study was carried out, and their working experiences had led them to develop an overall balanced perspective of recall - that it is generally beneficial in terms of enhancing safety and rehabilitation, but that in some cases the process of recall was carried out in ways that could be confusing or even traumatising.