Understanding the experience of Forensic Mental Health Services-Users using qualitative methods

Ms Judhika Ravindran

BSc. (Hons), MSc, PGDip.

Submitted in partial fulfilment of the requirements for the degree of

Doctorate in Clinical Psychology

School of Health and Wellbeing

College of Medical, Veterinary and Life Sciences

University of Glasgow

September 2023

Table of Contents

List of Tables

Chapter 1: Systematic Review

Chapter 2: Major Research Project

List of Figures

Acknowledgements

This project was very much a team effort. Thank you to my supervisory team, Dr Karen McKeown and Dr Fiona Mair for providing your support from the first of many ideas to the fruition of a meaningful and special project. I have come to recognise just how much knowledge and intellect you both hold, which you have shared with me in abundance to ensure this project is a close reflection of the lives involved. A further thank you is owed to Professor Hamish McLeod who provided support through the final yet challenging stages, as research advisor. Also, I would like to thank Dr Paul Cannon, who took time to support me with the systematic review search terms, helping it come to life. Alongside Dr Cannon I would also like to thank Amanda Minns, the Head of Evidence at NHS Lanarkshire for supporting me to develop a search strategy. Thank you to Niamh as my second reviewer, who also inspired me with her positivity and commitment. My thanks also goes to Dr Lynda Russell who provided me with ad hoc support in gaining a deeper understanding of qualitative research principles and reflexivity.

I would like to greatly thank Dr Sarah Lawson, my clinical supervisor, for her patience and great flexibility during data collection. She also helped me to see the light at the end of a long tunnel during challenging moments of the process. Thank you to all my colleagues in the team, who provided me the strength during a long and difficult year, both personally and professionally.

The project was only possible with the support of all the wonderful and supportive staff at the Forensic Mental Health Service, from the service manager to individual nurses and Occupational Therapists to admin staff; it was only possible with your determination and contribution that this project was made possible. I am so incredibly grateful. You have all inspired me with your colourful sense of humour and vibrancy.

A special thank you goes to my close family and friends, some of which I have gained while on training. To my close friends, thank you for being especially supportive, and patient while I did what I had to do! A special thanks goes to Maria, for sitting with me and gruelling through work as my study partner. I could not have done any of this without you.

Thank you to my parents, especially my dad, who really and truly inspired me to take on this profession. For my dad, I will continue to work my hardest to advocate for the silent, throughout my career and beyond. Thank you to my mum, for being an example to me when it comes to working hard and staying determined, raising me while caring for dad, and studying throughout the night.

And finally, to my darling, Rashanth, who without I would be lost in every way. You have provided me with so much love and care, that I have been often lost for words during this process. It is down to you, that I even continued to have hope I would eventually become a Clinical Psychologist one day! We did it everybody!

Chapter 1

How effectively do forensic mental health services based in White majority countries, adapt care during the lifespan of service users from Black and Ethnic Minority (BME) backgrounds: A Systematic Review

Prepared in accordance with the author requirements for the Journal of Forensic Psychology Research and Practice (https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=wfpp21).

ABSTRACT

Background: Within White majority countries, it is evident that forensic mental health (FMH) services support a disproportionate amount of BME (Black, Minority, and Ethnic) service users (SUs). However, while services have been documented as adopting person-centred care, the types of current cultural adaptations to forensic assessment and psychological intervention have not been reviewed.

Aims: This systematic review aims to determine how effective current efforts to culturally adapt assessment and psychological intervention in FMH services are, in White majority countries. Secondly, the review aims to recognise the differences and similarities between the cultural adaptations, between different nations.

Method: MEDLINE, Embase, PSychINFO, and HMIC (via Ovid) were systematically searched. Search terms originated from keywords such as "Forensic mental health" and "Black and ethnic minority". The articles identified were quality appraised using the MMAT (The Mixed Methods Appraisal Tool). This review adopted a qualitative synthesis methodology, systematically determining themes emerging from the data and reflecting on their applied meaning.

Results: Eleven published articles were found to have met the eligibility criteria. Three of the eleven articles focused on cultural adaptations to the assessment process in FMH services. The 'cultural formulation interview' was the most investigated type of cultural adaptation to the assessment process, which appears to hold merit however requires further evidence to support its application. Eight articles focused on cultural adaptations made to psychological intervention. Most of the criteria included in the MMAT required for a good quality study, were met across the sample. This review found that adaptations involving a facilitator from the same ethnic group and culturally adapted psychoeducation were the most effective types of adaptations to psychological intervention. Research focussed on Māori populations demonstrated the most positive and effective findings, as reported by participants. Further research is encouraged within migrant populations, such as cultural adaptations made for FMH service-users from Black and Asian ethnic groups within White-majority countries, as most research published, has focused on indigenous groups.

INTRODUCTION

Within the UK individuals who have committed a crime while mentally unwell, are recognised as "mentally disordered offenders" (MDOs) (The Baron Report, 2021). This is often determined by a mental health assessment undertaken by two independent psychiatric medical doctors. Following receipt of this label, the individual will be eligible for psychiatric treatment and rehabilitation in a forensic psychiatric hospital. The care received is often provided by a well-resourced multi-disciplinary team (MDT), including Psychiatrists, nursing staff, occupational therapists (OTs), and Clinical Psychologists (CPs) (The Forensic Network, 2019). Forensic mental health (FMH) care is often received as part of a long-term, established care plan spanning over several years until the service user (SU) and wider MDT agree that returning to living in the community is suitable. This package of care will include an in-depth psychiatric and/or psychological assessment period, functional rehabilitation treatment and an offer of psychological intervention, all of which is person-centred (The Forensic Network, 2019). Furthermore, FMH services are based on the Milan principle of reciprocity, ensuring its duty to "provide safe and appropriate services" (Mental Health Act, 2015). As a disproportionate number of patients now accessing FMH services in white majority countries are from Black and Ethnic Minority (BME) groups, it is worth systematically exploring the literature, to understand how FMH services are supporting BME SUs (De Pau, Vruggink, & Vandevelde, et al., 2023).

Overrepresentation in Forensic Services

FMH services based in White majority countries, have been found to disproportionally support individuals from BME backgrounds (Halvorsrud, Nazroo & Otis et al., 2018; Lawlor, Johnson & Cole et al., 2012). Within the UK, it is well documented that individuals from BME groups are overrepresented throughout the criminal justice system, including FMH services (Yasin & Sturge, 2020; Barnett, Mackay & Matthews et al., 2019). According to a Ministry of Justice report (Yasin & Sturge, 2020), which adopted the same methodology as the Lammy Review (2017), 27% of people in Prison in 2019 were from BME groups. Furthermore, this report found that half of BME offenders were more likely to be prosecuted for drug-related offences or carrying a weapon (Yasin & Sturge, 2020). Black or Black British SUs made up 16% and Asian or

Asian British SUs made up 7% of restricted patients in hospitals, in the UK (Davies, 2022). Literature acknowledges that globalization and immigration from ex-colonial countries may play a role, simply due to an increase of BME individuals in the UK population (Degnan, Berry and Crossley et al., 2023).

Possible explanations for an increase in BME SUs seen within FMH services vary greatly. For example, limited access to information on accessing treatment, language barriers, or differences in community understanding of mental health difficulties (Ohtani, Suzuki & Takeuchi., 2015; Ajayi, 2021) continues to contribute to this increase. Black families are more likely to seek support at the point of crisis due to difficulties in accessing the right support, having coped without help for a long period, often with wider familial and community support. Lack of support can lead to a development of fear, stigma, and mistrust in services to provide support during a time of crisis (Shefer, Rose & Nellums et al., 2013). Due to the increased level of risk associated with deteriorating severe mental health, SUs are more likely to enter the criminal justice system (Wasser, Pollard and Fisk, 2017).

While this provides a rationale for why BME SUs may not access support leading up to a crisis, it does not provide a further explanation of increased recidivism and readmission rates (Barnett et al., 2019). As a result, there is an increased need to consider how FMH services assess and rehabilitate BME SUs, considering cultural sensitivities to ensure the most effective care is received (Kirmayer, Fung, Rosseau et al., 2021).

The CHIME (Connectedness, Hope & optimism, Identity, Meaning and Empowerment) Framework (Leamy, Bird, & Boutillier., 2011) is a detailed and robust synthesis of SU personal recovery journeys, that indicates the key components, that should underpin the approach to care within general adult psychiatric care. In line with the CHIME framework, person-centred care would involve an acknowledgement of the SU's connectedness with themselves and others. Identity is also encouraged to be considered when agreeing on specific aspects of the care plan (e.g., social network involvement, or agreement with diagnosis). These aspects are specific to cultural background and understanding. Therefore, appropriate adaptations are vital to care planning and

treatment implementation. Cultural adaptions to intervention would enable SUs to develop a sense of hope, make meaning of themselves within a familiar cultural framework, empowering a BME SU to feel held within their own beliefs and ideology. Cultural adaptions of this kind within a secure service, would enable risk protocol and care plan provisions to be made more individualised and values based, in co-production with the SU.

Cultural Adaptations to Assessment and Psychological Intervention

Specific to FMH services, various parts of the system are based on research and clinical application of findings on the majority White population. For example, the risk assessment tools, mental health assessment structures and psychological intervention. While cultural adaptations to general adult mental health assessment and psychological interventions have been researched to a higher degree (Arundell, Barnett & Buckman et al., 2021), adaptations within FMH populations remain unclear and not well understood.

To account for differential BME needs in general mental health settings, there are several adaptations recommended and implemented currently. These include increasing the cultural competency of mental health professionals (Handtke, Schligen & Mosko 2019), providing access to culturally specific mental health services, and increasing awareness of mental health disparities among BME individuals. Furthermore, psychological interventions have been culturally adapted successfully and implemented with varied outcomes (Arundell et al., 2021).

Culturally adapting interventions continue to be one of the most effective methods of ensuring services remain an informed choice for all individuals from different cultural backgrounds (Arundell et al., 2021). However, if treatment cannot be accessed due to the inflexibility of time, or length of session then efforts to culturally adapt treatment would be fruitless. Arundell et al., (2020) suggest services work closely with community leaders and carers to develop a shared understanding of what specific practical and clinical needs must be considered for that group. This falls in line with the CHIME framework (Leamy et al., 2011) that highlights empowerment as a key aspect

of recovery, which provides an accessible and flexible service, that would address placing back control in the SU's hands.

Addressing forensic service needs

Further rationale for this systematic review looking at how FMH services culturally adapt assessment and psychological intervention, is the requirement to understand how services could improve (Shradavan and Bath, 2019). This is a particularly important area to explore due to the increased emphasis on diversity and inclusion in the field of criminal justice (Shiva, Haden, & Brooks, 2009). There is a gap in the research literature on this topic, making it difficult to inform the development of best practices (De Pau et al., 2023). Evidence suggests that while white SUs may be socialised with the concept of therapy, BME SUs may not be, viewing the option of intervention as not fitting with one's cultural ideology. Therefore, accessing psychological treatment, within FMH settings may be further stigmatised due to suspicion held around secure services and expectations by the service, to comply (De Pau et al., 2023). Within FMH services, research has pointed to how key tools and structures can act as a barrier for FMH SUs, who are more likely to view their care plan as something that must be conformed to as opposed to engaged with (Bhui, Stansfeld, Hull et al., 2018). Shepherd (2018) highlighted that risk assessment tools, do not take into account the language used, or the items covered which may not pick up on culturally specific areas of risk or differences in how mental illness may present.

The current review

The current systematic review aims to recognise how effective the cultural adaptations to FMH assessment and psychological interventions are. Due to the sparsity of this area, it is difficult to determine how this can be succinctly defined as it is expected that each adaptation will be specific to the population it is supporting. This also applies to recognising how effective an adaptation has been, as no two adaptations can be directly compared due to the various levels of confounding variables. Based on the stronger evidence base within general adult mental health settings that have successfully

analysed the effect of cultural adaptations, the "cultural formulation interview" (Aggarwal et al., 2020) and culturally adapted CBT-based interventions are likely to be more effective with a forensic population (Chowdhary et al., 2014). Therefore, the first objective of this review is to determine how effective the current attempts to culturally adapt FMH assessment and psychological interventions are, by providing a qualitative analysis. This methodology should provide a flexible way in which to analyse the findings. A qualitative synthesis should allow consideration of various aspects of the findings that cannot be standardised, due to cultural differences and sensitivities. A second objective is using qualitative synthesis to determine the differences and similarities between the findings, to determine the shared characteristics of each adaptation. By recognising the similarities, this review may be able to conclude how FMH research and services and continue to adopt similar adaptations to improve service accessibility and outcomes.

Review questions

1. What are the wider cultural adaptations made to assessment and psychological treatment in FMH services for BME SUs within white-majority countries?
2. What are the differences and similarities between cultural adaptations of assessment and psychological intervention, between different nations?
3.. Are the cultural adaptations made to assessment and psychological intervention differentially effective?

METHOD

Protocol

This systematic review protocol was registered on the Open Science Framework (https://archive.org/details/osf-registrations-nexuc-v1) and reported in line with PRISMA guidelines (Page, McKenzie, Bossyut et al., 2020). The present review included quantitative, qualitative, and mixed-method studies.

Inclusion and Exclusion Criteria

Table 1. Inclusion and Exclusion Criteria.

Inclusion Criteria	Exclusion criteria
Journal published articles, published between 1965 and 2023 using qualitative, quantitative, or mixed methodology.	Studies that have been run in nations that are not majority Caucasian white, (e.g., parts of Africa, Asia or South America).
Participants from BME backgrounds across a lifespan, (any ethnic group that is minoritized in that nation).	Not written in English
Participants must be part of the Forensic system. This can either be part of the criminal justice system such as the prison service or as part of FMH services (including community FMH services).	Studies that focus on carers or families of participants.
Any adaptation to the assessment process (including risk assessment or detention assessment) that is made specifically to benefit offenders from BME groups.	Studies that focus on court proceedings, and legal framework adaptations or any procedure that does not pertain to an individual's wellbeing or mental health.
Any adaptation to any psychologically informed intervention that is made specifically to benefit offenders from BME groups.	Any participant study that includes minors or juvenile participants aged 18 years old and below.

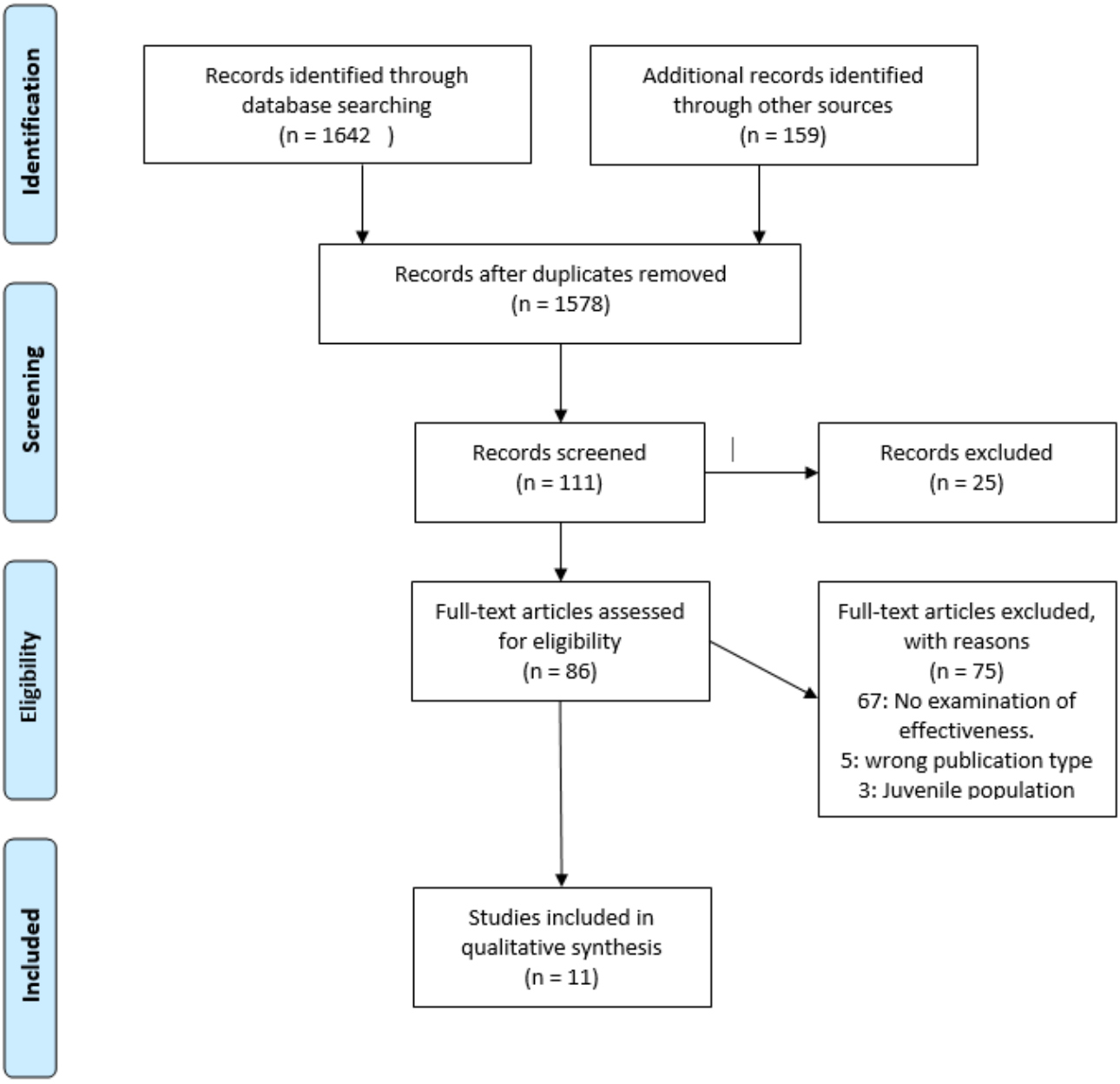
Search Strategy

The following bibliographic databases were systematically searched: MEDLINE, Embase, PSychINFO, and HMIC (via Ovid). Studies were restricted to those written in the English language and published between 1965 and 16th July 2023. To ensure a detailed search was performed, a manual search of reference lists of eligible studies was included, to identify studies that may not have appeared during the search. Search terms originated from the key terms "forensic mental health" and "Black and Ethnic Minority" alongside either "assessment" or "psychological intervention". These terms were then expanded within each database to include various minoritized ethnic groups,

the various ways in which forensic services are recognised and various types of assessment and psychological interventions. Search term examples included "Forensic*", "Correctional", "Ethnic*", and "Culture". (*An example of the search strategy is available in Appendix A.)*

Screening

All studies were screened at the title/abstract level by the first reviewer according to pre-determined inclusion criteria. The remaining studies were filtered at full text. A second reviewer reviewed 20% of references at the screening stage, resulting in 100% agreement. Conflicts were resolved by a consensus meeting with the first and second reviewer. Screening was undertaken using the EndNote application to screen initial searches by the first reviewer and Rayyan was used by the second reviewer. In addition to screening through electronic databases, the first reviewer manually searched through reference lists of eligible articles to find further eligible literature.


Identification
Screening
Eligibility
Included
Records identified through database searching (n = 1642)
Additional records identified through other sources (n = 159)
Records after duplicates removed (n = 1578)
Records screened (n = 111)
Records excluded (n = 25)
Full-text articles assessed for eligibility (n = 86)
Full-text articles excluded, with reasons (n = 75)
67: No examination of effectiveness.
5: wrong publication type
3: Juvenile population
Studies included in qualitative synthesis (n = 11)

Quality Appraisal

The Mixed Methods Appraisal Tool (MMAT) (Hong, Pluye & Fabregues et al., 2018) was used to assess the quality of the studies included. Studies went through two stages of analysis within the tool. Firstly, each study required confirmation that it is an empirical study by indicating "no" "can't tell" or "yes". The tool is designed to accommodate qualitative, quantitative, or mixed methods studies. Therefore, each study was reviewed based on the critical appraisal questions within each respective category with either a "can't tell", "no" or "yes". Each category of the tool included criteria based on the type of methodology in question, and so differed between categories. The MMAT discourages researchers from quantifying their findings and encourages using the tool to qualitatively examine the quality of the studies. Therefore, any quantitative description is provided by the reviewer, to indicate overall ratings of each section, and not of individual studies. The second reviewer appraised 70% of the articles included in the final set of studies. Where there was disagreement on certain parts of the appraisal, this was reviewed.

Data Extraction

The data extraction method involved developing a detailed table (*Table 2*) including all relevant information in a PICO (Participants, Intervention, Comparator and Outcome) format. The main outcomes of the study were qualitatively recorded as well as the intervention or assessment adaptation, and any information of a comparison group, which most studies did not have.

Data Analysis

Analysis was influenced and guided by narrative synthesis protocol (Popay, Roberts and Sowden et al., 2006). A narrative synthesis of included studies involved carefully reviewing the findings reported in each eligible study. A synthesis was conducted to summarize the findings, highlighting the key outcomes, patterns, or trends. Once the studies had been grouped by assessment or intervention, they were assessed for homogeneity and heterogeneity in the findings and analysed for effectiveness accordingly. The implications of the results in the context of the research question and overall body of evidence, are discussed as part of the analysis.

Table 2. Results - Data extraction table including study characteristics, nature of adaptation and its effect.

Study No.	Authors	Title of Study	Year of Publication	Research site Country	Publication Type	Type of Adaptation (Assessment or Intervention)	Participant population	Average age	Gender	Participant Sample No.	Research Method
1	*Aggarwal, Lam & Diaz et al.,*	Clinician perceptions of implementing the cultural formulation interview on a mixed forensic unit	2020	USA	Peer reviewed journal	Assessment	Forensic inpatients	46.34 yo (average)	10 Female/3 Male (all staff)	3	Mixed methods
2	*Ajaz, Owiti and Bhui*	Using a cultural formulation for assessment of homicide in forensic psychiatry in the UK	2014	UK	Peer reviewed journal	Assessment	Forensic inpatient	Not reported	1 Male	1	Case Study
3	*Ashdown, Treharne & Neha et al*	Maori Men's Experiences of Rehabilitation in the Moana House Therapeutic Community in Aotearoa/New Zealand: A Qualitative Enquiry	2019	New Zealand	Peer reviewed journal	Intervention	Forensic inpatient	22 to 48 yo	7 Male	7	Qualitative
4	*Durey, Wynaden, & Barr*	Improving forensic mental health care for aboriginal Australians: challenges and	2014	Australia	Peer Reviewed journal	Intervention	Forensic Inpatient Staff	31 to 50 yo	Majority Female staff	90	Mixed Methods
5	*Florencio, Healee & Ratahi*	Tu-Tahanga: Qualitative descriptive Study of a culturally adapted violence prevention programme in a FMHS	2022	New Zealand	Peer reviewed journal	Intervention	Forensic Inpatient	Not reported	2 Female/ 3 Male (SUs)	11	Qualitative
6	*Ober, Dingle, & Clavarino et al.,*	Validating a screening tool for mental health and substance use risk in an Ingigenous prison population	2013	Australia	Peer reviewed journal	Assessment	Prisoners	29-31 yo	45 Female/ 119 Male	419	Quantitative
7	*Rossiter, Power & Fowler et al.,*	Learning to become a better man: insights from a fathering programme for incarcerated indigenous men	2017	Australia	Journal	Intervention	Prisoners	21-50 yo	Male only	28	Qualitative
8	*Stewart, Hamilton & Wilton et al.,*	The Effectiveness of the Tupiq Program for Inuit Sex Offenders	2015	Canada	Journal	Intervention	Sex Offenders	Not reported	Male only	61 In treatment/ 114 control	Mixed Methods

Study No.	Authors	Title of Study	Year of Publication	Research Site Country	Publication Type	Type of Adaptation (Assessment or Intervention)	Participant Population	Age	Gender	Participant Sample No.	Research Method
9	*Terill & Robertson*	There's no cloud of shame on me: Maori men's experiences of prison-based psychological rehabilitation - Part II	2014	New Zealand	Psychological Society publication	Intervention	Prisoners	22-40 yo	Male only	6	Qualitative
10	*Wharewera-Mika, Field & Wiki ., et al*	A description of the maori minimum secure FMHS	2023	New Zealand	Peer reviewed journal	Intervention	Forensic Sus/ Staff/ family	Not reported	Not reported	6 (SUs); 5 (staff); 2 (Family)	Qualitative
11	*Yuen*	I've never been so free in all my life: healing through aboriginal ceremonies in prison	2011	Canada	Journal	Intervention	Prisoners	Not reported	Female only	19	Qualitative

Table 3. Results – Outcome Table describing effect of adaptation on specific outcomes.

Study No.	Authors	Type of Adaptation (Assessment or Intervention)	Key Characteristics	Adaptation	Description of Adaptation	Effect of Adaptation
1	*Aggarwal, Lam & Diaz et al.,*	Assessment	The CFI covers the following: Cultural identity in regards to lanugage, or interaction with host culture. Cultural explanations of the condtion is regarded. Cutlural factors regarding life stressors, type of social support available, and current functioning. How the clinician-patient interaction is effected by culture is ascertained.	Cultural Formulation Interview	The CFI is a culturally adapted tool in of itself and was not designed to be used solely for Forensic SUs. It follows a standard psychiatric assessment structure, with additional sections that aim to provide a cultural formulation.	Openess by clinicians to use CFI, but less likely to use due to requirements/legal protections of patients. Use of CFI is case dependent on patients symptom severity, staff-level skills, ability and confidence in administration.
2	*Ajaz, Owiti and Bhui*	Assessment	The CFI as mentioned above was used for this case study.	Cultural Formulation	As mentioned above the CFI is a culturally adapted tool in of itself. The participant the case study is based on, required a CFI in relation to their index offence and sentencing.	CFI enabled the assessing psychiatrists to exclude culture as a significant aspect of the case, enabling clarity in regards to diagnosis. Key aspects in which it is suggested psychiatrists are trained in is discussed.
3	*Ashdown, Treharne & Neha et al*	Intervention	The Māori Therapeutic Community Programme is a group-based rehabilitation programme designed to reduce offending by promoting Māori cultural concepts such as whānaungatanga (relationships), aroha (love and empathy), and whakapapa (genealogy).	Cutlurally reponsive therapeutic community	Family is heavily involved in all aspects of the therapeutic community (TC), especially intervention offered. Maori cultural practises and processes made up the daily fabric of the TC, which helped offenders contextualise themselves and provide new understanding of their index offence. Use of Te Reo (Maori language) was heavily encouraged. Group work is utilised more so that in non-adapted services.	Reconecting and healing family relationships, further connection with maori culture to ground identity and have a cultural awakening, and increased self awareness improving quality of life.

Study No.	Authors	Type of Adaptation (Assessment or Intervention)	Key Characteristics	Adaptation	Description of Adaptation	Effect of Adaptation
4	*Durey, Wynaden, & Barr*	Intervention	General care offered to Australian Aboriginal patients involved possessing good knowledge about the culture, history and colonization of Australia. Additonally, staff had further education and training about working with Aboriginal patients.	Culturally responsive aboriginal adaptations	Continued education and training in cultural competence and sensitivity, employing staff from the Aboriginal community, and use of culturally adapted assessment tools. Linking carefully and consistently with families and communities.	Difficulties experienced during "therapeutic encounters". Staff focused on opportunities to make authentic connections with Aboriginal patients. Staff reported the importance of remaining flexible, inclusive and expansive with potential opportunities for engagement and relationship building.
5	*Florencio, Healee & Ratahi*	Intervention	12-16 session CBT programme led by Maori facilitators (a Maori Cultural Worker and Psychologist) focused on male perpetrators of violent crimes. Programme involves assertiveness training, mindfulness training, role plays providing practise of active listening skills, empathy and expressing emotions.	Culturally adapted violence prevention programme	A Maori facilitator and use of Te Reo was crucial to the success of the programme. Cultural context and Maori principles integrated into each module. Using Maori models of understanding e.g., "Te Whare Tapa Wha" (holistic health model, described as 4 walls of a house. Programme held in culturally appropriate communal meeting place.	Positive impact on recidivism, as programme was targeted to the responsivity requirements of the Maori culture. Importance held in regards to culturally specific healing spaces, integration of culturally specific conflict resolution practices and creation of family-like support system facilitated by patients.
6	*Ober, Dingle, & Clavarino et al.,*	Assessment	The IRIS is a 13-item instrument specifically desgined for Aboriginal and Torres Strait Islander Adults in Australia. 2 factor screening process for alcohol, substance misuse and mental health issues.	Culturally adapted screening measure	The Indigenous Risk Impact Screen (IRIS) – an adapted tool that takes into consideration cultural factors that may impact the risk of substance abuse (including alcohol dependency) with consideration of mental health factors.	While the measure successfully captured most disorders, it did not do well in capturing anxiety disorders. Given that the custodial indigenous population is viewed as a "hard to reach" group, the study highlights how an adapted measure can successfully support people with fewer resources available. A limitation of the measure however is that it relies on self-report

Study No.	Authors	Type of Adaptation (Assessment or Intervention)	Key Characteristics	Adaptation	Description of Adaptation	Effect of Adaptation
7	*Rossiter, Power & Fowler et al.,*	Intervention	The Babiin-Miyagang programme is a parenting programme for Indigenous fathers. Facilitated by male Indigenous elder emphasising on story-telling, music and other culturally relevant practises. 5 3 hour sessions.	Fathering Programme for Indigenous men	Modules are: Being a dad today; Understanding our kids; Yarning; Keeping our kids safe; and Coaching or kids. Specific focus on Indigenous masculinity and fatherhood.	deeper understanding of identity and culture, and how this links to their style of parenting as a form of duty with potential to be role models to their children.
8	*Stewart, Hamilton & Wilton et al.,*	Intervention	The Tupiq programme integrates Inuit language, values and understanding of the Arctic environment using a cognitive behavourial appoach to skill training for 18 weeks, including group therapy sessions and 1:1 counselling. Based on CSC's National Sex Offender Treatment Program and National High Intensity Family Violence Program.	Culturally adapted sex offender programme	Co-facilitated by Inuit correctional program officers supervised and trained by a clinical psychologist. Each offender is linked to a counsellor in his home town. A inuit-specific therapeutic approach is adopted and led by a an Inuit Elder.	Significantly lower rates of reoffending in the intervention group vs control group.
9	*Terill & Robertson*	Intervention	The Special Treatment Unit - Rehabilitation Programme (STU-RP) consists of 6 modules over 9 months. Sus participate by living and working in the environment.	Culturally adapted psychological intervention	Alongside the 9 modules pps could meet once a week for a 2 hour session with a respected Elder to complete culturally specific activies such as carving, learning Te Reo. Art, role plays and group discussions are used to facilitate therapy. Pps must complete homework tasks. Attendance of a post-treatment assessment and maintenance group is required.	Helpful to enhance knowledge of culture and how this plays a role in their cognitive style. Developed a stronger connection with the maori facilitator. Stronger developed self-identity.

Study No.	Authors	Type of Adaptation (Assessment or Intervention)	Key Characteristics	Adaptation	Description of Adaptation	Effect of Adaptation
10	*Wharewera-` Mika, Field & Wiki ., et al*	Intervention	Te Ao Maori (The Maori Worldview) is merged with the Boston rehabilitation model (Western Clinical approach) This is reflected in the 7 tenets of wairuatanga (spirituality), Tikanga (correct procedure amd protocols), Whanaungatanga (family connection), taha tinana (physical health), taha hinengaro (mental health), tumanako (hope for the future) and whakapaitia (excellence in service delivery).	Culturally responsive Maori MSU	A maori management structure was adopted, including a Maori Elder and service manager. Reflective Maori decision-making processes were put in place. The communal meeting place held high significance in facilitating intervention. Regular Te Reo classes and Haka occurred. Disclosure groups and meditation took place daily. Family was heavily involved in at various points.	Embedding a holistic Maori view on health (the 'Whare Tapa Wha' mode, in addition to culturally adapted evidence-based programmes led to the development of a collectivist aim to prepare each other living in the community.
11	*Yuen*	Intervention	The Native Sisterhood were imprisoned women with a federal offence and sentence of 2 years of more. Sweat Lodge sessions occurred monthly in a sacred area, and was made from tree branches and blankets. A CCTV camera was installed inside for security.	Cultural healing ceremonies	Sweat facilitatoes stated the ceremony in the lodge is a "return to the mother's womb". The purpose was to encourage emotions to be expressed. These are run only by Aboriginal women for Aboriginal women.	A space to explore healing past trauma and connecting with their feminine identity through their culture.

QUALITATIVE ANALYSIS

Eleven studies in total met the eligibility criteria, two were quantitative studies, two were mixed-methods studies and seven were qualitative studies. Most studies were published from Australasia and Canada and focused on indigenous community approaches.

Adaptations to Assessment

Aggarwal et al., (2020), Ajaz et al., (2014) and Ober et al., (2013) were identified in the current literature that provide evidence of cultural adaptations made to how assessment is conducted in an FMH setting. Study 6 focused on a risk assessment measure for substance abuse and mental illness designed for indigenous people, which will be analysed separately. Firstly, Aggarwal et al., and Ajaz et al., will be reviewed as they are directly related. Both studies support the implementation of the cultural formulation (CF), which is used as part of the assessment process. Both findings agree that while the CF interview provides a quality of detail that is generally not accessible through general assessment means, there were expectedly some difficulties.

Namely, they both point to the difficulties the wider MDT may have in implementing the CF. Both studies identified that staff felt that the more distress SUs were experiencing, the increased difficulty SUs had in reflecting and processing the questions posed. SUs were perhaps unable to engage with a process that requires cognitive skills such as memory recall and information processing, that when in an elevated level of distress may not be possible to engage with. Therefore, staff fed back that SUs could not benefit from the CF. Staff also reported that they did not have confidence in administrating the CF interview, which is supported by Ajaz et al., which was implemented by a group of psychiatrists, who could be viewed as experts. This reflects staff concerns in Aggarwal et al., which were not made up of psychiatrists. Further lack of confidence in implementing the CF interview, appears to arise from the lack of support such an adaptation has from the surrounding legal structures, which require consideration when supporting “mentally disordered offenders”. Staff argued

the information gathered could be perceived as not useful to the case. Ajaz et al., points out that while this may be a concern, the detail and change of diagnosis that resulted from this CF interview were invaluable to the prognosis of this patient. However due to the strict timelines and guidelines that FMH units need to abide by for legal reasons, the length of culturally adapted assessment protocol may be a barrier to its thorough implementation.

It was recognised in both studies, that there was careful consideration of spiritual factors. This appears not to be considered in formal assessment tools used in FMH services. Furthermore, there appears to be recognition of how the wider family and support network plays a prominent role in their experience of mental health difficulties. This is recognised in both studies which include queries about familial relationships.

The two studies focused on assessment in this review, have adopted a qualitative methodological approach, using deductive content analysis in one study while the other is focused on a case study in the UK. The former study also adopts quantitative methodological techniques to analyse questionnaire responses from clinicians using the CF interview. While the methodological approach used in both studies, has its merits, within the scope of this review the main query would be whether the research approach used sits well within the topic discussed, namely cultural adaptation to a process embedded within a Western context. For example, one study recognising culturally adapted intervention that is discussed in this review, adopted a research approach viewed as appropriate for the culture studied (Wharewira-Mika et al., 2023). In Aggarwal et al., it seems appropriate that a Western research format be used, as the cultural background of the participant appears irrelevant to the research question which focuses on the experience of using the CF interview by clinicians. However, on the other hand, Aggarwal et al., could be viewed as reductionist as the ethnic identity of the SUs is not stated. Due to how culture varies acutely from person to person, it can be difficult to implement a research approach that would honour this.

In summary, it is difficult to generalise these findings due to individual differences of the SU, and the clinician using the tool. For example, one clinician in Aggarwal et al., reported that the CF interview may be viewed as an extensive piece of paperwork that

could be procrastinated over, based on how the clinician may view the relevance of the CF interview to the SU. It is, therefore, challenging to develop a protocol for adapting the assessment process that could be widely used and captured effectively by literature.

Regarding a specific assessment tool, Ober et al., presents promising findings surrounding the implementation of the Indigenous Risk Impact Screen (IRIS), suggesting that the screen can be used successfully within a custodial population. The tool is reported to have successfully identified individuals who are at risk of suffering from a substance use disorder including alcohol dependency and cannabis addiction. The study had a large sample size (n=419) meaning the results could be generalised to the wider population. When asked about substance misuse in the 12 months before imprisonment, 89% of men and 84% of women were screened as "high risk". However when using the IRIS the percentage changed to 59% of men and 44.8% of women. However, the study noted that, while the measure successfully captured most disorders, it did not do well in capturing specific anxiety disorders. For example with depressive disorders the IRIS demonstrated 58.5% for specificity and 81.5% for sensitivity however for anxiety disorders the IRIS demonstrated 68.2% and 60.2% for specificity. Given that the custodial indigenous population is viewed as a "hard to reach" group, the study highlights how an adapted measure can successfully support people with fewer resources available. A limitation of the measure however is that it relies on self-report. This could be an issue given the high levels of stigma towards psychological suffering that exist within ethnic communities. Despite this, the study illustrates by having a large sample size, and thorough quantitative methodology that such moves to adapt the assessment process for BME SUs are vitally effective.

Adaptations to Intervention

Most of the literature focused on cultural adaptations made within FMH settings in white-majority countries across the world and appears to mainly focus on interventions. Furthermore, most of the research conducted has mainly been published within New Zealand, Australia, and Canada, focusing on indigenous groups. One study focused on a specific psychological intervention adaptation within a prison setting. The remaining studies either focused on substance misuse, and parenting or focussed on a culturally significant practice that could be utilised as part of the development of wellbeing practices. The studies are grouped by similarity and difference, however, discuss the effect of the adaptation within the analysis.

SIMILARITY

Family involvement

All studies had a significant aspect of the intervention that involved or considered family involvement. It demonstrates the vital importance that minoritized cultures place on family, and how this is a vehicle of motivation for the success of the intervention. Many of the participants reported difficulties maintaining a close relationship with their family due to their offending history or mental health. Collectivist cultures view a loss of family connection as a highly distressing event, harming the existence and practice of important cultural activities and structures (Strand, Vossen, & Savage 2019). Furthermore, there exists a heavily dependent duty-bound family structure that can affect the livelihood of the family unit, due to a loss of status or stigmatisation from the wider community (Strand et al., 2019). As a result, the interventions proposed do well to insist on aspects of the intervention focusing on the value of family as a cornerstone.

Effect of Family Involvement

The involvement of family highlights the benefit of considering internal family systems and breaking long-held negative interaction cycles. By involving family, it appears to provide benefits directly linked to the wider family, who benefit from a deeper understanding of their incarcerated family member. As family is the cornerstone of many minoritized cultures, it is necessary that this would be reflected in a culturally adapted intervention (Arundell et al., 2021). Family involvement was highly effective

in supporting the intervention approach and supporting participants, to develop wider skills.

A Facilitator from the same community

Several of the studies highlighted the importance of adopting a facilitator who belongs to the same cultural background as the SUs (Ashdown et al., 2019; Florencio et al., 2022; Rossiter et al., 2017). The literature highlights that participants felt a deeper sense of connection with the goals of the intervention, due to their overall deeper connection with the facilitator. Reasons identified for this are linked to the similarities in upbringing, and values. Additionally, participants highlighted that they did not have to explain their cultural background and its intricacies in the development of their mental health difficulties, as this was already understood. Especially within the studies focused on indigenous groups (Ashdown et al., 2019; Florencio et al., 2022; Rossiter et al., 2017), feedback highlighted the importance of the facilitator being viewed as a father figure or "uncle".

The "bi-cultural therapy module" (Terril & Robertson (2014)) introduced in a prison setting in New Zealand is the only study that has a non-ethnic minority facilitator therapist. However, importantly the therapist had weekly supervision-style sessions with a local community leader. This addressed any potential areas for misinterpretation such as the use of language or colloquialisms and gaps of knowledge in cultural practises, relevant to the delivery of therapy. This demonstrates, the vital importance of involving members of the minority community to ensure its adaptation and application is accurate and appropriate.

Effect of a facilitator from the same community

A facilitator from the same community resulted in heightened respect for the intervention and facilitator. This illustrates the importance of a carefully curated relationship between the staff and SUs. The impact of this significant relationship on the perceived success of the intervention is viewed as crucial within the studies reviewed here. However, it did not highlight that having a facilitator from the same cultural group could be viewed as problematic due to fears of breaking confidentiality

in close-knit communities (Arundell et al., 2021). Furthermore, it could be viewed as increased pressure to conform to the cultural teachings that they may have abandoned, due to their circumstances (Arundell et al., 2021). Therefore, this could develop a sense of shame felt by the participants.

Connection with Identity

The third theme highlighted by the present review is the increased connection to identity because of taking part in a culturally adapted intervention. Providing the participants with psychoeducation within the context of their culture is a critical step to developing an understanding of the rationale behind techniques. A helpful by-product of this is that participants felt closer to their culture and understanding of where they fit into this identity, which they may have lacked previously. This sense that they lacked belonging may have been behind their offending behaviour and may form a significant part of their formulation.

Effect of Connection with Identity

All studies reported the significant effect of participants provided with an opportunity to connect with their identity on mental health and wellbeing, through qualitative data. Studies Ashdown et al., Florencio et al., Rossiter et al., Terill & Robertson, Wharewera-Mika et al., and Yuen reported the importance of this, in enabling SUs to find purpose, closeness and thus connectedness with themselves and their wider community.

Reducing stigma

The psychoeducation provided an opportunity to develop their knowledge of how their mental illness may have developed as an understandable response to the distress and trauma experienced as minoritized individuals. As a result, participants and their families reported that this has addressed the stigma and misunderstanding of mental illness. Consequentially, participants reported feeling more equipped and better able to demonstrate deeper self-compassion (Ashdown et al., Florencio et al.,). This appears to be another helpful by-product in culturally adapting intervention, which could support widening access to psychological services for minoritized communities if such options were widely available.

Effect of Reducing Stigma

All articles that focused on intervention, found that reducing self-stigmatisation was highly effective in coping with mental health difficulties. Overall, participants reported an increased level of self-compassion, self-awareness, and self-acceptance.

Values-Based treatment

All the literature and interventions reviewed in this paper focus on the culture the SU belongs to, to develop a therapeutic intervention catered to the values and belief system of that culture. This results in an intervention that bridges the gap between the secular, majority views and perhaps the spiritual developmental template, that the participant or facilitator may have had to reckon with independently. Participants were able to focus on learning and applying techniques from the beginning of treatment, without having to spend an amount of time focused on moulding the intervention to meet their internal belief system or cultural values.

Effect of Values-Based Treatment

This is of significant value as this supports participants to engage with the intervention at a quicker pace than if they had engaged with a non-adapted intervention. Thus, an adapted intervention could improve outcomes significantly earlier.

Recognition of Inter-generational Trauma (IGT)

As mentioned, the studies that focus on culturally adapted intervention are with indigenous ethnic groups, in which their home was colonised (Wharewera-Mika et al; Florencio et al., Ashdown et al.,). Well documented is the significant trauma experienced, because of widespread genocide, sexual exploitation, and enslavement (Hoffart and Jones.,2017) This is why some indigenous groups have been unable to thrive in society today, due to the long-term effects of this. For example, widespread

ongoing discrimination, and placement of communities in areas of high deprivation and devastation, lead to long-established poverty (Hoffart & Jones., 2017).

Effect of Recognition of IGT

Similarly, to other components of the interventions mentioned previously, recognition of IGT significantly supported participants in developing a sense of belonging and self-awareness around their community formulation. The positive effect of this also derives from having the opportunity to normalise experiences and develop a sense of community within their forensic unit, with SUs belonging to the same community.

Translated terminology and language

Studies reviewed in this paper point to the effective use of terminology translated into the ethnic group's native language (Wharewera-Mika et al; Florencio et al.,; Ashdown et al; Yuen). Participants reported that translated psychological terminology and concepts, help connect to the intervention and how their culture identifies with their goals for recovery. The use of language not only communicates the term and provides a deeper level of understanding, but also communicates a sense of belonging to their history and values.

Effect of translated terminology and language

The translation of terminology and language was highly impactful on participants, as it enabled increased engagement and increased participants' capacity to apply skills and knowledge learnt.

DIFFERENCES

Length of intervention

The length of each intervention varied depending on the style of the programme which differed. Length was also determined by the aim of the intervention, or the content of the programme which focussed on therapeutic rapport building to engage participants. Some programmes also had an extensive assessment process to ensure eligibility, which would have affected how long the intervention was.

Effect of Length of Intervention

The length of the intervention did not affect how well the intervention was received. Participants did not report dissatisfaction with the length of the intervention. The length of intervention is not stated within this review, as certain studies were focused on ward environments and long-stay therapeutic communities, as opposed to a single point of time or intervention.

Differing Cultural Values

As mentioned, many of the programmes were focused on having a strong foundation of psychoeducation that is based on the main values of that culture. Therefore, depending on the culture, the content of the programme would have differed. This would also apply to the style of facilitation, with some programmes including a local community leader or member whereas others did not. The values on which the programmes were built were heavily determined by several aspects of the programme. The closer the values genuinely sit within that community, the more effective the intervention.

Effect of Differing Cultural Values

As mentioned previously, each programme based its adaptations in line with the community's values. Therefore, there would be an increased significance in how the intervention would have been received. Participants generally reported similar themes of self-acceptance and self-compassion as a result. Additionally, the intervention was less challenging to engage with as participants reported feeling valued and heard.

QUALITY APPRAISAL ANALYSIS

Of the eleven studies included in this study 90% of the MMAT criteria were met. The three mixed-methods studies were lacking in 20% of the criteria (Aggarwal et al., Durey et al., Stewart et al.,). Namely, Durey et al., did not report the results in a way consistent with both methodological disciplines. The only quantitative study (Ober et

al.,) met 100% of the criteria of a robust study. Six of the studies were qualitative and 93% of the criteria were met for a robust and sound methodology in keeping with the topic. There were discrepancies with studies that did not report quotes or aspects of interviews of all participants, with one or two participants not mentioned. This affected the overall integrity of the research. However, it should be considered that the studies aimed to be reflective and true of the culture they are aiming to support; two of the studies (Florencio et al., and Ashdown et al.,) included followed a research design corresponding to the culture. As most research follows Western research principles, it is worth noting that any appraisal tool developed within the West may not successfully capture the robustness of the research, as two included studies adopted specifically adapted indigenous research principles.

The quantitative study was most robust, which is to be expected given the clear methodology and outcome data. The mixed studies received the results they did due to either the qualitative or quantitative aspect of the study being prioritised over the other.

Table 4. Quality Appraisal rating for qualitative studies – MMAT (Hong et al., 2018)

	Qualitative Methodological Quality Criteria				
Publication (Year)	*1.1 Qual. approach suitable?*	*1.2 Qual. Approach methodology appropriate?*	*1.3 Findings adequately derived from data?*	*1.4 Interpretation of results substantiated by data?*	*1.5 Coherence between data sources, collection, analysis and interpretation?*
Ajaz et al., (2014) (2)	Yes	Yes	Yes	Can't Tell	Yes
*Ashdown et al., (2019) (3)	Yes	Yes	Yes	Yes	Yes
*Florencio et al., (2022) (5)	Yes	Yes	Yes	Yes	Yes
Rossiter et al., (2017) (7)	Yes	Yes	Yes	Yes	Yes
*Terrill & Robertson (2014) (9)	Yes	Yes	No	Can't Tell	Yes

*Wharewera-mika et al., (2023) (10)	Yes	Yes	Yes	Yes	Yes
*Yuen (2011) (11)	Yes	Yes	Yes	Yes	Yes

Table 5. Quality Appraisal rating for quantitative studies – MMAT (Hong et al., 2018)

	Quantitative Methodological Quality Criteria				
Publication (Year)	*3.1 PPs representative of population?*	*3.2 Measurements appropriate for outcome and intervention?*	*3.3 Complete outcome data?*	*3.4 Confounders accounted for in design and analysis?*	*3.5 Intervention administered as intended?*
Ober et al., (2013) (6)	Yes	Yes	Yes	Yes	Yes

Table 6. Quality Appraisal rating for mixed-methods studies – MMAT (Hong et al., 2018)

	Mixed-Methods Methodological Quality Criteria				
Publication (Year)	*5.1 Adequate rationale for mixed methods?*	*5.2 Components of study effectively integrated?*	*5.3 Outputs of Qual. And Quant. adequately interpreted?*	*5.4 Divergencies and inconsistencies between Qual./Quant. adequately addressed?*	*5.5 Component of study adhere to quality criteria In each tradition of methods involved?*
*Aggarwal et al., (2020) (1)	Yes	Yes	Yes	No	Yes
*Durey, Wynaden, & Barr (2014) (4)	Yes	Yes	Yes	No	No

*Stewart, Hamilton & Wilton et al., (2015) (8)	Yes	Yes	Yes	Yes	Yes

Key:

- Those labelled with * indicated the studies rated by the second reviewer.
- Qual. = Qualitative
- Quant. = Quantitative

DISCUSSION

This study aimed to cover the body of literature on the topic of culturally adapted psychological assessment and intervention for patients in FMH services or prison services, to provide an overview of, how and why these adaptations are effective within the forensic population. This review recognised that most research focused on intervention and not the assessment process which there were only 3 of the 11 articles (Aggarwal et al.; Ajaz et al.; Ober et al.,). The remaining articles focused on adaptations made to psychological intervention or rehabilitation approaches. The majority of the articles focused on indigenous communities native to the research host country as opposed to migrant populations in a white-majority country. This illustrates the small and slowly emerging field of culturally sensitive research within forensic populations, which is surprising given the over-representation of minoritized ethnic individuals in forensic services. Services may have initiatives to ensure cultural adaptation where required, however, this may be a relatively small piece of work that would ordinarily not be published.

Effectiveness of Adaptations Made

Most studies involved tools, programmes, interventions, or adaptations to forensic environments, were based on previously designed tools, programmes etc., for the white majority, with aspects of it adapted to suit the ethnic group. There were few studies which appeared to be completely catered to the culture it was aiming to support and

included common aspects such as a lead facilitator from the local community or the use of the native language to illustrate a connection to the culture (Wharewera-Mika et al.;,, Florencio et al.,;, Ashdown et al.,) There appears to be an increase in strength-based approaches, aiming to support individuals collectively with a great emphasis on connections with others but also repairing familial connections. Most of the interventions included a portion that was dedicated to understanding cultural context which included trauma-informed historical education and psychoeducation to reduce self-stigmatisation. This appears to be generally based on wider cultural values to which the community strongly connect, while also using this as a foundation to set goals. Studies that reported on the effect of therapeutic environments specifically catered for the Māori community, appeared to yield the most significance. This is expected, due to the importance placed on a holistic approach, involving the adoption of a Māori way of life. Of the studies that were included in this review, three main adaptations have been the most positively received with a perceived high level of effectiveness:

- Adaptations made to language, from English to the SU's native language.
- Implementation of cultural values-based psychoeducation.
- A facilitator from the same community or cultural background. A systemic approach, involving family members at various points of the process.

Unsurprisingly there is a lack of follow-up research available which is perhaps due to the small sample numbers and lack of rationale for this research due to the novel nature of the culturally adapted approaches. This would significantly aid in supporting the positive results demonstrated in a reduction of recidivism and positive outcomes from participants, which could in turn support the implementation of such adaptations more widely and reliably.

Clinical and research implications

The current review highlights that while there have been some efforts to widen the knowledge surrounding adaptive psychological assessment tools and intervention for ethnic minorities in white-majority nations, the gap remains wide for several reasons. The studies included in this review point to how important person-centred and recovery-focused interventions are in supporting individuals from BME backgrounds.

This is in line with the evolving recovery approach adopted across the world within various models (Jacobson & Greenley, 2001), and supports the Milan Principles (Mental Health Act, 2015) and The Baron Report (2021). Within Western nations, there are differences in how services are resourced and funded however it is clear from the research that this should not be a barrier to implementation, as the most effective programmes were values-based. This was also possible by translating materials and including translated psychological terms, not just directly translated by also interpreted so an understanding within the cultural context could be made. Within Western forensic systems, it would therefore be necessary to have interventions co-produced with community leaders or with SUs themselves. This would enable careful adaptation of intervention and assessment that would be most likely to accurately support the individual, creating less room for assumptions. This would follow the aims of the Good Lives Model (Ward, Mann & Gannon 2007) as any adapted intervention would be more effective in reducing offending behaviour and providing a stronger foundation to rehabilitate.

It seems necessary to mention that the research involved in this review, mainly seems to be supported by local government funding and initiatives, due to what appears to be concerns surrounding a particular ethnic group, namely indigenous groups. This is a disappointing point, as it is not clear if this research could be commissioned without government lobbying and support. Given that there is a high disproportion of BME individuals in the forensic and justice system in White-majority countries (Davies, 2022), it is surprising that further efforts to publish culturally adapted interventions have not been encouraged. This is a barrier to its implementation, because for National Guidelines such as NICE (2017), to advocate for culturally adapted interventions and assessment procedures within FMH services in the UK, a strong evidence base is required. It was not clear from the interventions that included a local community leader, were paid staff members who were provided the same privileges as staff within the team. Conditions such as these would require funding from services, and on a large scale require Government support, which provides additional rationale for the necessity of research in this area. This systematic review provides clear evidence of this current gap in research, and makes a case for research with BME SUs to be made a priority, given structural and institutional inequalities that this group faces. As a result this group

remains marginalised, which is further encouraged by an absence for a call for necessary and urgent research. Research in this developing area is necessary for wider structural inequalities to be addressed and for policy change to be implemented, creating a fairer health economy.

Strengths and Limitations

At the time of writing, this seems to be the first systematic review of its kind exploring how forensic systems in White-majority nations adapt their psychological assessment tools and intervention programmes to support BME patients. A second strength is that the review included eleven studies from across various White majority countries. Furthermore, the review attempted to capture the differences between certain intervention adaptations and review how these findings add to the much-needed forensic landscape which has a disproportionate percentage of BME patients or prisoners. Regarding methodological rigour, this appears to have been met as a second reviewer was involved at each point of the screening process and appraisal process with 70% of studies appraised by the second reviewer.

Limitations exist of course, which would be helpful to consider when considering replication of this review in the future. The process of a systematic review is an iterative process that requires ensuring the latest research publications are included within this review. However, it is possible that while the search strategy for this study was detailed, and endeavoured to capture all relevant research, it may not have. The review did not include grey literature for example, such as government reports or unpublished doctoral theses.

Additionally, nine of the eleven studies had small sample sizes. The two with large sample sizes used either quantitative or mixed methodology to analyse their findings. However, the remaining studies used qualitative methodology and focused on SU or clinician interviews and self-reports. Therefore, researcher bias and confounding variables must be considered when interpreting the findings. Thus, the findings remain ungeneralisable. Applying these findings without heavily considering aspects of the community the adaptation aims to support, would not be advised. Except for adaptations to assessment, all adaptations made for intervention have been adapted to

the specific BME communities involved. Therefore, it is expected that much care and sensitivity towards the community in focus would be required to effectively adapt an intervention.

Furthermore, the eligibility criteria mean that only studies published in English were considered. This resulted in several studies within non-English speaking countries, were not included. Furthermore, the studies that were included were mostly from Canada and Australasia, which have different criminal justice systems. This would influence how SUs receive support. Furthermore, the search terms used, may not have captured all types of FMH BME research, due to the use of various terminology, that could have been missed

CONCLUSION

In conclusion, the current climate of research focused on adapting psychological assessment processes and interventions for FMH BME SUs is still an evolving area. Imperative to its development, future research recommendations should focus on ethnic migrant populations specifically groups which are disproportionately represented. Furthermore, case studies of adapted interventions or assessments within UK FMH BME populations should be published and disseminated. Understandably, research literature may be lacking, due to an overall recovery approach focused on person-centeredness in forensic services. Additionally considering designing a Randomised-Controlled Trial (RCT) to effectively capture effectiveness, may raise dilemmas due to small sample sizes or ethical difficulties such as holding comparison groups at Treatment as Usual, within an FMH population. As the BME population grows within White-majority countries due to increasing globalization and immigration due to conflict, the demand for adapted services will increase, calling for high-quality research to be produced.

REFERENCES

Aggarwal, N., Lam, P., Diaz, S., Cruz, A., & Lewis-Fernandez, R. (2020). Clinician perceptions of implementing the cultural formulation interview on a mixed forensic unit. *The Journal of the American Academy of Psychiatry and the Law, 48*, 216–225. https://doi.org/DOI:10.29158/JAAPL.003914-20

Ajayi (Sotubo), O. (2021). A perspective on health inequalities in BAME Communities and how to improve access to primary care. *Future Healthcare Journal*, *8*(1), 36–39. https://doi.org/10.7861/fhj.2020-0217

Arundell, L.-L., Greenwood, H., Baldwin, H., Kotas, E., Smith, S., Trojanowska, K., & Cooper, C. (2020). Advancing Mental Health Equality: A mapping review of interventions, economic evaluations and barriers and facilitators. *Systematic Reviews*, *9*(1). https://doi.org/10.1186/s13643-020-01333-6

Arundell, L.L., Barnett, P., Buckman, J. E. J., Saunders, R., & Pilling, S. (2021). The effectiveness of adapted psychological interventions for people from ethnic minority groups: A systematic review and conceptual typology. *Clinical Psychology Review*, *88*, 102063. https://doi.org/10.1016/j.cpr.2021.102063

Ashdown, J. D., Treharne, G. J., Neha, T., Dixon, B., & Aitken, C. (2018). Māori men's experiences of rehabilitation in the Moana House Therapeutic Community in Aotearoa/New Zealand: A qualitative enquiry. *International Journal of Offender Therapy and Comparative Criminology*, *63*(5), 734–751. https://doi.org/10.1177/0306624x18808675

Barnett, P., Mackay, E., Matthews, H., Gate, R., Greenwood, H., Ariyo, K., Bhui, K., Halvorsrud, K., Pilling, S., & Smith, S. (2019). Ethnic variations in compulsory detention under the Mental Health Act: A systematic review and meta-analysis of International Data. *The Lancet Psychiatry*, *6*(4), 305–317. https://doi.org/10.1016/s2215-0366(19)30027-6

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2018). Ethnic variations in pathways to and use of specialist mental health services in the UK. *British Journal of Psychiatry*, *182*(2), 105–116. https://doi.org/10.1192/bjp.182.2.105

Bignall, W. J., Jacquez, F., & Vaughn, L. M. (2015). Attributions of mental illness: An ethnically diverse community perspective. *Community Mental Health Journal*, *51*(5), 540–545. https://doi.org/10.1007/s10597-014-9820-x

Chowdhary, N., Jotheeswaran, A. T., Nadkarni, A., Hollon, S. D., King, M., Jordans, M. J., Rahman, A., Verdeli, H., Araya, R., & Patel, V. (2014). The methods and outcomes of cultural adaptations of psychological treatments for Depressive Disorders: A systematic review. *Psychological Medicine*, *44*(6), 1131–1146. https://doi.org/10.1017/s0033291713001785

Davies, M. (2022, May 27). *Chart of the week: The over-representation of black people as restricted patients in Secure Hospitals*. Nuffield Trust. https://www.nuffieldtrust.org.uk/resource/chart-of-the-week-the-over-representation-of-black-people-as-restricted-patients-in-secure-hospitals

Degnan, A., Berry, K., Crossley, N., & Edge, D. (2023). Social network characteristics of Black African and Caribbean people with psychosis in the UK. *Journal of Psychiatric Research*, *161*, 62–70. https://doi.org/10.1016/j.jpsychires.2023.03.006

De Pau, M., Vruggink, R., Vandevelde, S., & Vander Laenen, F. (2023). Culturally sensitive forensic mental healthcare for racialized people labeled as not criminally responsible: A scoping review. *International Journal of Forensic Mental Health*, 1–13. https://doi.org/10.1080/14999013.2023.2167891

Durey, A., Wynaden, D., Barr, L., & Ali, M. (2014). Improving forensic mental health care for Aboriginal Australians: Challenges and opportunities. *International Journal of Mental Health Nursing*, *23*(3), 195–202. https://doi.org/10.1111/inm.12042

Forensic Network (2019*) Principles of Structured Clinical Care - Forensic Network*. https://forensicnetwork.scot.nhs.uk/. (2019, August). https://forensicnetwork.scot.nhs.uk/wp-content/uploads/2022/03/Principles-of-Structured-Clinical-Care.pdf

Florencio, F., Healee, D., Ratahi, T., Wiki, N., & McKenna, B. (2021). Tū Tahanga: A qualitative descriptive study of a culturally adapted violence prevention programme in a Forensic Mental Health Service. *International Journal of Forensic Mental Health*, *21*(2), 185–193. https://doi.org/10.1080/14999013.2021.1953194

Halvorsrud, K., Nazroo, J., Otis, M., Brown Hajdukova, E., & Bhui, K. (2018). Ethnic inequalities and pathways to care in psychosis in England: A systematic review and meta-analysis. *BMC Medicine*, *16*(1). https://doi.org/10.1186/s12916-018-1201-9

Handtke, O., Schilgen, B., & Mösko, M. (2019). Culturally competent healthcare – a scoping review of strategies implemented in healthcare organizations and a model

of culturally competent healthcare provision. *PLOS ONE*, *14*(7). https://doi.org/10.1371/journal.pone.0219971

Health and Social Care, & Barron, D. T., Independent Forensic Mental Health Review: final report 1–19 (2021). Edinburgh; Scottish Government.

Hoffart, R., & Jones, N. A. (2017). Intimate partner violence and intergenerational trauma among indigenous women. *International Criminal Justice Review*, *28*(1), 25–44. https://doi.org/10.1177/1057567717719966

Hong, Q. N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M.-P., Griffiths, F., Nicolau, B., O'Cathain, A., Rousseau, M.-C., Vedel, I., & Pluye, P. (2018). The Mixed Methods Appraisal Tool (MMAT) version 2018 for information professionals and researchers. *Education for Information*, *34*(4), 285–291. https://doi.org/10.3233/efi-180221

Jacobson, N., & Greenley, D. (2001). What is recovery? A conceptual model and explication. *Psychiatric Services*, *52*(4), 482–485. https://doi.org/10.1176/appi.ps.52.4.482

Kirmayer, L. J., Fung, K., Rousseau, C., Lo, H. T., Menzies, P., Guzder, J., Ganesan, S., Andermann, L., & McKenzie, K. (2021). Guidelines for training in cultural psychiatry. *The Canadian Journal of Psychiatry*, *66*(2), 195–246. https://doi.org/10.1177/0706743720907505

Leamy, M., Bird, V., Boutillier, C. L., Williams, J., & Slade, M. (2011). Conceptual Framework for personal recovery in Mental Health: Systematic Review and narrative synthesis. *British Journal of Psychiatry*, *199*(6), 445–452. https://doi.org/10.1192/bjp.bp.110.083733

Lawlor, C., Johnson, S., Cole, L., & Howard, L. M. (2012). Ethnic variations in Pathways to Acute Care and compulsory detention for women experiencing a mental health crisis. *International Journal of Social Psychiatry*, *58*(1), 3–15. https://doi.org/10.1177/0020764010382369

Mental health act. Mental Welfare Commission for Scotland. (2015). https://www.mwcscot.org.uk/law-and-rights/mental-health-act#239

National Institute of Clinical Excellence (2017) Overview: Mental health of adults in contact with the criminal justice system: Guidance. NICE. https://www.nice.org.uk/guidance/ng66

Ober, C., Dingle, K., Clavarino, A., Najman, J. M., Alati, R., & Heffernan, E. B. (2013). Validating a screening tool for mental health and substance use risk in an indigenous prison population. *Drug and Alcohol Review*, *32*(6), 611–617. https://doi.org/10.1111/dar.12063

Ohtani, A., Suzuki, T., Takeuchi, H., & Uchida, H. (2015). Language barriers and access to psychiatric care: A systematic review. *Psychiatric Services*, *66*(8), 798–805. https://doi.org/10.1176/appi.ps.201400351

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2020). The Prisma 2020 statement: An updated guideline for reporting systematic reviews. *BMJ*. https://doi.org/10.1136/bmj.n71

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., & Rodgers, M. (2006, April). *Guidance on the conduct of narrative synthesis - Lancaster university*. Narrative Synthesis Guidance. https://www.lancaster.ac.uk/media/lancaster-university/content-assets/documents/fhm/dhr/chir/NSsynthesisguidanceVersion1-April2006.pdf

Rossiter, C., Power, T., Fowler, C., Jackson, D., Roche, M., & Dawson, A. (2017). "Learning to become a better man": Insights from a fathering programme for Incarcerated Indigenous Men. *Australian Journal of Social Issues*, *52*(1), 13–31. https://doi.org/10.1002/ajs4.4

Shadravan, S., & Bath, E. (2019). Invoking History and Structural Competency to Minimize Racial Bias. *Journal of the American Academy of Psychiatry and the Law, 47*(1), 2–6.

Shiva, A., Haden, S. C., & Brooks, J. (2009). Psychiatric Civil and forensic inpatient satisfaction with care: The impact of provider and recipient characteristics. *Social Psychiatry and Psychiatric Epidemiology*, *44*(11), 979–987. https://doi.org/10.1007/s00127-009-0019-3

Shefer, G., Rose, D., Nellums, L., Thornicroft, G., Henderson, C., & Evans-Lacko, S. (2013). 'Our Community Is the Worst': The influence of cultural beliefs on stigma, relationships with family and help-seeking in three ethnic communities in London. *International Journal of Social Psychiatry*, *59*(6), 535–544. https://doi.org/10.1177/0020764012443759

Shepherd, S. M., Campbell, R. E., & Ogloff, J. R. (2018). The utility of the HCR–20 in an Australian sample of forensic psychiatric patients. *Psychiatry, Psychology and Law*, *25*(2), 273–282. https://doi.org/10.1080/13218719.2017.1364676

Stewart, L. A., Hamilton, E., Wilton, G., Cousineau, C., & Varrette, S. K. (2014). The effectiveness of the TUPIQ program for Inuit sex offenders. *International Journal of Offender Therapy and Comparative Criminology*, *59*(12), 1338–1357. https://doi.org/10.1177/0306624x14536374

Strand, P. S., Vossen, J. J., & Savage, E. (2019). Culture and child attachment patterns: A behavioral systems synthesis. *Perspectives on Behavior Science*, *42*(4), 835–850. https://doi.org/10.1007/s40614-019-00220-3

Terrill, D., & Roberston, N. (2014). There's no cloud of shame on me: Māori men's experiences of prison-based psychological rehabilitation - Part II. *Psychology Aotearoa*, *6*(2), 73–79.

Ward, T., Mann, R. E., & Gannon, T. A. (2007). The good lives model of offender rehabilitation: Clinical implications. *Aggression and Violent Behavior*, *12*(1), 87–107. https://doi.org/10.1016/j.avb.2006.03.004

Wasser, T., Pollard, J., Fisk, D., & Srihari, V. (2017). First-episode psychosis and the criminal justice system: Using a sequential intercept framework to highlight risks and opportunities. *Psychiatric Services*, *68*(10), 994–996. https://doi.org/10.1176/appi.ps.201700313

Wampold, B. E., & Budge, S. L. (2012). The 2011 Leona Tyler Award Address. *The Counseling Psychologist*, *40*(4), 601–623. https://doi.org/10.1177/0011000011432709

Wampold, B. E. (2015). How important are the common factors in psychotherapy? an update. *World Psychiatry*, *14*(3), 270–277. https://doi.org/10.1002/wps.20238

Wharewera-Mika, J., Field, T., Wiki, N., Thomson, C., & McKenna, B. (2023). A description of a Māori, minimum secure, Forensic Mental Health Unit: A step toward equity. *International Journal of Forensic Mental Health*, 1–9. https://doi.org/10.1080/14999013.2023.2167892

Yasin, B., & Sturge, G. (2020, October 2). *Ethnicity and the criminal justice system: What does recent data say on ...* https://commonslibrary.parliament.uk. https://commonslibrary.parliament.uk/ethnicity-and-the-criminal-justice-system-what-does-recent-data-say/

Yuen, F. (2011). "I've never been so free in all my life": Healing through aboriginal ceremonies in prison. *Leisure/Loisir*, *35*(2), 97–113. https://doi.org/10.1080/14927713.2011.567060

Chapter 2

“A narrative analysis of recovery stories within a Scottish Forensic Mental Health Service”.

Prepared in accordance with the author requirements for the Journal of Forensic Psychology Research and Practice (https://www.tandfonline.com/action/authorSubmission?show=instructions&journalCode=wfpp21)

Plain Language Summary

Title: A narrative analysis of recovery stories within a Scottish forensic mental health service.

Background: There is a depth of understanding around the recovery approach however there is a lack of research that reflects how forensic mental health (FMH) services interpret and apply the recovery approach. Furthermore, at present, there is a gap in the research regarding the experiences and stories of FMH Service Users (SUs). The Scottish Government's Mental Health Strategy (2017-2027) strongly supports that the recovery approach should be implemented holistically, across all types of mental health services. However, principles of autonomy and choice can be challenging to apply within a forensic setting. That is because of the added responsibility FMH services have in providing security and protecting the public. Therefore, it is worth recognising how the recovery approach is applied within these settings, from the view of SUs in Scotland.

Aims and Questions:

1. What does recovery mean to forensic SUs?
2. What can we learn about the individual recovery journeys from SUs commencing the transition to the community and for those who have been discharged into the community?
3. How might this insight inform how Forensic Mental Health Services within Scotland, implement the recovery approach and how would this support the recovery of forensic SUs?

Methods:

This qualitative study used a narrative analysis approach, which recognises each participant's experience as a core story, that has been told and shared with the researcher. Participants who were either transitioning to living in the community or had been discharged took place. Interviews included open questions and remained unstructured, with minimal input from the researcher.

Emden's (1998) narrative analysis guidance was used to conduct the analysis, and Kirkpatrick's (2008) framework was adopted to break down the subplots.

Main Findings:

Personal Stories:

SUs emphasized freedom by way of discharge and acceptance of their mental health disorder, as signalling recovery.

Community Narratives:

Participants highlighted the importance of signs of respect and equality, such as autonomy in daily tasks. Most participants viewed the connections with the clinical staff as highly important to recovery. Some of the discharged participants continued to disagree with their psychiatric diagnostic label despite adhering to treatment.

Dominant Cultural Narratives:

Participants seldom spoke about the stigma they had faced, except for one participant. Participants highlighted the importance of the high quality of care delivered. Changes in approach to care over the past two decades were recognised. Furthermore, there was recognition of a lack of standardisation between hospitals within the same security level.

Conclusions:

The findings confirm the challenges FMH services have in applying the recovery approach, including the need for services to adopt standardised service delivery within the same level of security. Participants recognised and welcomed the change in approach. This study brings light to the importance of connection with staff and using the SU's definition of recovery as a suitable yardstick, to work towards.

REFERENCES

Emden, C. (1998). Conducting a narrative analysis. Collegian, 5(3), 34–39. https://doi.org/10.1016/s1322-7696(08)60299-1

Kirkpatrick, H. (2008). A Narrative Framework for Understanding Experiences of People with Severe Mental Illnesses. *Archives of Psychiatric Nursing*, *22*(2), 61–68. https://doi.org/10.1016/j.apnu.2007.12.002

Scottish Government. (2017-2027). *Mental Health and Well Being Strategy: 2017-2027*. Edinburgh. Scottish Government.

ABSTRACT

Background: Forensic Mental Health (FMH) Service Users (SUs) with complex mental health needs experience differences in their care, compared to general adult psychiatric SUs. This is due to the responsibility of the service to protect the public and provide security. The Scottish Government advocates for the recovery approach to care which aims to empower service-users. However, this can be challenging to apply within an FMH service, given the risk management procedures. Furthermore, there is a gap in understanding the unique recovery journeys FMH SUs take.

Aims: This study aimed to develop a shared understanding of what recovery means to FMH SUs who have either been discharged into the community or are transitioning to living in the community, from an inpatient ward.

Method: A narrative approach was adopted for this qualitative study, which was chosen because this approach encourages the participants to tell their stories, in their style and wording, with minimal interaction from the researcher. Six male participants were invited to take part in open unstructured interviews. The data was analysed according to Emden's (1998) narrative analysis guidance. Each core story was broken down using Kirkpatrick's (2008) "A Narrative Framework for Understanding Experiences of People with Severe Mental Illness".

Results: Participants reported that "freedom" from the service and self-acceptance of their mental health challenges were the main indicators of personal recovery (personal stories). Participants recognised the change in approach to care over the past decade, and highly valued daily gestures of autonomy, equality, and respect (community narrative). Surprisingly, only one participant discussed stigma surrounding their mental health challenges, while only half mentioned their index offence (dominant cultural narratives). These findings indicate that the application of the recovery approach is recognised by FMH SUs, however, there continue to be difficulties in translating the core recovery principles into tangible actions, because of FMH services risk management protocol. Further research must consider how other groups within FMH services experience recovery (e.g., female populations, LGBTQIA+ and BME individuals.

INTRODUCTION

The Recovery Approach in Context

Forensic Mental Health (FMH) Services are designed to rehabilitate and support "mentally disordered offenders and others who are requiring similar services" (The Baron Report, 2021) by managing risk to the public. Personal recovery is viewed as more meaningful, and lifegoal orientated than the traditional medical approach to recovery, which focuses on psychiatric symptom reduction (Senneseth, Pollak and Urheim et al., 2021). FMH SUs often have their care determined by a careful collaboration of both the criminal justice system and the healthcare system. For FMH SUs this can mean, that they are ordered by court to adhere to treatment within secure psychiatric hospitals, to reduce the risk of future offending. Thus, there exist challenges between the implementation of the recovery approach and how risk to the public is managed (Mann, Matias, & Allen, 2014). The Scottish Recovery Network (SRN) supports the recovery approach within its Strategic Plan (2021-2024). The recovery approach is defined as an encouragement of community resources resulting in every individual affected by mental illness having, the opportunity to access support at their own pace (SRN Strategic Plan 2021-2024). The plan aims for "A Scotland where people can get the right help at the right time, expect recovery, and enjoy their rights free from stigma and discrimination" (Mental Health Strategy 2017-2027, p7)

The recovery approach, therefore, supports the individual to make sense of their own needs and advocate for themselves. This differs from the directive medical approach which minimises the voice of SUs (Dorkins and Adsheard, 2011). Recovery is viewed as an ongoing journey, through which an individual continues to work towards the quality of life they hoped for, as opposed to being clinically "recovered". Research highlighting the application of the recovery approach and its impact on FMH settings is limited.

Dorkins and Adsheard (2011) suggest that the application of recovery principles within a forensic setting can be highly beneficial but difficult to apply due to the legal constraints placed on FMH SUs. They argue it is beneficial due to the trauma-inflicted lives most FMH SUs have experienced, whereby principles such as autonomy and connectedness do not have a place. Thus, the recovery approach which promotes these

values, encourages SUs to view themselves and the world around them with an increased balanced outlook (Dorkins and Adsheard, 2011).

The recovery approach attempts to balance the power clinicians naturally adopt, by respecting the concept of "personal recovery", from the SU's perspective, (Jacobson and Greenley, 2001). Slade (2009) suggests that clinical recovery, measured by clinical outcomes and symptom reduction, should not be the main goal of mental health services. Slade argued that personal recovery as opposed to clinical recovery, acknowledges the SU's personal understanding of recovery, capturing a journey of personal discovery and identity development. Jacobson and Greenley (2001) identified the 6 principles which make up this approach to care as summarised in Table 1:

Table 1. Original diagram adapted from Jacobson and Greenley, (2001). (SU= service-user)

The Recovery Principles (Jacobson & Greenley, 2001)
1. Uniqueness of the individual – This recognizes the individuality of service users and encourages clinicians to recognise how recovery is defined by the individual, when considering their care plan.
2. Real Choices - This recognises the importance of empowering SUs to make their own choices, based on their strengths and values.
3. Attitudes and rights – This involves understanding and acting on individual needs, by actively listening to SUs and their carers.
4. Dignity and Respect – This involves respecting the SUs values, beliefs and culture, while tackling discrimination within services and wider community.
5. Partnership and Communication – This recognizes that a SU is an expert in their own life, therefore working together and communicating clearly to achieve shared goals is crucial.
6. Evaluating recovery – the mental health system can use key outcomes to evaluate progress e.g.,. Housing, employment, education, social and family relationships, health and well-being.

However, stigma and discrimination can be a barrier to the application of the recovery approach. A study conducted in Scotland by Macinnes, Macpherson and Austin, (2016) found that 48.5% of FMH SUs experienced emotional abuse, 44% experienced physical abuse, 56% experienced physical neglect and 47% had experienced sexual abuse before entering the criminal justice system. This level of adversity can result in further social exclusion and lack of community integration which may affect their sense of

empowerment and ability to make choices (Dorkins and Adsheard, 2011), affecting how the recovery approach is engaged with.

Existing Research on Recovery in Forensic Settings

The CHIME Framework (Leamy, Bird, & Boutillier., 2011) is a detailed and robust synthesis of SUs' personal recovery journeys, that indicates the key components, that should underpin the approach to care within general adult psychiatric care. In line with the CHIME framework, person-centred care would involve an acknowledgement of the SU's connectedness with themselves and others. Identity is also encouraged to be considered when agreeing on specific aspects of the care plan (e.g., social network involvement, or agreement with diagnosis). McDonnaugh, Underwood and Williams (2020) conducted an Interpretive Phenomenological Analysis (IPA) on semi-structured interviews with forensic SUs, on conditional discharge in English medium secure units. They reported a decreased sense of achievement in SU's, leaving little incentive to focus on recovery. This finding supports the aims of the CHIME-Secure framework (Senneseth et al., 2021) which recognises six recovery processes as opposed to the original CHIME (Connectedness, Hope, Identity, Meaning-Making, Empowerment, and Safety) framework (Leamy et al., 2011). This includes hope which if present for the SU would encourage the person through the recovery process. However, due to the restrictions placed by the criminal justice system and risk management policy, achieving Connectedness, Hope, Identity, Meaning-Making, Empowerment, Safety and Security (CHIME-S) may be complicated. The present study supports the application of CHIME-S, by enhancing the voice of SUs.

Within Scotland specifically, there are limited publications regarding the meaning of recovery within FMH settings. One Scottish study by Cooney, Tansey, and Quayle (2020) used a grounded theory approach. They found that for participants the "sense of self appears to be fragile and there is uncertainty regarding the self and how they fit in the world around them" (Cooney et al., 2020; p. 56). This study supports the findings of Adshead, Ferrite and Bose (2015), who argued that participants' sense of acceptance of their index offence and their mental health diagnosis was vital for active recovery journeys.

However, these studies, do not consider the personal stories of SUs, which play a substantial part in their understanding of themselves and how services may decide to support them. Frank (1995) argues that society can constrict which stories it is willing to accept about groups of people, especially those without the same legal rights. Mental illness itself and the oppression suffered because of it, can severely dampen the voice of SUs. Voicing their stories, using a narrative approach, can begin to empower SUs with the potential to improve the knowledge clinicians hold about dominant cultural narratives that impact SU's approach to recovery.

Narrative Methodology

The narrative approach is a qualitative methodology which allows for discussion and development of understanding, within wider contextual, cultural, social, and historical layers, by focusing on facilitating individual accounts of experiences (Kirkpatrick, 2008). Other forms of qualitative methodology, may have been appropriate however only the narrative approach, allows for careful consideration of cultural and wider contextual issues (Sutherland., 2018). The narrative approach can provide richness and help develop links or contradictions within participants' stories (Squire, Andrews and Tamboukou, 2008), considering the direct positionality of the researcher. Squire et al., (2008) state that the approach, is based on the natural tendency for human beings to make sense of and give meaning to their lives, through storytelling. How a story is interpreted by the listener can greatly depend on the listener's own story. Thus, the narrative approach places a strong emphasis on reflexivity, encouraging the reader to be open to their reflexive processes (Kirkpatrick, 2008).

Current research on understanding recovery within forensic populations (Bengston, Lund & Langstrom 2019; Warner, Glazier, & Lane 2021), appears to rely upon quantitative analysis of reoffending rates or remission of symptoms. Therefore, risk management methods may not take into consideration important aspects of SU experience, as this is not supported by the current evidence base. This constrains how recovery is researched and how findings are applied to government policy and FMH practice, in line with traditional models of recovery. Adopting a narrative approach to understand how SUs make sense of their recovery journey, provides new insights (Squire, Andrews Tamboukou, 2008). The approach values how the story is told,

structured, and communicated by whom and for whom, to add value to the content of the story. The narrative approach recognises different and contradictory meanings of stories to understand the individual and the adversity they have faced within the context of social change. This provides FMH Services within Scotland the opportunity to consider factors that may impact SUs' experience of the system, increasing opportunities for developing recovery-focused care in FMH settings.

Aims and Research Questions

This study aimed to develop a shared understanding of what recovery means to forensic SUs as, due to the additional restriction of choice placed on their care, this may vary from the general mental health SU population. The secondary aim is to understand individual journeys towards recovery from a SU perspective and ways in which these may mediate the recovery process.

1. What does recovery mean to SUs of FMHSs?

2. What can we learn about the individual recovery journeys of SUs commencing the transition to the community and for those who have been discharged into the community?

3. How might this insight inform how FMHSs within Scotland, implement the recovery approach and how would this support the recovery of forensic SUs?

METHOD

Design

This study adopted a qualitative design, using Emden's (1998) narrative approach to data collection and analysis. This consisted of unstructured interviews, that varied in length and was led by the participant. The design was inspired and influenced by

Sutherland's (2018) narrative study, which analysed the stories of SUs of an English low-secure FMH. All interviews were recorded using a Dictaphone and were manually transcribed. The interviews were supported by an interview prompt sheet, which contained the main open question of the interview. Following Emden's guidance, the interviewer attempted not to have any effect on the flow of the story or its delivery. Throughout this process, the researcher kept a reflective diary to remain transparent of the researchers' values and storied themes that may interact with the research process.

The stories told were broken down using Kirkpatrick's (2008) "A Narrative Framework for Understanding Experiences of People with Severe Mental Illness". This framework adequately allowed for stories to be heard, that refer to a SU's understanding of their mental health challenges. Subplots can be compared to themes emerging from the data. However, subplots differ from themes, as they account for the wider context surrounding the SU such as cultural differences or social status. These are separated into three categories: Personal stories, community narratives and dominant cultural narratives. A sub-category is counterstories. Personal stories are subplots that are individual to the participant and are not shared across the sample. Community narratives are subplots which are shared across the sample, with a similar essence and purpose. Dominant cultural narratives are recognised as overarching, culturally constructed ideas, often recognised as stereotypes (e.g., single parents, benefit claimant, etc.,) that help to bring about a general understanding of an individual's position in society. Counterstories, which can be found in all three categories however are the stories that do not fit within the general subplots, as noticed by the researcher, often recognised through deep reflexivity (i.e., subplots that provide an unexpected alternative perspective). Thus, a narrative approach can empower the storyteller (Rappaport, 1995), and potentially provide an alternative lens to their experience.

Participants & Recruitment

The FMH Service from which participants were recruited, consists of a low secure inpatient unit, a rehabilitation ward, and a Forensic Community Mental Health Team (fCMHT).

Inclusion Criteria:

- Aged 18 years and over.
- Have lived in the community or inpatients that have commenced transition back into the community, who have been allocated with overnight passes.
- SUs, who at the time of admission, had a formal mental health diagnosis and were held under the Mental Health (Care and Treatment) (Scotland) Act 2003.
- Have provided informed consent to participate.

Exclusion Criteria:

- Non-proficiency in spoken English.
- Have been under acute mental distress or mentally unwell that resulted in impairment of meaningful participation. This was determined by the MDT.
- Have had an assessment or psychological intervention with the researcher at the point of recruitment.

Four of the participants had a psychosis-related diagnosis and two had a diagnosis of bipolar disorder. All six participants were on overnight passes living in the community. One participant was transitioning into the community currently on one overnight pass. A purposive sampling technique was used to identify participants. The researcher liaised with the field supervisor on attending team meetings, where information posters and participant information leaflets were distributed. Interest in the study was determined by the potential participant being contacted by their key worker or forensic Community Practitioner Nurse (fCPN) for an initial conversation about participating in the study. Those who were interested in participating were provided with the research study advert, an invitation letter, a consent form, and a study information sheet. This outlined the study's aims, procedures and right for participants to withdraw. A telephone discussion with the researcher was then arranged. The discussion with the researcher was a chance to explain the study and respond to questions. Each participant was provided three days to make an informed decision. If the participant consented to the research interview, the MDT was notified, and the interview was arranged to be in person at the service base. Before the interview took place, the participant's "right to withdraw" was reiterated and informed written consent was obtained.

Materials

In line with the narrative approach, the interviews followed an unstructured format with an open question. The researcher created and used an "interview prompts" sheet including a brief format for the introduction, consent signing stage before the interview commenced, and ending the interviews. The interviews were manually transcribed in turn using Microsoft Word. Narrative analysis was conducted manually using Microsoft Word to complete the analysis. The researcher kept a carefully maintained reflective diary log throughout the interview and research process to maintain a level of reflexivity. *(Refer to Appendix F for the interview prompt sheet and Appendix M for the reflective diary log.)*

Research procedure

The six participants were asked to share their recovery journey during a face-to-face interview at the service base, which is where all participants would routinely visit for medical reviews or Occupational Therapy sessions. Interviews ranged from 21 minutes to 1 hour and 27 mins. Mishler (1995) recognised how the rapport between researcher and participant could affect the way the story is told, affecting how the narrative is drawn out. Therefore, minimal participation from the researcher is crucial (Mishler, 1995). In order to maintain the autonomy of the participant, which is highly important within narrative methodology (Emden, 1998), one main open question was asked (Refer to Appendix F for interview prompt sheet). Additionally the participant was informed about the importance of hearing their story in their words during the pre-interview discussion, which was additionally covered in the 'Participant Information' sheet. The pre-interview discussion also provided an important opportunity to build natural rapport between the researcher and the participant. The participants were asked to share their story, in their own words, and were encouraged to only share what they wished to, and start their story where they felt it should. During the interview, the researcher prompted the participant if this was necessary to encourage the story to centre on recovery, aiming to minimise the way the interview naturally progressed.

Data Analysis

The narrative analysis was guided by Emden's (1998) method to identify core stories. Core stories were then analysed using Kirkpatrick's framework. Subplots, from the core stories were identified. Using Kirkpatrick's framework, the subplots were categorised into the corresponding level of narrative e.g., personal stories, community narratives, dominant cultural narratives. The subplots were examined to recognise which stories were shared amongst all participants, and those that differ from the stories of other participants. Kirkpatrick's framework was referred to again, to recognise which narrative category the shared subplots and differing subplots fell into. This highlighted counterstories and the different levels of narratives that exist within the data set. The reflective notes kept by the researcher aided recognition of any influence the researcher may have had on how the story was interpreted, constructed, and delivered. The analysis plan was in keeping with Emden's guidance (1998) which states the eight steps involved in conducting narrative analysis. This was followed accordingly to ensure quality and adherence to the method. A peer reviewer checked that each stage of Emden's guidance was followed throughout the analysis process which involved analysing a sample of transcripts with a follow-up discussion around the developed core story. Additionally, the researcher held a reflective practice session with a qualitative researcher, independent from the project to credibility check emergent themes and narratives. *(Refer to Appendix K for an example excerpt of the narrative analysis table.)*

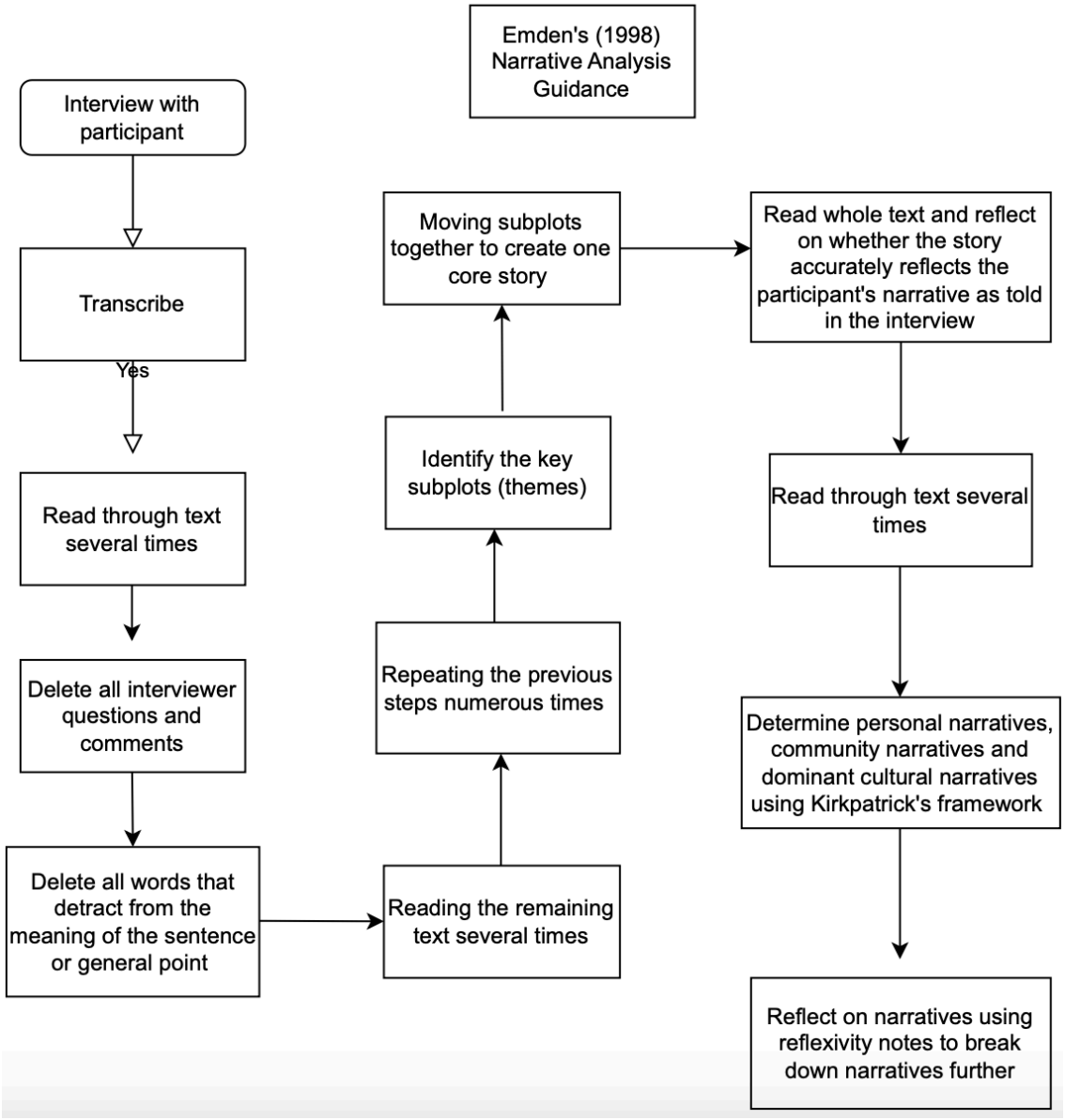


Figure 1. Flow diagram depicting the steps taken following Emden's (1998) Narrative Analysis guidance.

Researcher's Positionality

As part of the narrative approach, there is vital importance set on the biases the researcher may hold about the research population and how the story told, could be

interpreted as a result. At the time of data collection, the researcher was a Trainee Clinical Psychologist, on clinical placement in the service. It has been important to reflect on the researcher's clinical position to provide support through a trauma-informed lens, which means there is likely a bias towards the recovery approach. The researcher holds a social-constructionist view that mental illness and the experience of inequality within society, have developed and are supported by the gap between the poor and wealthy.

Ethics

Ethical approval was granted on 2nd May 2023 *(refer to Appendices I and J for approval confirmation from the Research Ethics Committee (REC) and local NHS ethical approval)*. When considering risk management for either the researcher or the participants, interviews took place on-site, and local NHS risk management protocols were followed. Each participant engaged in a staged consent process, which provided three opportunities for the participant to withdraw consent (before, during and after the research interview). The interviews were recorded on an encrypted Dictaphone and transcripts were stored on an encrypted and password-protected NHS laptop. The data was stored on this device and on completion of the study, the data was deleted. During each phase of the study, only the researcher had access to the data collected. Once data had been transcribed and analysed, all recordings were removed and deleted. Responsibility for the data will be transferred to the University for Longer-term Storage in line with university and NHS requirements. All participants' personal and identifiable information was omitted from the transcripts, and the data analysis and final findings were produced, in line with GDPR requirements, the University of Glasgow and NHS confidentiality guidelines. Any identifiable information in the direct quotes from interviews used in the final production of the report were removed. Furthermore, participants were allocated a suitable pseudonym to protect their confidentiality.

RESULTS

Following the narrative analysis approach outlined by Emden's guidance, adopting Kirkpatrick's "A Narrative Framework for Understanding Experiences of People with Severe Mental Illness", the domains are split between personal stories, community narratives and dominant culture narratives. The results have been presented in line with how Kirkpatrick determines each subplot within each story. The participants included in this study have been provided with pseudonyms to protect their identity, and any identifiable information has been replaced with "XXXX".

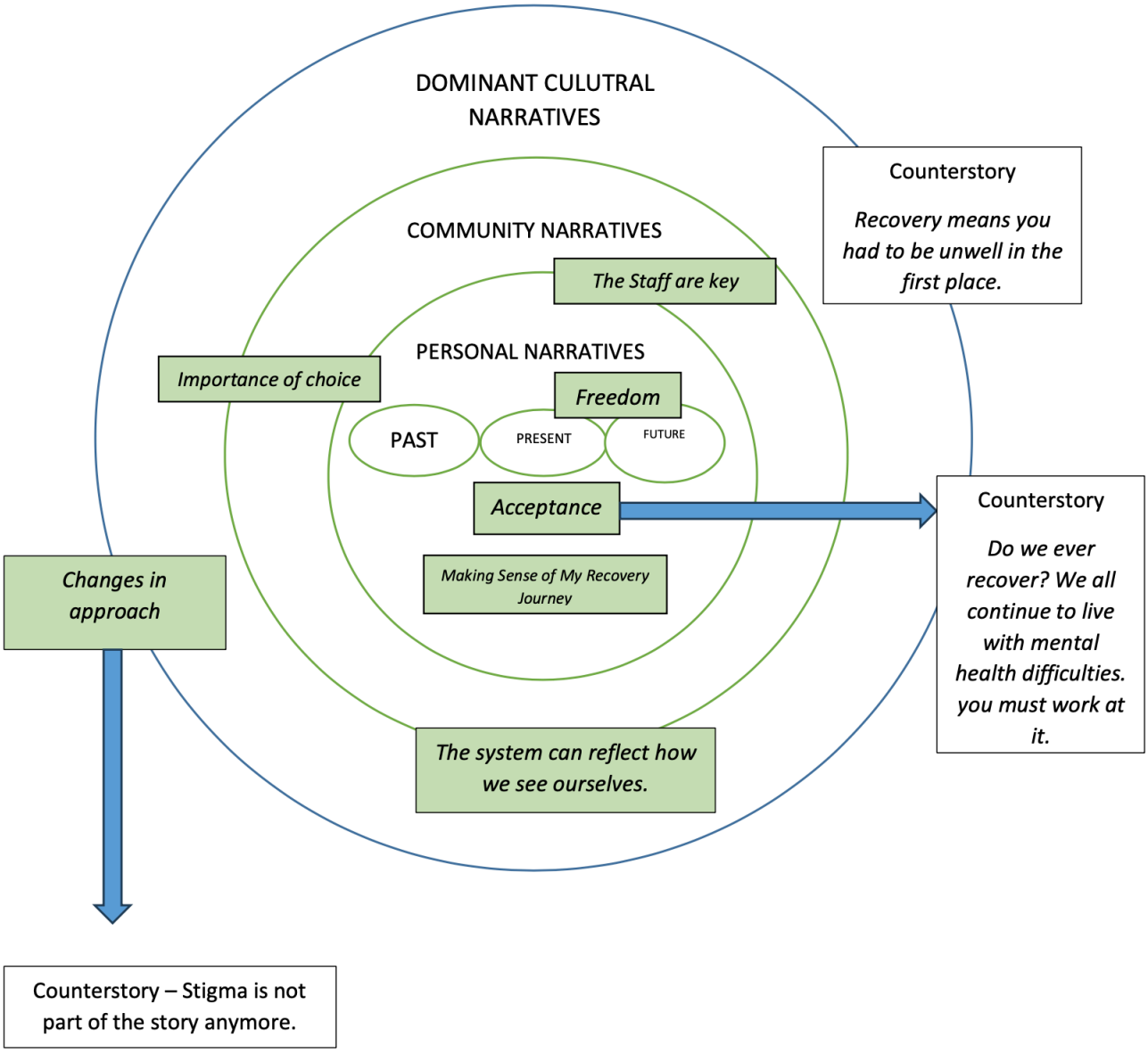


Figure 2. A visual representation of the results curated following Kirkpatrick's (2008) guidance and Sutherland (2018).

Key: Subplots (green boxes); Counter stories (white boxes); Derived counter stories from subplots (Blue arrows)

Personal stories of recovery

Subplot - Making sense of my recovery journey

Each participant narrated their journey of recovery providing reflections on helpful and unhelpful aspects of their care at the beginning of their journey. The precipitating factors leading up to their first admission were not discussed. This was unexpected, due to how a story would typically be narrated, starting with when the individual's mental health may have begun deteriorating. This highlighted the expectations and norms held about the format a person should generally utilise to narrate their story.

Three of the participants reflected on how drugs or alcohol had a place in their story and how this impacted their care. This was expected to be discussed, due to the frequency by which forensic patients commonly had a history with substance misuse leading up to their index offence. For example, John and Matthew reflected:

"I used to take too much drugs." (John)

"I would stay away from me family and then take my drugs. I was getting out of control". (Matthew)

For Billy, mental health services provided an opportunity to break the relationship with alcohol.

"That's another good thing about XXX and these kinda services. They didn't allow me alcohol. Thank God, what a change in my life I've had…"

Two participants spoke about the role of medication in their journey, with reflections about how the medication was viewed by the system and concerns around its effects, on their personality. Marlon stated:

"I couldn't perform, I couldn't sit here and have with this conversation with you, I was lethargic all the time" (Marlon)

Matthew felt positive towards his journey with medication:

"I'll keep to my meds as long as it needs to be, cos I don't get any horrible side effects, I don't really you know, that why I'll make sure to take my medication you know." (Matthew)

Three of the six participants reflected on the role of the offence in their recovery journey. For Kenny, the offence was the result of his attempt to cope with hearing voices, which he felt was not well understood at the time of sentencing by the legal system.

"I cannae remember, driving half the time, sometimes the voices were really bad, and getting in a motor used to take them away, so it's what I always done." (Kenny)

Billy reflected on the remorse he feels for the index offence and indicated that the hospital was a time for him to reflect on this historical point of the journey.

"…But I think they [the staff] preferred it if I was thinking about my index offence. I'm so sorry about it all… it wasn't justified really, however, that's all done and dusted now". (Billy)

John expressed how grateful he was to receive the support, he felt was necessary. His statement also reflects his recognition that the forensic service had the resources to help him more effectively.

"I am not glad of the offence, but I am glad of where I ended up because of the help, I would have ended up dead cos I was going crazy, really crazy, losing my head." (John)

Subplot - Freedom and Acceptance

Three participants fundamentally disagreed with their mental health diagnosis as they did not believe they were suffering from a mental health disorder. As a result, this meant freedom marked by being back in the community was the main goal of

complying with treatment and could be understood as their personal understanding of recovery. For example, Billy stated:

"Recovery means freedom for me, getting back to normal again I suppose, I never really… I still don't know as if I was ill in the first place however the Doctor knows about me, my opinion." (Billy)

For one participant recovery was defined by acceptance of their mental health difficulties, and learning to live with the symptoms as best they can. Kenny stated:

"I think I've just started to realise that it's not going to get any better and you accept it, the life you've got the now, and try and make the best of it cos you cannae keep chasing rainbows." (Kenny)

Whereas for John, recovery was defined by his length of stay in hospital, psychiatric symptom reduction and perception of his ability to cope with his circumstances.

"My recovery had been fairly quick compared to some of the people in here, I have heard of horror stories of some people being in for years. I was here for 4 and a half months…" (John)

Participants discussed the role of clinicians and the trust they have placed in them to care for them which appears to provide them hope of moving forward. For example, Billy reflected:

"The doctor was very good with me like you know, he seen that I wanted to get on, go through the system and behave myself and cooperate and so he reciprocated like you know and he allowed me a great deal of freedoms." (Billy)

"The journey with the psychology, the journey, through my childhood, made me unwell. The journey through the hospital made me well, like through a nervous breakdown. The

journey with psychology, with yous guys, I'm well, the only way I can understand you, perform, is if I'm well. You cannae, work with somebody who's not on medication, it does nae work!" (Marlon)

John felt that understanding himself and recognising the life he wanted to return to, provided him with the hope and motivation to continue moving through his recovery journey.

"If you don't have a passion in your life, or aren't driven, you don't have anything, you just exist. It's like being in a car, not going anywhere, it's like you are staying still." (John)

Counterstory – Do we ever recover?

Marlon, Matthew and Brian highlighted that mental health difficulties can continue even with freedom and acceptance, which is a core principle within the recovery approach.

"My recovery process is ongoing. I has a manic episode, nervous breakdown. Mine's was quite severe. It took me 18 months, to totally be clear of that problem, then what I have unearthed is the next problem, the problem that got me there in the first place, the systemic problem that I can't recover from." (Marlon)

"I am not mentally ill, she's my doctor, we tend to disagree about mental health. Mental health… I never have been. Survive in the community so am not mentally ill, I told her to prove it. I didn't have to prove to anybody." (Brian)

"I don't think there was a change [in my beliefs]. I did nae benefit from any of that." (Matthew)

Community narratives

Subplot - The system can reflect how we see ourselves

How participants viewed their recovery and their identity appeared to be shaped by the way the environment is designed to encourage rehabilitation. Three participants viewed themselves as needing support with their mental health, however, the other three participants did not recognise the mental health diagnosis.

Billy highlighted the importance of food in the hospitals and expressed this as an effective way to directly affect behaviour on the ward.

"I found that if I eat a lot, the people roundabout me are eating a lot, you tend to sit around and digest it. They are not… gonnae be hyperactive and noisy. I really appreciated the freedoms you get, being able to go down, have your own cup of tea, in your own cup, a ceramic cup." (Billy)

Subplot - The importance of choice

Billy recalled a specific conversation with a family member that stayed with him. A loved one highlighting certain aspects of his current situation led Billy to accept that the journey he is on, would eventually lead him to a life where he could claim back his identity and have choice again.

"And she took hold of my hand and she leaned forward, and said ' Billy take everything that God has given you and you enjoy it, you have got food, you have got clothes, money, CDs, you don't have a wife on the outside anymore, your children are scattered, you don't have a house. Relax. Just take everything as it comes and enjoy the experience' … And I took that on, once I thought yeah okay, that helped, that was a big part of it for me ." (Billy)

For Marlon, he was aware of the power that the hospital and the criminal justice system held in making decisions about his care.

"End of the day, I am here under order. The courts are involved because of my situation, I totally get that, for me to be well. But for me to get well, I can sit here all day and listen all day but if I don't wanna change, I will nae. What I tactically did was make moves." (Marlon)

It was interesting that despite guidance suggesting he connect with the local community as a way of coping with mental health challenges, Brian felt this was not relevant to him.

"I keep my distance between my neighbours. I think that's how I survive… I have lasted long in the community, only reason why is because I have had to work at it. " (Brian)

Counter story – lack of homogeneity between levels of security

Billy highlighted that he had experienced several low-security services across the country. He found that the same level of security varied depending on the approach the staff took and the resources available.

"I like a bit of countryside round about me. So, the idea of coming into (a low-security hospital) I wasn't happy about it. And so when I did eventually arrive in (low-security hospital) it was completely … it was far more like (high-security hospital)."(Billy)

Dominant cultural narratives

Subplot – The staff are key

There was a consensus across the interviews that the current low secure service provided high-quality care. Those participants who had received care over many decades had noticed the change in approach to care.

"The workers, I don't know how they do that, I take my hat off to them, I cannae bow down anymore. You have no idea, what they put themselves through for, for me, it's unbelievable."(Marlon)

It seems the staff were approachable and provided an opportunity for Marlon to reflect on himself.

"Say, I did really well, I had all these people to talk to. All these patients and all these staff changes to routines, must get on with it, I could explain it myself." (Marlon)

Brian and John, both agreed that the staff were invaluable. John further reflected that the staff provided a strong contribution to his recovery which he considers quick due to his quick discharge from the hospital.

"More than contributed, some of the guys in here don't realise how lucky they are, they don't, they don't realise, treat some of the staff… you don't realise how where you are, could be in a place a million times worse."(John)

"Staff in here are delights…" (Brian)

Kenny understood that where he felt staff took time to listen to his experiences and hear his voice, he felt most understood and cared for.

"That's worth all the suffering for 2 hours or 3 hours without it.
So, the 20/21 hours of suffering, if you get 3 hours or 4 hours without it because somebody is sitting and listening to you that's worth it. I don't like reading stuff through books, I like to see what's happening, and how it's happening. Don't get me wrong, I'm not shaming it or saying it's bad, but does nae solve anything."(Kenny)

Subplot – Change in approach

Billy felt the environment in a previous service, communicated to him that those who are unwell and have been labelled “at risk to others”, do not deserve to experience the world the way the rest of society does.

“The windows in the hospital weren’t that conducive to happiness, they were quite high up. You can get up and move to other windows and see them. You can notice more the seasons going by and doors. You’re looking at the world through the windows.” (Billy)

Kenny appeared to feel disheartened by the changes in approach to mental health in the last decade. Kenny felt that if that change in approach had happened earlier, his journey may have been quite different.

“*The court saw it as you’re breaking the law. Naebody had any scope for mental health back then…” (Kenny)*

Counterstory – Stigma is not part of the story.

The lack of discussion surrounding stigma is a counterstory because it goes against the expectations of the researcher’s position and understanding of mental health. It was surprising Kenny was the only participant who reflected on the stigma experienced by society around mental health.

Kenny went on to describe how he feels people must view mental health difficulties as something to be fearful of. There was a sense of frustration towards individuals who have not experienced mental health difficulties, led by thinking of society as us (those with mental health difficulties) and them (those without).

“Still some people that are not interested if you suffer from mental health or not, they’re a lot of people that are scared of mental health because they don’t know how to deal with you, but at the end of the day, it’s not your fault and mental health does nae take any prisoners. It’s not a nice, some people are lucky that they don’t experience it but other people are not so lucky.” (Kenny)

Kenny reflected on his own difficulty in understanding his mental health difficulties. This indicated a sense of self-stigmatisation because of a lack of understanding in his own presentation.

"To be honest, it's not easy for people with mental health to understand why they've got it either, or why they're different from everybody else."

Counter story – Recovery means you had to be unwell first

Kenny highlighted that recovery is only possible if you have something to recover from. He highlights the irony of the juxtaposition that SUs may feel being labelled as mentally ill, while clinicians begin focusing on how they will recover from this.

"I know it sounds funny but you wouldn't recover if you didn't have them." (Kenny)

Marlon felt he did not understand the diagnosis in respect to his experience:

"I don't really relate to this bipolar diagnosis to be honest with you. I don't really get it." (Marlon)

DISCUSSION

The study aimed to recognise and understand the recovery journeys in the form of stories using a narrative approach, of participants who are currently part of the FMH service either living in the community or currently transitioning to living in the community. The study aimed to discover what contributes to recovery journeys and how the meaning of recovery may differ between individuals. This research supported the findings of a similar study, carried out in England by Sutherland (2018).

The Meaning of Recovery to Scotland's FMH Service-Users

The stories developed through the narrative approach allowed for interesting findings to be drawn, bringing attention to similarities and differences between each participant's narratives. Fitting with the research (Adshead et al., 2015; Cooney et al., 2020) acceptance of their diagnosis and environment led to a development of hope in their recovery journey. Interestingly there were differences in how personal recovery was understood. Some participants felt the diagnosis was not fitting with their understanding of themselves. Others felt the diagnosis was helpful to receive the support they needed to recover. Another aspect of the narratives which differed was the role the index offence plays in their journey. Some participants did not mention what the offence was; whereas others felt the offence was not related to their mental health directly. This raises questions about how recovery is viewed by the SU who does not agree with the diagnostic label provided or how the index offence may have been impacted by their mental health disorder. This leads to a question of how SUs genuinely respond to their treatment and the lack of choice they may feel about their care. This finding confirms that services may have to delicately consider the language used surrounding how the nature of index offence is discussed about their mental health.

Another interesting finding was the high value SUs place on daily gestures of equality and respect. Most participants in this study came from low socioeconomic backgrounds and may have been homeless at a stage in their journey. Hospitals where attractive food options were offered, provided a basis for participants to feel stimulated and cared for by their environment. Furthermore, if the food offered was viewed as good quality, it added further confirmation to how some participants negatively viewed themselves. This is further supported by participants describing the impact of good quality utensils and large windows. These "small" aspects of care, remind SUs that they are respected and trusted, helping them to treasure themselves and feel motivated to continue working towards the quality of life they hope for.

In summary, the meaning of recovery is highly personal to the SU. However, co-producing services and initiatives with SUs appears to be an effective method of ensuring the recovery approach continues to be applied. Co-production allows services to consider aspects of their experience, often taken for granted (Markham, 2021).

Transitioning vs. Discharged from FMH Inpatient Services

Participants spoke highly of the connections made with the service and its clinicians and how this profoundly shaped their journey. This fits with previous findings (Sutherland, 2018; Chandley and Rouski, 2014). Participants felt their clinical team was key to how their journey continued. This community-level narrative demonstrates how the service provided the foundation for which their recovery is built, and how their identity within the system is formed. Accepting the view of the team, often supported their recovery journey, resulting in freedom from the system. When discharged into the community, the freedom provided a shift in how they view themselves. Participants reported recognition of themselves as independent and responsible individuals, which was a significant part of their recovery.

Dominant cultural narratives pointed to the change in approach to care, that participants who had been part of the service for over a decade, could recognise. Participants reported an overall improvement in a holistic, compassionate approach to recovery. This is supported culturally, by the increased awareness driven by universal media. This may have led to wider cultural acceptance surrounding mental health difficulties. This is further supported by the Scottish Government's Mental Health and Wellbeing Strategy (2017-2027), which promotes increased support to reduce discrimination and stigma, with further emphasis on implementing a trauma-informed "Whole System Approach". Participants who reported awareness of the change in approach to care tended to be those who had been discharged and had lived in the community for over 12 months. This fact may indicate that they have had time away from the service to reflect on their experience and develop this insight. However, a counter story identified is that despite the overall systemic changes, a participant highlighted that there were noticeable differences in approach between the hospitals within the same level of security. The Barron Report (2021) addresses this by suggesting a Forensic Mental Health Board, independent from general health boards in Scotland. Separation of FMH services would hopefully result in standardisation across services of the same level of security.

A counter story present within the data, is the lack of discussion and stigma surrounding the offence, despite all participants either transitioning into the community or now discharged. When discussed by participants, it was hastily discussed as part of the beginning of their journey. This may highlight the continued marginalisation and stigma held around committing the offence, despite the positive developments in political acceptance and approach to mental health. Furthermore, it is interesting that most participants did not discuss their social background or the system within which the offence may have occurred e.g., gang-related violence or homelessness. This may have been due to the interview taking place within NHS grounds by an NHS member of staff, who may be seen as not understanding of that set of circumstances or someone to whom a desirable image should be presented. However, this may also indicate, that the participants in this study, no longer related to their previous circumstances, having made changes to their lifestyle and associations while living in the community.

Implementation of the Recovery Approach

The current research indicates SUs can recognise the differences in their care, following the implementation of recovery approach principles. Furthermore, the response SUs receive from the clinicians and staff within the system is what supports SUs to feel heard and accepted in society despite their forensic history or mental health.

Furthermore, the current research highlights how SUs recognising that they are experts in their own care is an important aspect of their recovery, as this seems to encourage self-empowerment, autonomy, and responsibility. However, Forensic SUs appear to have difficulty in developing their identity away from their mental health journey and their recovery. For the participants in this study, their daily routine and weekly activities were intertwined with the service, with little mention of personal hobbies or interests. In line with CHIME-S research, it would be important to consider how to increase opportunities for forensic SUs to connect with their identity (Senneseth, et al., 2021). This may be encouraged by providing further opportunities to make choices in their care and the environment, for example currently location is carefully considered by housing officers, in collaboration with SUs. Continuing to find opportunities within

the current system to provide choice and autonomy, will ensure the recovery approach continues to be applied as systems move forward.

Furthermore, conversations around self-acceptance and self-stigmatisation do not only need to remain the parameter of psychological work. These types of discussions would thrive more effectively within several conversations with various members of staff. Half the participants did not discuss their offence, which may indicate a lack of self-acceptance around this. This may be caused by stigma or trauma surrounding the offence. Frequent discussions could promote an overall culture of acceptance and break the taboo around the cultural stigmatisation of serious mental illness and offending.

Another clinical implication is the environment in which SUs feel the most empowered (McDonnaugh et al., 2020). Ward environments with flatter hierarchy and regular gestures of equality and respect are enthusiastically received. For example, good quality food and the development of genuine connections with staff. Deeper development of this would enable more empowered conversations between the SU and staff around their own definition of recovery. Services may have to use the SU's definition as a yardstick for recovery milestones as opposed to set parameters. Additionally, recovery has been viewed as more successful if supported by friends and family. However, it is worth considering the language used around this. SUs who wish to not involve their family may be viewed as disengaging from their recovery. It is recognised within addiction and forensic services that family and friends may be a negative influence on a patient's recovery (Rowaert, De Pau & De Meyer et al., 2022).

Strengths and limitations

This study has focused on a small and developing area of forensic research, aiming to capture narrative recovery stories from FMH SUs. The study has merit in attempting to capture recovery stories, authentically, attempting to preserve the story as it was told to conduct analysis. The narrative approach has merits in highlighting the voice of SUs, carefully considering the cultural and political context surrounding how stories of perceived oppressed individuals are heard and used to educate healthcare providers.

Additionally, this approach holds a unique strength in allowing the researcher to capture stories that were not told, including this as part of the analysis.

There are limitations to this study. The first being that the recruitment for the study was based on recommendations from the MDT, of who would be suitable for the study with the purpose being to discuss recovery journeys. This meant that those contacted may have been considered because they were positively viewed as SUs who would engage. Therefore, there may be a bias surrounding the types of recovery stories provided. The community participants may have felt that due to being contacted about participating in the study, they should provide a positive view of their experience.

Furthermore, the narrative approach, had positive intentions to highlight unheard recovery stories of SUs with the following assumptions in mind. Firstly, that the participants interviewed would find this a rewarding positive interaction, in which their story could be told in their words. However for some participants, this may have been quite challenging given NHS clinicians ordinarily hold more power. Therefore, the researcher may have perceived the power dynamics to be in favour of the participant, however this cannot be accurately determined. Self-perception of recovery stage would have had further impact of how this was perceived. Secondly, despite the interview adopting an unstructured, open question interview, the topic and motivation for the discussion, lay within the discretion of the researcher. Therefore the participant may have found this confusing to navigate, when asked about a topic from the viewpoint of a researcher and not a clinician. These aspects of the interview place the participants within a juxta positionality. As a consequence, participants may have been reticent to expose their authentic selves. Evidence of this is recognised by the way participants seldom mentioned stigma or their own identity outside of the system, such as personal hobbies or interests. Therefore the stories of SUs in the present research may have been biased towards how the participant wished to be perceived by the audience (NHS researcher).

A further limitation was that no women were recruited despite the service including a small proportion of female service-users. Female participants were asked to participate however declined on this occasion. Barriers to female participant recruitment must be

considered carefully. It is necessary to replicate this research with a female population, to capture and recognise narratives between male and female recovery stories. Additionally, any question of bias was highly reflected upon to ensure stories curated were limited in bias held by the researcher. For example, it was evident that contradictory narratives were identified. On the one hand, discharge and freedom from the inpatient service was viewed as a clear indicator of recovery. However, on the other hand, NHS services were considered highly and seen to provide effective support. This contradiction may have been the result of the interview taking place on an NHS site, by a researcher employed by the service. Therefore, due to association this could have limited participants' willingness to be honest and open about how they viewed their care, providing contrasting messages.

Future Research

Future narrative research should consider ways in which autonomy, a key proponent of narrative analysis could be ensured. For example, selecting a neutral location for the interview to take place, such as a community centre for discharged participants. Furthermore, future research should focus on considering creative ways to encourage participants to share their story, which can be an alien process. Meeting a participant on more than one occasion may be helpful, to encourage an authentic retelling, as trust between the researcher and participant could develop during the first interview session. The role of the participant and researcher could then be established to encourage the most fitting dynamic for the narrative approach.

Further research considerations would be important to explore. A replication of this study with a female participant group as already mentioned would be highly important. There is a significant proportion of FMH service users who are from diverse and minoritized groups (e.g., LGBTQIA+ or Black and Ethnic Minority groups). Therefore, it would be crucial to consider how journeys between different identifying groups potentially, may vary. Furthermore, it would be important to recognise the recovery stories of those in high and medium security, with potential follow-up once the patient has entered low-security services.

CONCLUSION

This narrative study demonstrates the sensitive intricacies of the FMH system. Furthermore, this study provides further evidence of how a sense of identity and choice is key to the way a SU and the system around them, view their "successful" recovery. "Freedom" from the service and "acceptance" of their mental health challenges were reported by participants as the main indicators of recovery. Discharged SU participants felt the clinical team was key to their ongoing management of their recovery journey. However ambivalent messages suggested tactfully working with the system to strike a balance between their own lives and life attached to the service. This study also pointed to the importance of extending frank and open conversations outside of psychological intervention or psychiatric reviews. The wider system continues to hold power in ways that may be unapparent to staff and can only be understood if one were a SU themselves. Thus, this study provides advocation for trauma-informed co-produced services that honour lived experience.

REFERENCES

Adshead, G., Ferrito, M., & Bose, S. (2015). Recovery after homicide: Narrative shifts in therapy with homicide perpetrators. Criminal Justice and Behaviour, 42(1), 70-81.

Bengtson, S., Lund, J., Ibsen, M. and Långström, N., 2019. Long-Term Violent Reoffending Following Forensic Psychiatric Treatment: Comparing Forensic Psychiatric Examinees and General Offender Controls. *Frontiers in Psychiatry*, 10.

Chandley, M., & Rouski, M. (2014). Recovery, turning points and forensics: Views from the ward in an English high secure facility. *Mental Health and Social Inclusion*, *18*(2), 83–91. https://doi.org/10.1108/mhsi-01-2014-0001

Cooney, S., Tansey, L., & Quayle, E. (2020). Searching for the self and belonging an exploration of values of men in medium secure units. *Not Published*. Published.

Dorkins, E., & Adshead, G. (2011). Working with offenders: challenges to the recovery agenda. *Advances in Psychiatric Treatment*, *17*(3), 178–187. https://doi.org/10.1192/apt.bp.109.007179

Emden, C. (1998). Conducting a narrative analysis. Collegian, 5(3), 34–39. https://doi.org/10.1016/s1322-7696(08)60299-1

Frank, A. W. (1995). The wounded storyteller: Body, illness, and ethics. Chicago, IL: University of Chicago Press.

Health and Social Care, & Barron, D. T., Independent Forensic Mental Health Review: final report 1–19 (2021). Edinburgh; Scottish Government.

Jacobson, N., & Greenley, D. (2001). What Is Recovery? A Conceptual Model and Explication. Psychiatric Services, 52(4), 482–485. https://doi.org/10.1176/appi.ps.52.4.482

Kirkpatrick, H. (2008). A Narrative Framework for Understanding Experiences of People with Severe Mental Illnesses. *Archives of Psychiatric Nursing*, *22*(2), 61–68. https://doi.org/10.1016/j.apnu.2007.12.002

Leamy, M., Bird, V., Boutillier, C. L., Williams, J., & Slade, M. (2011). Conceptual Framework for personal recovery in Mental Health: Systematic Review and narrative synthesis. *British Journal of Psychiatry*, *199*(6), 445–452. https://doi.org/10.1192/bjp.bp.110.083733

Macinnes, M., Macpherson, G., Austin, J., & Schwannauer, M. (2016). Examining the effect of childhood trauma on psychological distress, risk of violence and engagement, in forensic mental health. Psychiatry Research, 246, 314–320. https://doi.org/10.1016/j.psychres.2016.09.05

Mann, B., Matias, E., & Allen, J. (2014). Recovery in forensic services: Facing the Challenge. *Advances in Psychiatric Treatment*, *20*(2), 125–131. https://doi.org/10.1192/apt.bp.113.011403

Markham, S. (2021, May 6). *Production in prison, secure and Forensic Mental Health Services*. Co-Production Collective. https://www.coproductioncollective.co.uk/news/co-production-in-prison-secure-and-forensic-mental-health-services

McDonnaugh, T., Underwood, A., & Williams, A. (2020). "Swimming against the tide": conditional discharge from medium secure care. The Journal of Forensic Practice, 22(2), 57-69. doi: 10.1108/jfp-06-2019-0023

Mishler, E. G. (1995). Models of Narrative Analysis: A Typology. *Journal of Narrative and Life History*, *5*(2), 87–123. https://doi.org/10.1075/jnlh.5.2.01mod

NHS Education for Scotland. (2016). *Good Mental Health for All*. Edinburgh. NHS Education for Scotland

Rappaport, J. (1995). Empowerment meets narrative: Listening to stories and creating settings. American Journal of Community Psychology, 23, 795−807.

Rowaert, S., De Pau, M., De Meyer, F., Nicaise, P., Vander Laenen, F., & Vanderplasschen, W. (2022). Voices to be heard: Understanding family perspectives in forensic care trajectories. *Frontiers in Psychiatry*, *13*. https://doi.org/10.3389/fpsyt.2022.1022490

Senneseth, M., Pollak, C., Urheim, R., Logan, C., & Palmstierna, T. (2021). Personal recovery and its challenges in forensic mental health: systematic review and thematic synthesis of the qualitative literature. *Bjpsych Open*, *8*(1). doi: 10.1192/bjo.2021.1068

Scottish Government. (2017). *Mental Health Strategy: 2017–2027*. Edinburgh. Scottish Government.

Scottish Recovery Network (2021) *Scottish Recovery Network Strategic Plan*. (May 28). https://www.scottishrecovery.net/resources/scottish-recovery-network-strategic-plan/

Slade, M. (2009). The contribution of mental health services to recovery. *Journal of Mental Health*, *18*(5), 367–371. https://doi.org/10.3109/09638230903191256

Squire, C., Andrews, M., & Tamboukou, M. (2008). *Introduction: What is narrative Research*. SAGE Publications.

Sutherland, S. (2018). Narratives of recovery: Capturing recovery stories from people who have used Forensic Mental Health Services. *Not Published*. Published. https://eprints.staffs.ac.uk/4904/1/SutherlandS_DClinPsy%20thesis.pdf

Warner, A., Glazier, S., Lavagnino, L., Ruiz, A., Hernandez, S. and Lane, S., 2021. Inpatient early intervention for serious mental illnesses and post-discharge criminal involvement in a high-volume psychiatric hospital setting. *Journal of Psychiatric Research*, 143, pp.285-291.

World Health Organization. (2019). *ICD-11: International classification of diseases* (11th revision). Retrieved from https://icd.who.int/

APPENDICES

APPENDIX A

Example of Search Strategy in EMBASE, Medline, & PsychInfo.

Interface: Ovid Database: EMBASE Date Searched: 16.07.2023 Records Retrieved: 3		
#	Search Strategy	Results
S23	9 and 12 and 14	0
S22	9 and 12 and 13	3
S21	5 and 9 and 14	1
S20	5 and 9 and 13	2
S19	1 and 9 and 13	531
S18	10 and 13	2
S17	9 and 12	164
S16	detain.mp.	296
S15	mental hospital/ or exp mental health care/	151021
S14	exp psychologic assessment/ or exp psychophysiologic assessment/ or exp psychological interview/ or exp psychological rating scale/	74116
S13	psychotherapy/ or exp art therapy/ or exp assertive training/ or exp autogenic training/ or exp aversion therapy/ or exp balint group/ or exp behavior contracting/ or exp behavior modification/ or exp behavior therapy/ or exp bibliotherapy/ or exp body psychotherapy/ or exp catharsis/ or exp client centered therapy/ or exp cognitive rehabilitation/ or exp cognitive therapy/ or exp couple therapy/ or exp dance therapy/ or exp drama therapy/ or exp emotion-focused therapy/ or exp "eye movement desensitization and reprocessing"/ or exp family therapy/ or exp gestalt therapy/ or exp group therapy/ or exp guided imagery/ or exp hypnosis/ or exp interpersonal psychotherapy/ or exp logotherapy/ or exp marital therapy/ or exp mentalization-based treatment/ or exp milieu therapy/ or exp mindfulness/ or exp music therapy/ or exp narrative therapy/ or exp play therapy/ or exp psychodrama/ or exp psychodynamic psychotherapy/ or exp	295108

	psychosocial intervention/ or exp rational emotive behavior therapy/ or exp reality therapy/ or exp relaxation training/ or exp role playing/ or exp schema therapy/ or exp sex therapy/ or exp short term psychotherapy/ or exp snoezelen/ or exp sociotherapy/ or exp solution-focused therapy/ or exp telepsychotherapy/ or exp therapeutic community/ or exp validation therapy/	
S12	exp correctional facility/	3180
S11	exp cultural background/	2780
S10	5 and 9	22
S9	6 or 7 or 8	415262
S8	minority.ti,ab.	106107
S7	ethnic.ti,ab.	135250
S6	black.ti,ab.	218847
S5	forensic mental health.ti,ab.	977
S4	1 and 2 and 3	18
S3	ethnic identity/	326
S2	exp black person/ or exp ancestry group/ or exp african american/ or exp african brazilian/ or exp african caribbean/	402513
S1	forensic psychology/ or exp forensic science/ or exp psychology/	492825

Interface: Ovid Database: MEDLINE Date Searched: 16.07.2023 Records Retrieved:122		
#	Search Strategy	Results
S12	1 and 2 and 8 and 11	122
S11	culture/ or ceremonial behavior/ or cultural diversity/	48447
S10	2 and 3 and 8	24
S9	3 and 6 and 8	0
S8	psychotherapy/ or animal assisted therapy/ or art therapy/ or behavior therapy/ or crisis intervention/ or emotion-focused therapy/ or gestalt therapy/ or hypnosis/ or imagery, psychotherapy/ or interpersonal psychotherapy/ or logotherapy/ or mentalization-based therapy/ or music therapy/ or narrative therapy/ or person-centered psychotherapy/ or play therapy/ or psychoanalytic therapy/ or psychosocial intervention/ or psychotherapeutic processes/ or psychotherapy, brief/ or psychotherapy, multiple/ or psychotherapy, psychodynamic/ or	130179

	psychotherapy, rational-emotive/ or reality therapy/ or schema therapy/ or socioenvironmental therapy/ or therapeutic alliance/	
S7	Psychology/ or Psychology, Clinical/	27170
S6	black.mp. and minority ethnic.ti,ab. [mp=title, book title, abstract, original title, name of substance word, subject heading word, floating sub-heading word, keyword heading word, organism supplementary concept word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms, population supplementary concept word, anatomy supplementary concept word]	927
S5	forensic mental health.ti,ab.	694
S4	Prisons/px, rh [Psychology, Rehabilitation]	5
S3	correctional facilities/ or jails/ or prisons/	11551
S2	"emigrants and immigrants"/ or exp "black or african american"/ or amish/ or arabs/ or "asian american native hawaiian and pacific islander"/ or "hispanic or latino"/ or indigenous peoples/ or jews/ or roma/ or population groups/ or african people/ or asian people/ or black people/ or caribbean people/ or central american people/ or european people/ or "middle eastern and north africans"/ or north american people/ or oceanians/ or south american people/ or white people/	241878
S1	exp forensic psychiatry/ or exp "commitment of mentally ill"/ or exp confidentiality/ or exp insanity defense/ or exp forensic psychology/ or psychotherapy/ or art therapy/ or behavior therapy/ or crisis intervention/ or dance therapy/ or emotion-focused therapy/ or feedback, psychological/ or gestalt therapy/ or hypnosis/ or interpersonal psychotherapy/ or mentalization-based therapy/ or music therapy/ or narrative therapy/ or person-centered psychotherapy/ or play therapy/ or psychoanalytic therapy/ or psychosocial intervention/ or psychotherapeutic processes/ or psychotherapy, brief/ or psychotherapy, multiple/ or psychotherapy, psychodynamic/ or psychotherapy, rational-emotive/ or reality therapy/ or schema therapy/ or therapeutic alliance/	201874

Interface: Ovid Database: PsychInfo Date Searched: 16.07.2023 Records Retrieved:135		
#	Search Strategy	Results
S18	1 and 6 and 16	135
S17	1 and 5 and 16	217
S16	2 and 3 and 4	153658
S15	7 and 14	0
S14	cultural adaptation.ti,ab.	2674

S13	7 and 12	1
S12	10 and 11	994
S11	ethnic minority.ti,ab.	9298
S10	black.ti,ab.	68721
S9	correctional institutions/ or exp facilities/ or exp prisons/ or exp reformatories/ or exp criminal rehabilitation/ or exp formerly incarcerated/ or exp incarcerated/ or exp incarceration/ or exp maximum security facilities/	145013
S8	culture.ti,ab.	135512
S7	forensic mental health.ti,ab.	1553
S6	psychological assessment/ or exp measurement/ or exp behavioral assessment/ or exp cognitive assessment/ or exp emotional assessment/ or exp "mental health and illness assessment"/ or exp neuropsychological assessment/ or exp nonsubstance related addiction measures/ or exp personality measures/ or exp psychodiagnostic measures/ or exp psychosocial assessment/ or exp psychiatric evaluation/ or exp psychodiagnosis/ or exp psychodiagnostic interview/ or exp psychoeducational assessment/ or exp psychological report/ or exp psychopathology/ or exp structured clinical interview/	578735
S5	psychotherapy/ or exp treatment/ or exp brief psychotherapy/ or exp brief relational therapy/ or exp child psychotherapy/ or exp client centered therapy/ or exp couples therapy/ or exp existential therapy/ or exp experiential psychotherapy/ or exp eye movement desensitization therapy/ or exp group psychotherapy/ or exp humanistic psychotherapy/ or exp hypnotherapy/ or exp individual psychotherapy/ or exp integrative psychotherapy/ or exp interpersonal psychotherapy/ or exp narrative therapy/ or exp psychoanalysis/ or exp psychotherapeutic counseling/ or exp psychotherapeutic techniques/ or exp rational emotive behavior therapy/ or exp reality therapy/ or exp relationship therapy/ or exp solution focused therapy/ or exp transactional analysis/ or exp cognitive therapy/ or exp marriage counseling/ or exp online therapy/ or exp pastoral counseling/ or exp psychotherapeutic processes/ or exp recreation therapy/	1249715
S4	"racial and ethnic groups"/ or exp african cultural groups/ or exp asians/ or exp blacks/ or exp caribbean cultural groups/ or exp european cultural groups/ or exp indigenous populations/ or exp "latinos/latinas"/ or exp "middle eastern and north african cultural groups"/ or exp multiracial/ or exp "people of color"/ or exp romanies/	153658
S3	minority groups/ or exp alaska natives/ or exp american indians/ or exp asians/ or exp blacks/ or exp hawaii natives/ or exp indigenous populations/ or exp inuit/ or exp jews/ or exp "latinos/latinas"/ or exp multiculturalism/ or exp pacific islanders/ or exp "race and ethnic discrimination"/ or exp "racial and ethnic groups"/ or exp romanies/	181673

S2	exp blacks/ or exp "racial and ethnic groups"/ or exp african cultural groups/ or exp black lives matter/ or exp minority groups/	171525
S1	exp criminal justice/ or exp forensic evaluation/ or exp forensic psychology/ or exp mental health commitment/	26058

APPENDIX B – MMAT Tool

Part I: Mixed Methods Appraisal Tool (MMAT), version 2018

Category of study designs	**Methodological quality criteria**	**Responses**			
		Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?				
	S2. Do the collected data allow to address the research questions?				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

APPENDIX C – MRP Proposal

https://osf.io/r7n8z

APPENDIX D – Consent Form

https://osf.io/8nhpd

APPENDIX E – Participant Information Sheet

https://osf.io/kgnsq

APPENDIX F – Interview Prompt Sheet

OSF

APPENDIX G – Responsible Medical Officer Letter

https://osf.io/npvr8

APPENDIX H - MRP Project Advert

https://osf.io/by7p6

APPENDIX I - REC Approval Letter

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow and Clyde

Dr Karen McKeown
University of Glasgow 1st Floor,
Admin Building (Room 21) Gartnavel Royal Hospital
1055 Great Western Road
G12 0XH

West of Scotland REC 5
West of Scotland Research Ethics Service
Ward 11, Dykebar Hospital
Grahamston Road
PAISLEY
PA2 7DE

Date 02 May 2023

Direct line 0141 314 0213
E-mail WoSREC5@ggc.scot.nhs.uk

Dear Dr McKeown

Study title: **A narrative analysis of service users' stories of recovery within a Scottish Forensic Mental Health Service**
REC reference: **23/WS/0042**
IRAS project ID: **319039**

Thank you for your documents received in full on 27 April 2023, responding to the Research Ethics Committee's (REC) 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 and a member of the Committee.

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.

Good practice principles and responsibilities

The UK Policy Framework for Health and Social Care Research sets out principles of good practice in the management and conduct of health and social care research. It also outlines the responsibilities of individuals and organisations, including those related to the four elements of research transparency:

1. registering research studies
2. reporting results
3. informing participants
4. sharing study data and tissue

Conditions of the favourable opinion

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

the study.

Confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or NHS management permission (in Scotland) 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 HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System.

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 research should be registered in a publicly accessible database and we expect all researchers, research sponsors and others to meet this fundamental best practice standard.

It is a condition of the REC favourable opinion that **all clinical trials are registered** on a publicly accessible database within six weeks of recruiting the first research participant. For this purpose, 'clinical trials' are defined as:

- clinical trial of an investigational medicinal product
- clinical investigation or other study of a medical device
- combined trial of an investigational medicinal product and an investigational medical device
- other clinical trial to study a novel intervention or randomised clinical trial to compare interventions in clinical practice.

Failure to register a clinical trial is a breach of these approval conditions, unless a deferral has been agreed by the HRA (for more information on registration and requesting a deferral see: Research registration and research project identifiers).

If you have not already included registration details in your IRAS application form you should notify the REC of the registration details as soon as possible.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter.

Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/

N.B. If your study is related to COVID-19 we will aim to publish your research summary within 3 days rather than three months.

During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you haven't already done so, please register your study on a public registry as soon as possible and provide the REC with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at: https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

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).

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, including early termination of the study
- Final report
- Reporting results

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

Ethical review of research sites

NHS/HSC sites

The favourable opinion applies to all NHS/HSC sites taking part in the study, subject to confirmation of Capacity and Capability (in England, Northern Ireland and Wales) or management permission (in Scotland) being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

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

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [MRP advert]	3	10 February 2023
GP/consultant information sheets or letters [Responsible Medical Officer Letter]	2	10 February 2023
Interview schedules or topic guides for participants [Interview prompts v2]	2	06 April 2023
IRAS Application Form [IRAS_Form_14022023]		14 February 2023
Other [REC response]	1.0	
Participant consent form [Consent Form v4]	4	06 April 2023
Participant information sheet (PIS) [PIS v4.0]	4	06 April 2023
Referee's report or other scientific critique report [Peer review form 1]		31 January 2023

Referee's report or other scientific critique report [Peer review form 2]		30 January 2023
Research protocol or project proposal [MRP proposal update]	12	06 April 2023
Summary CV for Chief Investigator (CI) [CI CV]		30 January 2023
Summary CV for student [Student CV]		30 January 2023
Summary CV for supervisor (student research) [Supervisor CV]		30 January 2023

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.

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 Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

IRAS project ID: 319039 Please quote this number on all correspondence

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

Yours sincerely

for
Mrs Naomi Hickey
Chair

Important information: **After ethical review guidance for sponsors and investigators – Non CTIMP Standard Conditions of Approval]**

Copy to: Mr Raymond Hamill, NHS Lanarkshire
Lead Nation

APPENDIX J – Local NHS R&D Approval Letter

Dr Karen McKeown
Clinical Psychologist
University of Glasgow 1st Floor, Admin Building (Room 21)
Gartnavel Royal Hospital
1055 Great Western Road

R&D Department
David Matthews Building
University Hospital Monklands
Monkscourt Avenue
AIRDRIE
ML6 0JS

Date 12.07.2023
Enquiries to Lorraine Quinn,
Senior R&D Facilitator
Direct Line 01698 752382
Email lorraine.quinn@lanarkshire.scot.nhs.uk

Dear Dr McKeown

Project title: A narrative analysis of service users' stories of recovery within a Scottish Forensic Mental Health Service

R&D ID: L22059

I am writing to you as Chief Investigator of the above study to advise that R&D Management approval has been granted for the conduct of your study within NHS Lanarkshire as detailed below:

NAME	TITLE	ROLE	NHSL SITE TO WHICH APPROVAL APPLIES
Ms Judhika Ravindran	Trainee Clinical Psychologist	Principal Investigator	NHS Lanarkshire

As you are aware, NHS Lanarkshire has agreed to be the Sponsor for your study. On its behalf, the R&D Department has a number of responsibilities; these include ensuring that you understand your own role as Chief Investigator of this study. To help with this we have outlined the responsibilities of the Chief Investigator in the attached document for your information.

All research projects within NHS Lanarkshire will be subject to annual audit via a questionnaire that we will ask you to complete. In addition, we are required to carry out formal monitoring of a proportion of projects, in particular those projects that are Sponsored by NHS Lanarkshire. In either case, you will find it helpful to maintain a well organised Site File. You may find it helpful to use the folder that we have included for that purpose.

For the study to be carried out you are subject to the following conditions:

Conditions

- You are required to comply with Good Clinical Practice, Ethics Guidelines, Health & Safety Act 1999 and relevant UK-GDPR and Data Protection 2018 legislation
- The research is carried out in accordance with the Scottish Executive's Research Governance Framework for Health and Community Care (copy available via the Chief Scientist Office website: http://www.show.scot.nhs.uk/cso/ or the Research & Development Intranet site: http://firstport/sites/randd/default.aspx.
- You must ensure that all confidential information is maintained in secure storage. You are further obligated under this agreement to report to the NHS Lanarkshire Data Protection Office and the Research & Development Office infringements, either by accident or otherwise, which constitutes a breach of confidentiality.
- Clinical trial agreements (if applicable), or any other agreements in relation to the study, have been signed off by all relevant signatories.
- You must contact the Lead Nation Coordinating Centre if/when the project is subject to any minor or substantial amendments so that these can be appropriately assessed, and approved, where necessary.
- You notify the R&D Department if any additional researchers become involved in the project within NHS Lanarkshire
- You notify the R&D Department when you have completed your research, or if you decide to terminate it prematurely.
- You must send brief annual reports followed by a final report and summary to the R&D office in hard copy and electronic formats as well as any publications.
- If the research involves any investigators who are not employed by NHS Lanarkshire, but who will be dealing with NHS Lanarkshire patients, there may be a requirement for an SCRO check and occupational health assessment. If this is the case, please contact the R&D Department to make arrangements for this to be undertaken and an honorary contract issued.

I trust these conditions are acceptable to you.

Yours sincerely,

Raymond Hamill – Senior R&D Manager

c.c.

NAME	TITLE	CONTACT ADDRESS	ROLE
Ms Judhika Ravindran	Trainee Clinical Psychologist	Judhika.Ravindran@lanarkshire.scot.nhs.uk	Principal Investigator
Fiona Mair	Clinical Psychologist	Fiona.Mair@lanarkshire.scot.nhs.uk	Named Contact

Enc 1 x Responsibilities as Sponsor Notes

Responsibilities as Sponsor

Site File

As an aid to the conduct of your study we have provided a Site File that you may wish to use. As Sponsor of the study we are required to carry out audit of all project, and to conduct detailed monitoring visits for a proportion (approximately 10%) - The study Site File should help you ensure that you have the relevant documentation to assist in this process. If your project is selected for monitoring, we will contact you well in advance to arrange a suitable time.

Our responsibilities as Sponsor are defined within the Research Governance Framework for Health and Community Care. A summary of these, along with those of the Chief Investigator, is provided in the following table for your information.

RESPONSIBILITIES OF CHIEF INVESTIGATOR	NHSL RESPONSIBILITIES AS SPONSOR
Obtain relevant / appropriate Research Ethics opinion.	Assess adequateness of the independent, expert review.
Obtain NHSL Research Management Approval.	Ensure that the Chief/Principle Investigator has the necessary expertise, experience and education to conduct the study.
Ensure that the members of the research team have the necessary expertise, experience and education to perform their roles.	Provide a formal written agreement of sponsorship conditions, and notification of confirmation of the sponsorship role.
Ensure the necessary resources are available for the study.	Provide NHS indemnity to the Chief Investigator and research team.
Act in accordance with regulations set out by your professional body(s) and the conditions of your employment contract.	Provide mechanisms and processes to exploit any potential Intellectual Property.
Identify archiving arrangements at the study outset.	Project monitoring commensurate with risk.
Record and review significant developments that may affect the study, particularly those which put the safety of the individuals at risk or affect the scientific direction and report to the sponsor as appropriate.	Make available local, national and international guidelines, regulations and legislation governing research in the UK.
Record, report and review all untoward medical occurrence (adverse events or reactions) including classification of causality, seriousness and expectedness.	Provide ongoing advice and guidance to promote quality study management and conduct.
Notify R&D and appropriate REC of significant news, changes, amendments and modifications to the study.	Determine the acceptability of the archive arrangements proposed by the Chief Investigator and, if the archive facility becomes unsuitable, provide alternative arrangements.
Maintain a record of all incidents, providing an annual report to the sponsor.	Determine length of archive/retention period for essential study documents and subsequent destruction date
Inform REC and R&D of the study end.	
Maintain a log of archived documents and their location.	
Inform R&D of any publications arising from the study or dissemination of findings.	
Inform R&D of any potential Intellectual Property.	

APPENDIX K – Analysis Table Excerpt for John

John	Ending of a relationship leading to despair. (1)	Personal: *life doesn't take the course you plan it to take.* Community: losing a source of support so crucial to coping with daily life.	*I call the place heartbreak hospital because of the album (...)I was with my girlfriend for 4 years and I split up with her and then 2 years after that I was losing it(.) Because obviously it you think you are gonna be with them for the rest of your life but your life deviates from what you think it's gonna be(.)*
	Drugs and alcohol triggering mental health decline. (2)	Personal: *relationship to drugs and alcohol to cope with a relationship ending.*	*So from that I just went from being clean and sober to being an absolute wreck(.) I used to take too much drugs(…)*
	Recovery was faster than expected. (4)	Personal: *the length of time in hospital is what defines recovery.* Community*: I am lucky compared to other people who have longer admissions.*	*My recovery had been fairly quick compared to some of the people in here because the turnaround had been, I have heard of horror stories of some people being in for years(.) I was here for 4 and a half months (…)*
	Gratitude towards services.	Personal: *the offence led to the help that was needed.* Culture: *the type of help/resources that was needed was only available due to the type of offence committed.*	*I am not glad of the offence, but I am glad of where I ended up because of the help, I would have ended up dead cos I was going crazy, really crazy, losing my head(.)*
	The prison was horrible(3)	*Personal: prison was scary and I felt out of control* *Community:* not sure of what support was available or what was doing to happen. Insecurity whilst being in a completely secure place.	*I was treated like a fucking animal (.) It was horrible, just a horrible place (…) I was taking my life second by second, I didn't know what was happening(.) Most unsure what was happening, didn't know what was happening next second, never mind next minute(.) No place is as scary(.) You don't know what they'd done or what they were doing(.)*

	The right food for the medication to work. (5)	*Personal:* I had to work hard to get to a healthy weight. *Community:* good food and nourishment allows for the medication to work. *Culture:* food that can meet the needs and satisfaction of the individual.	*I have put on a hella lot of a weight(.) I am now a healthy weight(.) Feeding you on decent meals (.) If you are on medication, you will eat (.) But they feed you regular amount of food, right nutrients, right amount of time for the medication to work.*
	Therapy vs medication to cope (7)	*Personal:* counter-story - CBT techniques support me more effectively than medication. *Culture:* the expectation is that medication solves everything and is the answer. *Community:* blame was placed on the team that the medication was not working.	*I remember snapping at one of them once because the PRN never worked for me and so I snapped and I never took the PRN again, because of what it did for me (.) So it changed for that PRN (.) I don't need PRNs anymore, I just say apple, caravan and I am calm (.)*
	Gratitude towards the NHS (9)	*Personal:* gratitude for the service and how it supported recovery. *Culture:* the lack of gratitude towards the NHS effects the recovery journey. It is free to receive this support. *Community:* patients around me did not have the same gratitude.	*More than contributed, some of the guys in here don't realise how lucky they are, they don't, they don't realise, treat some of the staff (…) you don't realise how where you are, could be in a place a million times worse(.)*

	The beauty of freedom (10)	*Personal:* I could not be with my family or support network at the times I valued most, I had to comply to make sure this didn't happen again. *Community:* complying with the system leads to recovery.	*When you spend Christmas and New Year in a hospital (…) In a locked ward(.) You don't get to have freedom (.) You make sure you behave (.) Cos when you are out, you don't wanna go back in (.)*
	The support of friends and family. (6)	*Personal:* luck is heavily involved in what support is there for you, to progress through the system. *Culture/Community:* parents, and friends provide support to put practical measures in place.	*There was just mishaps and mishaps that led me to it (.) Now I am just thriving, I have a good bunch of pals with me, and mum and dad has been so helpful (.) I mean we still argue(.) We fallout like families do but I swear to god, they're so supportive (.) I was very quick and lucky that I had things to go back to and things set up for me before I come out (.) Like a tenancy, some people don't have that or things to do with themselves (.)*
	Lack of identity leads to mental illness and can maintain it (8)	*Personal*: knowing myself, provides the basis for which you can begin recovery to find yourself again. *Culture:* your background, equality of opportunity and familial culture contributes to what your identity/passsions are.	*If you don't have a passion in your life, or aren't driven, you don't have anything, you just exist (.) It's like being in a car, not going anywhere, it's like you are staying still (.) Not going anywhere (.) In your head, it's a long time, stuck in the same place (.)*

Appendices L and M removed due to confidentiality issues.