

'Swimming Against the Tide'

Conditional Discharge from Medium Secure Care

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Abstract

Purpose

This paper explores the experiences of mentally disordered offenders (MDOs) conditionally discharged from secure hospitals on a restrictive Section of the Mental Health Act (Section 37/41).

Design/methodology/approach

Data were derived from seven semi-structured interviews from three Forensic Community Teams.

Findings

Thematic analysis identified seven predominant themes: (1) the uncertainty of the discharge timeframe; (2) fear of jeopardising discharge; (3) progress; (4) engagement with community life; (5) barriers to social engagement; (6) evolving identity; and, (7) someone to turn to. Findings are discussed in relation to the Recovery Model and the Good Lives Model.

Practical implications

The findings highlight the importance of fostering trust between MDOs and their care teams to encourage help-seeking. They also suggest that resources should be sequenced appropriately throughout the discharge process, to match the 'window of engagement' and maximize impact and effectiveness.

Originality/Value

This research gained rarely obtained first-hand perspectives from MDO's, with the findings contributing to a more effective evaluation of the discharge pathway.

Keywords: Forensic, Mentally disordered offenders, Rehabilitation, Inpatient, Recovery, Good Lives Model, Recovery Model, Section 37/41, Reintegration, Thematic analysis, Desistance.

Article classification: Research Paper.

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Introduction

Discharge from psychiatric hospitals is often challenging, characterised by loneliness, unemployment, stigma and fear of relapse (Nolan, Bradley, & Brimblecombe, 2011). Conditional discharge from a secure forensic psychiatric hospital presents additional challenges from added restrictions and the dual role of effective treatment and public protection.

Medium secure settings provide treatment to people with a severe and enduring mental health problem who are assessed to be a risk to others (NHS England, 2018). All individuals are detained under the Mental Health Act (MHA) (1983, as amended 2007), commonly under Section 37/41, a hospital order following recommendation

of treatment rather than prison after a criminal conviction. Detention has no fixed end date but must be reviewed every 12 months by process of tribunal (MOJ, 2009a).

Discharge is sought when the continuing risk can be safely managed with community resources and is preceded by a lengthy preparation period for the patient and his/her care team (MOJ, 2009a). When conditionally discharged into the community most restricted patients will remain under Section 41 for some time subject to certain conditions and liable to be recalled to hospital if these conditions are not upheld (MOJ, 2018).

The management and mitigation of risk is arguably the main focus throughout the discharge process, thus most research literature in this area examines reoffending and readmission. Rates of reoffending range from 30% to 50% (Coid, Hickey, Kahtan, Zhang, & Yang, 2007; Davies, Clarke, Hollin, & Duggan, 2007), and tools have been developed to quantify that risk (Coid, Kallis, Doyle, Shaw, & Ullrich, 2015; Fazel, Singh, & Grann, 2012; Yang, Wong, & Coid, 2010). , such as the HCR-20 (Webster, Douglas, Eaves, & Hart, 1997). Re-admission rates are also high: 44.5% over two years following discharge (Jewell, Cocks, Cullen, Fahy, & Dean, 2018), and 38% over a 20-year period (Davies, et al. (2007). National statistics (MOJ, 2018) report that 28% of those admitted in 2017 were re-admissions.

There is little research into the broader, lived experience of discharge from secure forensic units. One of the few (Coffey, 2012) focussed on the challenges associated with creating a “non-deviant” identity in the outside world, a task made more difficult by continued supervision and monitoring. Other studies using a sample of

the prison population (Tarpey & Friend, 2016) yielded relevant findings, identifying the importance of self-fulfilment, suitable support systems, and the decision to change.

The move from long term, institutional mental health care towards community care has been based largely on the Recovery Model (Davidson, 2005), with an emphasis on social recovery alongside clinical recovery, and on participation in wider society (Anthony, 1993; Repper & Perkins, 2003). In this model, individuals can live fulfilling lives despite residual symptoms of mental illness, facilitated by personal autonomy and empowerment, life satisfaction, social inclusion, hope and optimism and a positive sense of identity (Bonney & Stickley, 2008; Resnick, Fontana, Lehman, & Rosenheck, 2005). Environments that foster personal growth and recovery, facilitate competence, relatedness, and autonomy (Ryan & Deci, 2000), but the duties of public protection and risk management severely constrain this in the secure hospital environment, undermining preparation for the transition into the community.

It is therefore important to explore patients' experiences of undergoing these changes during the discharge process, and to investigate the experience of working towards recovery while moving into the community. This paper explores the experiences and attitudes of mentally disordered offenders (MDOs) discharged from medium secure care, with continuing restrictions in the community.

Research aims will explore:

- The experience of increased responsibility and freedom.

- The perceived barriers and facilitators to progress and community reintegration.
- Changes in perceived identity throughout the discharge process.

Method

Setting

Participants were recruited from five multi-disciplinary Forensic Community Teams (FCTs) within a large inner city mental health trust. These teams provide psychiatric care and monitoring to individuals discharged from secure hospitals in the locality.

Participants

Inclusion criteria

Participants were considered for recruitment if they fulfilled the following inclusion criteria: male, over 18 years of age, detained on a Section 37/41 and conditionally discharged from inpatient care, remaining on a Section 41 at the time of interview, and discharged between two months and four years ago. Participants were excluded if they were currently self-harming, were experiencing a deterioration in mental health, or had a diagnosed intellectual disability (IQ<70).

Sample Size

Twenty service users met the inclusion criteria and were subsequently invited to participate in the study; seven participants agreed to take part.

Participant demographics

MDOs under the care of the FCTs tend to have a primary diagnosis of paranoid or treatment resistant schizophrenia, and a long-standing history of mental health problems prior to the index offence. Index offences can include: manslaughter, grievous bodily harm, sexual offences, arson and robbery, amongst others. All participants were living in supported, community accommodation at the time of interview. General participant demographics can be found in Table.

Table 1. Participant demographics

Participant Number	Age Range	Ethnicity	Time Since Discharge	Length of Detention
1	28-34	White British	2 years	5 years
2	48-54	Black Caribbean British	14 months	8 years
3	38-44	White British	2.5 years	5 years
4	48-54	White British	3 years	10 years
5	48-54	White British	4 years	8 years
6	38-44	White British	5 months	8 years
7	38-44	White British	4 months	7 years

Ethics

Ethical approval was obtained through NHS Ethics (Project ID: 17/LO/0786). All participant data was processed, stored and disposed of in accordance with the Data Protection Act (1998) and every phase of the research was carried out in a way that ensured participants' rights were protected.

A speech and language therapist was consulted on the content and layout of the Participant Information Sheet, advising on accessibility and ease of understanding for the target population.

Procedure

Caseloads were screened by the researcher and members of the FCTs for individuals meeting the inclusion criteria. Suitable participants were first contacted by an FCT clinician and provided with a brief introductory letter outlining basic information about the study. The researcher then contacted those patients who wished to participate. Written consent was obtained, and participants received a £10 supermarket voucher for their time. Each participant took part in one semi-structured interview lasting between 60 and 90 minutes.

Materials

The content of the semi-structured interview was informed by the research questions with milestones of the discharge pathway (ground leave, escorted community leave,

unescorted community leave, overnight stays in the community, conditional discharge from hospital) used as a framework.

I referred to the guidelines set out by Barker and Pistrang (2015) for adopting the most appropriate interview style (e.g. maintaining a loose structure; maintaining an empathic, non-judgmental stance etc.).

Data Analysis

The interview data was analysed using thematic analysis (Braun & Clarke, 2006), the flexibility of which allows a focus on specific research questions, while also allowing for the identification of potentially unexpected themes.

The following steps recommended by Braun and Clarke (2006) were followed: 1) transcription of data; 2) immersion in the data; 3) generating initial codes; 4) searching for themes; and 5) reviewing and redefining themes. All data were coded without directly relating to the research questions to protect against the loss of potential themes or sub-themes. In addition to this Patton's (1987) criteria, which states that categories should be internally homogenous and externally heterogeneous, was used to re-examine themes.

Quality Evaluation

I adhered to the guidelines set out by Elliott, Fischer and Rennie (1999) for good practice in qualitative research: (a) disclosure of perspective; (b) adequately describing the sample; (c) grounding interpretations in the data; (d) demonstrating coherence of the interpretive framework; and (e) providing credibility checks such as triangulation and testimonial validity.

Credibility checks

Inter-rater agreement of themes was conducted with randomly selected transcripts coded by a suitably qualified research assistant before discussing the degree to which they converged.

Attempts were made to gather testimonial feedback from the participants on the logic of the coding and the constructing of themes.

Results

Seven key themes were identified: (1) the uncertainty of the discharge timeframe; (2) fear of jeopardising discharge; (3) progress; (4) engagement with community life; (5) barriers to social engagement; (6) evolving identity; and, (7) someone to turn to.

Evidence for each theme was identified across all transcripts.

The seven themes were brought together into the thematic map seen in Figure 1. (p. 12), based on whether they pertained mostly to inpatient or discharged experience and how they related to one another across the discharge pathway. Participants are numbered so that P1 indicates Participant number one.

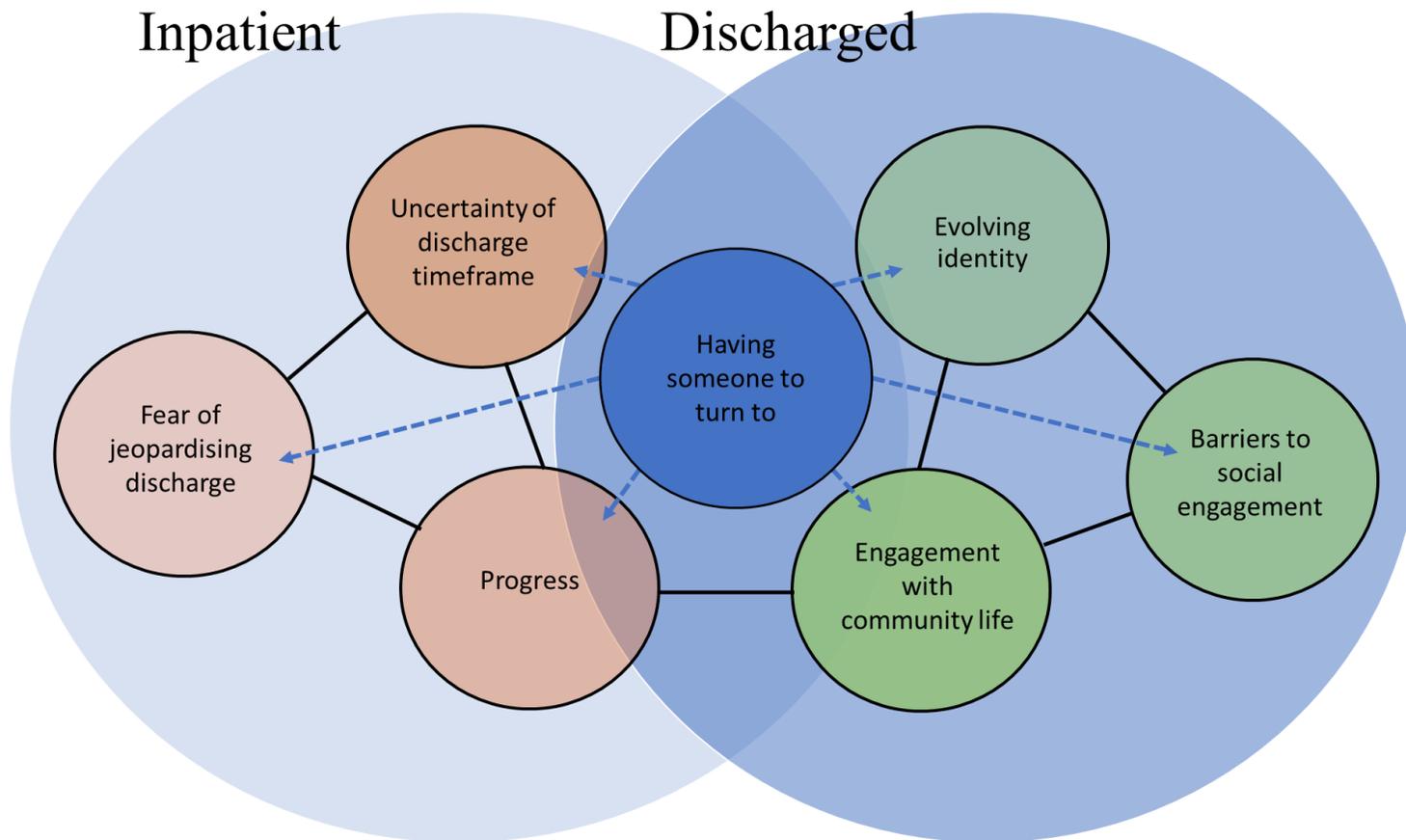


Figure 1: Thematic Map

Note. This map shows the overlap between pre-discharge and post-discharge experiences. Those themes positioned across both were identified to some degree in both pre-discharge and post-discharge experience; for example, 'Engagement with community life', which begins pre-discharge and continues post-discharge.

Theme 1: The uncertainty of the discharge timeframe

Six participants referred to the uncertainty around the discharge timeframe, in terms of the length of stay on the MSU, time until discharge, and time between milestones. Participants endorsing this theme spoke of the intangibility of discharge and how it could often seem unattainable, especially in the early stages of the process.

P4: *.... on this section 37/41 I was there for a long time and sometimes you couldn't see, like, freedom.*

P5: *..... nothing's guaranteed. So my first concern when I was in hospital with the possibility of discharge was actually to get out of hospital! So I couldn't actually plan and say "I'm gonna get out this date" or that date until I actually go to that tribunal and they say "you've got your discharge" and even then it's a drawn out process afterwards so you're constantly working toward that goal but it's not set out in stone for you, it's a bit of an unknown.*

Several participants elaborated on how the intangibility of discharge made it difficult for them to find motivation while in hospital. This meant they were unable to take up certain offers of occupational activities even though this might have supported progression.

P5: *It's difficult because everything's so rigid in hospital, erm, when you're gonna get out, if you're gonna get out, so you get into a lazy routine where you don't want to do anything. So even if they did offer you more OT (occupational therapy) for example or cooking and stuff like that, which they did offer me and I didn't go to, it would be a struggle*

to get up and grapple and grasp how this is going to help you on the outside world not knowing when you're gonna get out or not is a bit of a conflict.

Theme 2: Fear of jeopardising discharge

The theme 'fear or jeopardising discharge' captures the many references made to the anxiety linked to achieving discharge, and the fear of moving backward along the pathway.

This theme was characterised by (a) fear of making mistakes; and (b) managing self-image. Participants described the types of mistakes they feared making (e.g. making poor decisions while on leave, falling into old habits with drugs or alcohol, not using time wisely etc.), the potential consequences and how they reduced the likelihood of this happening.

P4: *When you go out with someone for the first time, you do need that support, cos just being around people and places, you know.....you're thinking "Where am I gonna go? What am I gonna see? Am I gonna get into the same situation that brought me here?"*

P2: *You have to like, condition yourself to get it all right and not do a wrong because one thing about cases like this is it gets noted and documented but if you do a right it gets overlooked. So you could do ten rights and just one wrong out of ten rights and the single wrong will go on file forever! And all the nine rights, they ignore that. So, you don't wanna make a mistake, you know?*

Participants also described observing the mistakes made by others and how these acted as a deterrent or a guide for how to conduct themselves while moving through the discharge process.

P7: *(talking about tobacco) they'd lose their leave losing their leave a lot of the time and they'd have to wait weeks or months to get it back, then they'd lose it again and that process was going back and forth - and I could see this process was ridiculous, this losing it all the time then waiting to get it back, it's just prolonging your stay there..... and it goes on forever.*

Participants talked of how they used self-monitoring and self-correction in order not to arouse doubt over their readiness for discharge. Participants used different strategies to achieve this, including: masking negative emotions, carefully managing interactions with both staff and patients on the ward, complying with all requests from staff, and isolating themselves to avoid trouble.

P1: *Sometimes you just wanna put your head in your hands and just say "when am I getting out of here!?" and you can't really do that in front of other people ... it gets reported saying, saying, oh "X was a bit depressed or something"; but it never did get reported back cos I was good at putting on a front.*

P6: *..... I might do something that could be misconstrued as worrying or erm, you know supposing I started walking too quickly, it might be something that was noted or if I did something that was note-worthy*

P7: yeah, you've gotta watch yourself all the time, so that can cause a bit of anxiety actually.....

Theme 3: Progress

The theme 'progress' pertained to references about making and maintaining progress.

Participants described progress strategies which included: ensuring structured activities while on UCL; engaging in meaningful activity; and psychology input on the ward.

P5: (referring to a training position in the community) *It gave me a routine and a reason to get up, because you have to do it, which I needed because I was laying in a lot in bed, which is what you do in hospital - that inertia of getting up in the morning is really, really difficult once you come out of hospital.*

Some participants referred to the role of continuing restrictions and monitoring (Section 41) in the community helping them to stay on track. Similarly, five participants detailed how, on reflection, they found the staged process of discharge helpful.

P7: those restrictions are in place for a reason to help me stay away from involvement with the police and the criminal system again, so it's wise that they're in place because I don't wanna go back to prison ever again...

P5 *I feel it was a necessary process..... and, erm, I think it went very well as a whole, and erm, I think it got me used to the outside world.*

Theme 4: Evolving identity

The theme ‘evolving identity’ contains comments made in relation to a sense of changing identity during the transition to life in the community. Participants described certain factors as aiding the process of feeling ‘normal’ or ‘real’ which included being given more responsibility and autonomy, for example having money for the first time while on community leave.

P6: (*Interviewer – “what do you think it was about that experience that made you feel like a real person as you said?”*)

Well the freedom and being in a crowd of people..... seeing, you know, everyday people going about doing everyday things, having money, having cash rather than credit in a hospital

Theme 5: Engaging with community life

This theme pertains to experiences of engaging with community life, and the challenges of building new relationships.

There was a wide consensus that community life was challenging. Participants described finding it hard to adapt to the lack of structure after being in the highly restrictive MSU setting, and subsequently feeling overwhelmed by the freedom and responsibility.

P4: *...going out doing shopping, making yourself something to eat cos it was all sort of done for you. You know, like when you're in hospital I found it quite hard to start with....*

P3: *I've not had a case of independent living for quite some time, and I think it would be quite scary..... Yeah, it's more than scary it's a nightmare (laughs)..... if I don't get any sleep, or my anxiety and stress keys up I need someone to talk to...*

Participants also described how the realities of community life became apparent some-time after being discharged, and often following an initial period of excitement happiness, and stability.

P1: *I think most people do, they come out on a high, then they realise life has to go on, and they've gotta get back to normal life and it's a bit daunting.*

P4: *(Interviewer – “it sounds like you really wanted the freedom but there was something about it that was quite difficult to handle at first?”)*
Yeah, yeahProbably you know, I was sort of like, thinking this isn't a lot worse or better than it was (on the ward). When I sort of got used to it I was ok and it was probably better that way than the other waysort of going out there and thinking you'd have the world at your feet.....

Participants spoke to the importance of being actively involved in community life. All reported feeling like valued members of their community and identified facilitating factors such as finding work or other meaningful hobbies.

P6: *(talking about isolation) It's decreased. I've actually started doing some activities in the community, drawing classes at college. I'm thinking I might start doing the sculpture classes as well which is another interest of mine*

P5: *.... there's a community activity organised here, which I think is going to be bowling so I think I'm gonna do that..... But this is progress because I'm meeting people in the community...*

Theme 6: Barriers to social engagement

This theme relates to references regarding: (a) difficulty forming new relationships; and (b) loss of old relationships.

Participants spoke of difficulties forming new relationships or social networks once they were discharged from hospital, and of experiencing anxiety, uncertainty or conflict about how much of their criminal and psychiatric past to divulge to new acquaintances. They reported subsequently feeling that their criminal identity hung over interactions they had with people in the community.

P1: *I told one boy (XXX), who I became friends with, I told him in the end, I told him exactly what I'd done and he was shocked.... I didn't tell anyone else.....*

Participants also referenced the loss of existing relationships with some reporting actively distancing themselves from friends or associates linked to their old lifestyles.

P4: *With being on a 37/41 in a way you're recalled ahead of time, So sometimes I feel better on my own you know, because I don't wanna go back to hospital, and some people feel its ok for them.*

Other participants described how the loss of old relationships was not their choice with several describing feeling ostracized and rejected by old friends because of the crimes they had committed.

P1: *..... basically, all my friends that I used to know I don't speak no anymore.because my offenceit was upsetting, sad like, and people I've known all my life don't answer the phone to me.*

Theme 7: Someone to turn to

This final theme captures the many references attesting to the importance of emotional and practical support throughout the entire discharge process. Reference was made to the role staff played in providing emotional support and the importance of having a named person to talk to about anxieties and concerns.

P2: *I don't like crowds so that was an obstacle and it was a big problem I got over that by reporting it to my team, you know? You're taught you've gotta nip it in the bud you don't have to wait that long for the problem to be blown out of proportion...*

P5: (Interviewer – “was there anything that helped you to manage or cope with that transition period?”)

Trust me it was the team, because everyone is allocated a key worker Whenever I would get a paranoid feeling, suspicion, confused - I would go straight to my key worker I speak my mind, what’s on my mind what I’m scared of You can’t pull it off on your own, it can be very difficult.

Some participants worried about the potential consequences of not having support in the future and how this might impact negatively on their mental health.

P3: *If I’m in independent living I hope I’ve got a phone number of a CPN or something like that so I can ring them and say “look, look at this I’m having problems.”.....*
Relationship between themes

Discussion

Using a qualitative approach this study explored MDO’s experiences of conditional discharge from an MSU with continuing Section 41 restrictions in the community. The findings will now be discussed and interpreted in relation to the research questions, the existing literature and relevant psychological theory.

Experience of increased freedom and autonomy

Although the participants in this study generally welcomed the increased freedom and autonomy that discharge brought, many seemed reluctant to repossess full responsibility due to a lack of confidence in their ability to make good decisions. This was demonstrated in the ‘fear of jeopardising discharge’ theme, which strongly reflected how highly anxious service users were about making mistakes that could jeopardise their discharge.

For participants in this study, this awareness led to a perceived need to constantly monitor and manage the way they appeared to staff involved in their care. Importantly the findings suggest that individuals from this population may use strategies to hide emotional states they perceive as not conducive to discharge (e.g. low mood, paranoia), despite highly valuing emotional, psychological and practical support highlighted by the theme ‘someone to turn to’. A potential consequence is that deteriorating mental health may not be addressed as early as possible leading to missed opportunities to prevent relapse and improve quality of life. The tendency for individuals to hide negative emotions also brings into question the reliability of risk assessments, particularly for staff using patient compliance as an indication of reduced risk.

In addition to this, the findings point to a possible disparity between what MDOs believe to be circumstances under which discharge would be jeopardised, and the realities of this as stated by the MOJ (2009b). Individuals may benefit from knowing where flexibility exists, and this could reduce anxiety and promote help-seeking.

Barriers and facilitators to progress and community integration

One barrier consistently constraining progress was that of a lack of time-frame which affected motivation. Many participants reflected on not being able to find the motivation to take up activities that might have helped support their progress early on in the discharge pathway. Theories of motivation (Bandura, 1997, p. 2); Vroom, 1964) inform us that unless an individual believes they can achieve the desired effects by their actions, they will have little incentive to act. In terms of MDOs at the start of the discharge process, the uncertain time-frame can make the end goal of discharge seem intangible and unattainable. This finding highlights a ‘window of engagement’ for patients; a point where discharge is more tangible and motivation levels have increased. It is likely that resources focused within this window will facilitate maximum engagement resulting in greater impact and effectiveness.

The contribution of the restricted and regimented MSU environment to the low motivation reported by these participants must also be considered. Due to the focus on risk management, secure inpatient environments often fail to meet those basic environmental needs necessary to facilitate recovery and personal growth: (a) the need for competence; (b) the need for relatedness; c) the need for autonomy (Ryan and Deci, 2000). In a sense, inpatient MDOs must ‘swim against the tide’ to battle the demotivating effects of their environment.

Among all participants there was a general consensus of a ‘delayed transition effect’, where the challenges of discharge, including managing increased autonomy and responsibility tended to occur a short while after discharge following an initial period of stability.

Discharge from an MSU to the community, although gradual, is a considerable transition; in her 1981 paper on Transition Theory Schlossberg identifies three factors that interact to influence the quality of a transition: (a) the perception of the transition, (b) the characteristics of the pre-transition and post-transition environments; (c) characteristics of the individual. For recently discharged MDOs a number of potentially depleting factors coincide shortly after discharge where: (a) that which has been lost, in terms of social groups and resources is yet to be replaced; (b) support and social contact has reduced; (c) and they have not yet had enough time to develop and practice psychosocial competencies that work in their new community environment.

All participants in this study highly valued the help and support provided by their FCT in progressing them towards discharge. It may be the case that those who value help are more likely to seek help, and this contributes to successful discharge. If this is the case then fostering trust between inpatient MDOs and staff, alongside encouraging help-seeking on inpatient units, will be beneficial. This is something strongly advocated for by Repper and Perkins (2016) with collaborative risk planning.

Changes in perceived identity throughout the discharge process

The theme ‘evolving identity’, with its specific emphasis on becoming a ‘normal’ or ‘real’ person, reflected how participants strove for a more positive identity in the community, distanced from their forensic and mental health histories, and is consistent with forensic identity research (Coffey, 2012). Service user accounts suggest that the process of becoming ‘normal’ is strongly bound with community integration and building new social networks with people who do not know their criminal and psychiatric pasts.

The value placed on becoming part of ‘normal’ society can be understood using Social Identity Theory (Tajfel & Turner, 1979), with the notion that self-concepts are built based on belonging to groups with loss of membership to that group (even if that group is considered undesirable) resulting in a perceived loss of certain aspects of the self. This challenge can be managed by increasing the number of groups to which one belongs (Jetten, 2012) and elucidates the importance of MDOs forming new social networks post-discharge in the context of limited opportunities to gain membership to other groups whilst in secure care.

Limitations

There are several potential limitations to this study and these must be considered when interpreting the findings.

It was not possible to define characteristics of those who refused to take part, which raises the possibility that those who participated were different in some way to those who declined. For example, those who refused to take part might not have felt as positively about help-seeking and this might have influenced their decision not to take part in the research.

There was a lack of ethnic diversity within the sample with only one non-white participant. This did not reflect the overrepresentation of black and ethnic minority individuals on forensic Sections in the UK (Approximately: 8.5% Black British, 5.6% Asian and Asian British, and 12.5% mixed ethnicity (Care Quality Commission, 2013)). Factors cited as deterring BME individuals from utilising generic mental health services e.g. mistrust of

services, lack of cultural appropriateness, social stigma, and shame (Islam, Rabiee, & Singh, 2015; Keating & Robertson, 2004); Sainsbury Centre for Mental Health, 2002) may apply.

I believe I obtained honest and full accounts from participants, however the prospect remains that participants censored their accounts to some degree, and unfortunately, it was not possible to gather testimonial feedback from participants, as they either declined or did not respond.

Conclusions

This study is one of the first to solely focus on MDOs' experience of discharge using a sample of participants' subject to continuing restrictions in the community. The findings provide further evidence for the benefits of a staged process of discharge into the community with participants valuing this as a means of smoothing the transition. The importance of continued support and monitoring of emotional and psychological well-being for an extended period post-discharge has been reaffirmed.

Clinical implications

- For forensic inpatient teams to consider the following important areas for development across the discharge pathway, namely: (1) how do we make discharge feel more concrete, tangible and achievable from admission? (2) how do we create environments that foster recovery as well as managing risk? And (3) how do we instill confidence to seek help in times of difficulty?

- Forensic inpatient and community teams should be more consistent in drawing on strengths-based approaches to offender rehabilitation like the Good Lives Model (Willis et al., 2013), which focuses on assisting offenders to construct and achieve meaningful life plans (e.g. creativity, community, play, relatedness, spirituality and agency), and embedding these in practice throughout the discharge process.
- Forensic inpatient teams should use a recovery-focussed approach to risk management, with the aim of creating forensic inpatient environments which embrace the Recovery Model alongside effectively managing risk. Co-produced safety plans (Repper & Perkins, 2016) are one example of this.

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