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Values and Recovery in Forensic Mental Health

Doctoral Thesis

Stuart Andrew Cooney
Doctorate in Clinical Psychology
The University of Edinburgh
February 2020
Values and Recovery in Forensic Mental Health

DClinPsychol Declaration of Own Work

Name: Stuart Cooney
Title of Work: Values and recovery in forensic mental health

I confirm that this work is my own except where indicated, and that I have:

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- Composed and undertaken the work myself
- Clearly referenced/listed all sources as appropriate
- Referenced and put in inverted commas any quoted text of more than three words (from books, web, etc.)
- Given the sources of all pictures, data etc. that are not my own
- Not made undue use of essay(s) of any other student(s), either past or present (or where used, this has been referenced appropriately)
- Not sought or used the help of any external professional agencies for the work (or where used, this has been referenced appropriately)
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- Acknowledged in appropriate places any help that I have received from others (e.g. fellow students, technicians, statisticians, external sources)
- Complied with other plagiarism criteria specified in the Programme Handbook
- I understand that any false claim for this work will be penalised in accordance with the University regulations
- Received ethical approval from the School of Health in Social Science, University of Edinburgh
  OR
- Received ethical approval from an approved external body and registered this application and confirmation of approval with the School of Health in Social Science’s Ethical Committee

Signature ... Date ...28/02/2020.............
Acknowledgements

Like the content I explore in this thesis, the journey to write this and complete the doctorate has entailed various challenges and opportunities. Going through this process has challenged and illuminated my understanding of my own values. At times it has reaffirmed my pursuit of these goals and values, whilst at other times has certainly tested this resolve. Despite spending many a solitary evening at my desk or in the library, this has not been a journey I have taken on my own. This would not have been possible without the support, guidance, reassurance and patience of some very special people.

Firstly, I was struck by the openness of the kind nine individuals from the Orchard Clinic who took the time to meet with me. I am so grateful for your time and I hope I do justice to your stories. Thanks also to all of the staff at the Orchard Clinic during my time working and carrying out my research.

Thank you to my supervisors Ethel Quayle and Louise Tansey for everything they have done to help me through these past four years. Also thank you to Ros Evans and Richard Payne for their support across the wider doctoral process. It was also a privilege to share this training journey with a great group of friends and colleagues. A particular thanks goes to David Barker for giving his time and input, being my second marker for my systematic review. Also, to David Carmichael for getting me through the long days and nights in the library together.
I am lucky to have such supportive parents and in-laws. Thanks for everything over the years and for all the practical support and kindness you’ve shown in getting me through this.

Most importantly I want to thank my wife Yvonne. It’s hard to express how important she has been in keeping me going and helping me through all of this. Without complaining (much!) she has put up with countless evenings and weekends of me working away. She is an amazing partner, friend, support and mother to our daughter, Ailsa. Thank you.

In the second year of my doctorate we welcomed our beautiful daughter to the world. Thank you Ailsa, for giving me a reason to keep going with all of this and to finally finish it. I’m sorry that Daddy’s always been away working or studying but that’ll change now and I can’t wait for all of the fun we’re going to have together. Lastly, I’d like to dedicate this to our soon to be born baby boy. We’re so excited to meet you.

In Loving memory of Janet Bulloch, 1922 - 2020
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Overall Abstract

Background: Strength-based approaches to working with Mentally Disordered Offenders (MDOs) move from a focus on mental disorder and risk to a wider consideration of the individual that considers their strengths, personal priorities and competencies. There is an increasing emphasis on values and recovery in health and forensic mental health services. This represents a shift in perspective from a deficit focus to an abilities focus. There is however a paucity of research into values and strength-based approaches. This thesis portfolio aims to contribute to this area of research.

Methods: A systematic review of the literature was conducted to review strength-based approaches for mentally disordered offenders in forensic mental health settings. Four databases (MELINE, PsycINFO, EMBASE and SCOPUS) were searched and 10 studies were included in the review. The outcomes measures in the included studies were recovery, quality of life, violence/risk, recidivism, mental health symptoms, therapeutic milieu, and engagement.

In the empirical study, a Grounded Theory Methods was used to build a theory of values of men in a medium secure unit who have offended. Interviews were conducted with nine inpatients in a Scottish medium secure unit.

Results: The findings of the systematic review, although limited, suggest that a strength-based approach will facilitate outcomes in quality of life, recovery, mental health symptoms, violence, risk, recidivism, and engagement. Limited evidence was found and there was also a lack of consistent findings. Further consideration of the long-term impact of such an approach and further high-quality research is needed to establish the effectiveness of strength-based approaches.

In the empirical paper, a model of values in mentally disordered offenders was produced. The expressed values of MDOs were made up four separate categories relating to: (1.) connecting with others; (2.) living a healthy life; (3.) being productive and contributing; and (4.) having agency and being in control. As part of the model, a consideration is given to the development of values throughout life and the barriers and opportunities that impact on an individual’s life and the impact that has on values.

Conclusions: The findings of this thesis indicate that there is a benefit to using strength-based and values informed approaches to working with mentally disordered offenders. The findings of this research support the view that mentally disordered offenders share similar values to non-offenders. Further research is needed, to be able to clearly support the effectiveness of strength-based
Values and Recovery in Forensic Mental Health approaches and also to evaluate the use of values to guide clinical care and treatment.

**Overall Thesis Word count: 20,551**
Lay Summary of Thesis

There has been a recent shift in treatment approaches to offenders with mental disorders. Previously, there has been a focus on managing risk and focusing on mental health difficulties. Strength-based approaches have helped move towards a way of working with people in forensic mental health services that also places an importance on working with the person’s strengths, and values, which are the things in life that are important to them.

The first part of the thesis aimed to review how effective new strength-based approaches have been in forensic mental health settings. This was done by bringing together all of the studies that have reported on this. This review found 10 studies, from many data bases that documented strength-based approaches in forensic mental health settings. The review found that there was some evidence to support the effectiveness of strength-based approaches in improving people’s quality of life, recovery, mental health symptoms, engagement and a reduction in violence and risk. The conclusions that can be made from this review are limited however, as the quality of studies found was generally poor. Further high-quality research is needed therefore, to establish the effectiveness of this approach in forensic mental health settings.

The second part of the thesis explored the values of men in a Scottish Medium Secure Unit. Nine inpatients were interviewed, and Grounded Theory Methods (a qualitative research approach) was used to understand and develop a theory of the
Values and Recovery in Forensic Mental Health

values of mentally disordered offenders. From the interviews, four categories of values emerged: connecting with others; living a healthy life; being productive and contributing; and having agency and control. This seems to suggest that mentally disordered offenders share similar values to non-offenders. Moreover, the men interviewed discussed the barriers that stop them from living a life in line with their values. This included interpersonal relationships; environment and culture; health challenges; and the consequences of offending. This study helps build an understanding of the values of men in medium secure units and the areas in life that prevent them from living a life in line with their values. It is hoped that this will help inform treatment and care in forensic mental health settings.
Part A: Systematic Review

Systematic Review of Strength-Based Approaches in Forensic Mental Health

Prepared for submission to the

*Journal of Aggression and Violent Behaviour*

(See Appendix 3 for the journal’s guide for Authors)
Abstract
Strength-based approaches to working with MDOs move from a focus on mental disorder and risk to a wider consideration of the individual that considers their strengths, personal priorities and competencies. This represents a shift in perspective from a deficit focus to an abilities focus. Within forensic mental health, the Recovery Model and Good Lives Model have been the most prominent of strength-based approaches that have been adopted with the goal of changing how forensic mental health practitioners work with MDOs. There is however a paucity of treatment literature in both forensic mental health and strength-based approaches.

This systematic review critically reviews the current research literature on strength-based approaches for mentally disordered offenders in forensic mental health settings. Four databases (MELINE, PsycINFO, EMBASE and SCOPUS) were searched and 10 studies were included in the review. The outcomes measured in the included studies were recovery, quality of life, violence/risk, recidivism, mental health symptoms, therapeutic milieu, and engagement.

The findings, although limited, suggest that a strength-based approach can facilitate outcomes in quality of life, recovery, mental health symptoms, violence, risk,
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recidivism, and engagement. Further consideration however, of the long-term impact of this approach is needed.

Keywords: strength-based; recover; good lives model; forensic mental health; mentally disordered offender; United Kingdom

1. Introduction

1.1. Mentally Disordered Offenders

Mentally Disordered Offenders (MDOs) are defined as people with a mental illness, personality disorder or intellectual disability and have a history of significant offending behaviour, and/or representing a significant risk to others (Forensic Mental Health Matrix, 2011). They are a complex group and diverse population who present with a range of chronic, complex and co-morbid mental health difficulties (Palijan et al., 2010) and are often regarded as difficult to treat (Barnao & Ward, 2015). MDOs are subject to compulsory measures under mental health legislation and require care and management with increased security and by specialist forensic expertise.

From a legal perspective, offenders with mental illness have been treated as objects rather than subjects due to a predominantly risk-driven criminal justice service, and a fear that their mental status would result in recidivism (Vandevelde, 2017). The treatment and management of mentally disordered offenders is informed by two distinct institutions: the criminal justice and the mental health systems, and
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therefore has to balance risk centered and psychopathology approaches. This creates difficult conceptual, clinical and ethical issues in forensic populations as the patient’s well-being is balanced with a focus on protecting the public through the reduction of risk and recidivism. Balancing the aims of these two distinct institutions is considered problematic (Barnao & Ward 2015) and is thought to contribute to MDOs being disadvantaged with regard to access to mental health care (Grounds, 2019). The challenge of working with MDOs is further compounded by a small evidence base for interventions and paucity of theories and rehabilitation models to guide clinical practice (Robertson et al., 2011).

Interventions for mentally disordered offenders have taken three broad approaches which need to balance the priorities of the criminal justice and mental health systems: (1) treatment targeting mental illness and other psychological issues; (2) interventions based on the principles of the Risk-Need-Responsivity (RNR) model (Andrews et al., 1990), with a focus on reducing recidivism; and (3) strength based approaches that aim to enhance individuals’ well-being (Barnao & Ward, 2015). Within forensic mental health, the first two approaches, the risk and psychopathology paradigms, have been utilised by teams in combination to develop a rehabilitation framework. These two approaches however, have diverging aims and assumptions, and values, which have made this combined approach problematic (Barnao & Ward, 2015). Moreover, research with mentally disordered offenders and personality disorders has highlighted the importance of treatment
consisting of more than direct individual interventions but also that effective therapeutic milieus are developed (Long et al., 2012).

1.2. Strength Based Approaches and Forensic Mental Health

A recent critical review explored potential discrimination towards MDOS. It found evidence that offenders with a mental disorder were not able to access the equivalent mental health care to that available for non offenders with a mental disorder (Grounds, 2019). Efforts have been made to promote the voice and rights of MDOs and the adoption of a strength-based approach to criminal justice has resulted in developments facilitating individuals to be able to play a more active role in the whole legal process. This is supported in case law of the European Court for Human Rights, which gives mentally disordered offenders the right to actively participate in the earliest stage of criminal proceedings at the stage of police interrogation (Verbeke et al., 2015).

Strength-based approaches to working with MDOs move from a focus only on mental disorder and risk to a wider consideration of the individual that considers their strengths, personal priorities and competencies. This represents a shift in perspective from a deficit focus to an abilities focus. Strength based approaches have been used within general mental health services for a number of years to inform interventions with patients from a service level to individual interventions with patients, however there is limited evidence currently in support of this shift. A meta-analysis of the strengths-based model of service delivery in general mental
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health did not find evidence to support the effectiveness of this approach in improving functioning and quality of life (Ibrahim et al., 2014).

This paradigm shift away from a deficits model is not only within clinical psychology but a shift to strength-based approaches has occurred in different disciplines within forensic mental health, general mental health, criminal and educational domains. These are all part of a strength based movement and include: law (human rights), criminology (desistance paradigm), mental health care (the recovery paradigm), forensic psychology (the Good Lives Model), special needs education (Quality of Life-approach) and family studies (family recovery) (Vandevelde et al., 2017). The term strength-based practice has however, been found to have been used loosely to describe a variety of approaches (Vandevelde et al., 2017) and further research is needed therefore to clarify this.

Within forensic mental health, the Recovery Model and Good Lives Model have been the most prominent of strength-based approaches that have been adopted with the goal of changing how forensic mental health practitioners work with MDOs (Drennan & Alred, 2012). The Recovery Model is one of the most prominent of strength-based approaches, which has been used in mental health services and extended to forensic based populations. The Good Lives Model (GLM) is a psychological intervention that shifts from an offending focus to a broader consideration of personal strengths and goals in the pursuit of living a “good life” (Ward & Maruna, 2007). Through the development of strength-based approaches,
there is greater acknowledgment of the difficulties of dual recovery from mental illness and offending behavior as there is an additional process of “offender recovery”. This process entails the individual building a non-offender identity. Dual recovery attempts to balance risk management and restoring a meaningful and satisfying life in patients (Drennan & Alred, 2010).

2. Aims of the Review

The overall aim of this review is to present and explore strength-based approaches with a focus on empirical evidence of the effectiveness of these approaches in forensic mental health and, in particular, mentally disordered offenders. There is a recognised paucity of treatment literature in forensic mental health (Davies et al., 2007; Hillbrand & Young, 2008) and this limitation is also true of strength-based approaches (Barnao & Ward, 2015; Vandevelde et al., 2017). The review will, therefore, consider the use of strength-based approaches in a broad sense: from a systemic and therapeutic milieu-based level to direct clinical interventions with patients. It will also consider a range of quantitative designs and use of outcome measures, including studies without controls. These methods should aid the exploration of the efficacy of this emerging approach to forensic mental health, whilst acknowledging and working within the limitations of the current evidence base.
3. **Methods**

3.1. *Literature search strategy*

The focus of the review was to examine strength-based approaches in forensic mental health settings and MEDLINE, PsycINFO, EMBASE and SCOPUS databases were searched for peer-reviewed articles, working papers and policy reports, published in English between 1 January 1990 and 7th October 2019. The following search terms were used:

(psychiatr* OR mental*) AND (forensic OR secure OR offender* OR prison*) AND ("strength* based" OR "strength* model*" OR "strength* perspective*" OR "recovery model*" OR "recovery approach*" OR "recovery paradigm*" OR "good lives model*")

All articles including the search terms in either the title or abstract or key words were identified.

3.2. *Inclusion and exclusion criteria*

To be included in the main review and further analysis, the papers had to meet the following inclusion criteria: (i) Participants included either males or females, aged over 18 years old and diagnosed or defined as mentally disordered offenders (using the definition stated earlier from the Forensic Mental Health Matrix, 2011); (ii) Studies were included from low, medium, and high secure units; prison samples; people detained in hospital and described as mentally disordered or forensic
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patients; and forensic outpatients who were managed in the community.  (iii) The study reported on empirical intervention studies of strength-based approaches (including formal interventions and overarching models of care); (iv) was available in English language; and (v) included pre- and post-intervention measures.

Papers were excluded if they (i) employed non-strength-based approaches; (ii) were qualitative studies, (iii) were single case studies; (iv) or did not report any new data (e.g. review papers).

The inclusion and exclusion criteria were chosen to reflect the relative paucity in the evidence base for psychological approaches within forensic mental health.

3.3. Outcome measures

Studies were included that used psychometric outcome measures and reporting of clinical data, for example violent incidents and PRN medication use. Outcome measures of particular interest were measures of recovery, quality of life, violence, risk, recidivism, mental health symptoms, engagement, and therapeutic milieu.

3.4. Assessment of quality

To rate the quality of papers, quality criteria developed in a previous systematic review (Ross et al., 2013) were adapted for the present review. The 11 quality criteria used were informed by guidelines from the Centre for Research and Dissertations (CRD, part of the National Institute for Health Research, CRD, 2008);
and assessed the following areas: risk of internal and external bias, statistical issues, quality of the intervention, generalisability, and choice of outcome measure. Using the quality criteria, each was scored as either: Well covered = 3, Adequately addressed = 2, Poorly addressed = 1, Not addressed = 0 and Not applicable = 0. Each paper was then given a total score. The quality criteria used are provided in Appendix 1.

To ensure inter-rater reliability, a second marker was utilised to review 50% of the papers. From independently reviewing 5 papers, an exact agreement was found on 76% of ratings, with an intraclass correlation co-efficient (ICC) of 0.97, indicating excellent inter-rater agreement. The ICC estimates were calculated using SPSS Statistical package version 24 (IBM corp., 2016), using a two-way mixed effects model. Through this process, any conflicts of scoring were reviewed and if appropriate, amendments were made.

4. Results

4.1. Search results

The comprehensive literature search of the four databases produced 640 papers. After de-duplication 506 papers remained. 452 studies were excluded during a screening of the title and abstract. Following a full text review of the remaining 54 papers, 10 met all the inclusion criteria for in-depth review and assessment. The other 44 articles did not meet the inclusion criteria for this review due to: study design (19 papers: qualitative (5); case study (4); commentary/ service description
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(9); and review (1) based designs); **intervention** (14 papers: interventions based on the Risk-Need-Responsivity (RNR) model or a focus on reducing recidivism (11); no strength based mental health intervention (3)); **not a mentally disordered offenders population** (9 papers: sex offenders (4); prison population (4); family members of MDOs(1)). Furthermore, 2 papers were excluded as they utilised the same data from a sample across multiple papers. Figure 1. shows a PRISMA flow chart of the search process in this review:

**Figure 1.** PRISMA Flow diagram of the search strategy.
4.2. **Study setting and characteristics**

The ten included studies that met all the inclusion criteria are summarised in table 1. One study was a randomised control trial (RCT) design (MacIness et al., 2016). The other nine studies were pre- and post-intervention studies. The participants in the studies were all adults considered to be mentally disordered offenders (MDOs) or offenders not guilty by reason of insanity (NRGI). In 9 of the studies, the participants were predominantly male, with the exception of one study of eight female MDOs (Wiglesworth & Farnworth, 2016). Studies were undertaken in the UK, Netherlands, Canada, USA, and Australia. The settings for the studies included a range of forensic services: low secure unit (2), medium secure units (4), forensic mental health hospitals (3), and forensic outpatient services in the community (2) (one study included both low and medium secure sites). Participants in the included studies had a range of diagnoses including psychotic disorder, personality disorder, and substance misuse. Furthermore, there was a range of recorded offences, predominantly consisting of violent offences but also including sexual offences and property offences.

4.3. **Types of intervention**

Eight of the included papers presented interventions at a therapeutic milieu or a service level. Two papers described direct interventions. Furthermore, one paper described a case management and direct intervention approach. These different types of interventions were reported as being informed by either a strength-based
Values and Recovery in Forensic Mental Health approach, the recovery model or the Good Lives model, all of which come under the broader strength-based umbrella.

4.3.1. Therapeutic Milieu

Eight studies describe a strength-based approach as part of the therapeutic milieu. Of these eight, two papers explored interventions informed by the Good Lives Model (Bouman et al., 2009; and Ward & Attwell, 2014). The Good Lives Model proposes that offenders have the same needs and aspirations as everyone else (Ward, 2002). The aim of GLM is to build resources for the individual to live a life that is meaningful, fulfilling, in line with their values and to reduce risk. As such, these principles were utilised in the service design, for example using goal orientated action plans that are created collaboratively, to identify “primary goods” and consider ways to achieve this alongside possible obstacles.

Four of the included papers describe the service as being informed by the recovery approach (Corlett & Miles, 2010; Doyle et al, 2012; Gudjonsson et al., 2011; Wiglesworth & Farnworth, 2016), with the aim of increasing treatment motivation and engagement, reducing challenging behavior, violence and risk. Wiglesworth and Farnworth (2016) described the introduction of a sensory room as part of a recovery-based approach, rather than the previously utilized Risk-Need-Responsivity (RNR) based method of seclusion and considers the implications at a service level. Two papers described their interventions as strength based and did not define this further (Livingston et al., 2013; and Macness et al., 2016). Macness
et al. (2016) described an approach to increase participation of the patient in their care with the staff team, with the aim of improving quality of life.

4.3.2. Direct Intervention

Two studies described direct interventions using a strength-based approach. Walker and Paton (2015) evaluated “LifeMusic”, a recovery-based music therapy group, with the aim of creating ways for individuals to express emotion, connect with others and improve self-esteem. Smith, Jennings, and Cimino (2010) evaluated the “Stage Progressive Model”, a program that appears to be both a direct intervention and also a case management-based intervention. The program has 5 levels with the aim of individuals progressing through the program to develop life skills, coping skills and community supports to facilitate a successful transition into the community and increased independence. This approach also used a positive behavioural management approach, with privileges attached to different levels of the program and increases in independence.
<table>
<thead>
<tr>
<th>Author(s), Year, Country</th>
<th>Participants</th>
<th>Setting</th>
<th>Intervention</th>
<th>Outcome Measures</th>
<th>Design</th>
<th>Main Findings</th>
</tr>
</thead>
</table>
| Bouman et al. (2009) (NL) | 135 adult males, MDOs, forensic outpatients. | Forensic outpatient treatment centre | Therapeutic milieu/service level intervention: Good Lives Model informed service design. | Quality of Life:  
- Lancashire Quality of Life Profile (LQoLP; van Nieuwenhuizen et al., 1998)  
Violence/ risk:  
- Self-reported Delinquent Behaviour Inventory (SRDB; van Dam et al., 1999)  
Recidivism:  
- Recidivism data | Prospective multicentre study with random sample | No control | 24.5% of those that completed the intervention were convicted of a new offence. The study found a modest negative relationship between subjective wellbeing and recidivism. The data suggested that satisfaction with health was significantly correlated with recidivism in relation to violent offences (AUC = 0.72, p < 0.01). |
| Corlett & Miles (2010) (UK) | 17 adult males, MDOs, forensic inpatients.  
26 staff members. | Medium Secure Unit | Therapeutic milieu/service level intervention: Application of recovery model in a secure NHS forensic service. | Recovery:  
- Developing Recovery Enhancing Environments Measure (DREEM; Ridgeway & Press, 2001) | Service evaluation | No control | On ratings of 24 recovery elements, MDO’s and staff rated all elements as moderately important (above median value). However, it was found that staff rated them as more important and better implemented in the service than MDOs. There was a significant effect on the implementation of recovery elements by the MDO’s forensic history, including restriction status and index offence type (F(2,12)=7.250, p < 0.01). |
- Milestones to recovery scale (MTRS; Doyle et al., 2012) | Service evaluation and validation of MTR framework | No control | The MTR was found to be a valid tool for clinicians for planning and assessing treatment for MDO’s and for promoting patient recovery. Therapeutic engagement in structured activities and treatment (using the recovery model) was found to be associated with recovery and important for progression through the medium secure unit pathway. The therapeutic engagement scale had the lowest AUC = 0.24, p = 0.008 and best |
## Values and Recovery in Forensic Mental Health

<table>
<thead>
<tr>
<th>Gudjonsson et al. (2011) (UK)</th>
<th>75 adults (71 male, 4 female) MDOs, forensic inpatients</th>
<th>Medium Secure Unit (73), Low Secure Unit (2)</th>
<th>Therapeutic milieu/service level intervention: Application of recovery model in a secure NHS forensic service.</th>
<th>Recovery</th>
<th>Service evaluation</th>
<th>Theory validation.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Quality of Life:</td>
<td>The recovery journey, as measured by the RJQ, correlated positively with treatment motivation (medium effect size, ( r = 0.39 )), treatment engagement (large effect size, ( r = 0.70 )), and negatively with social problems (large effect size, ( r = -0.50 )).</td>
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<td></td>
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<td></td>
<td>Mental health:</td>
<td>Furthermore, recovery correlated positively with quality of life (medium effect size, ( r = 0.43 )) and negatively with hopelessness (medium effect size, ( r = -0.40 )).</td>
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<td>Engagement</td>
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<td></td>
<td>Behaviour/ Offending:</td>
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<td></td>
<td>Recovery</td>
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Livingston et al. (2013) (Canada)

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<td></td>
<td></td>
<td></td>
<td>Quality of Life:</td>
<td>The intervention was found to have a limited impact on recovery, empowerment, internalised stigma, service engagement, and the therapeutic milieu of the service; with most patient scores not being statistically different on pre and post measures.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Mental health:</td>
<td>Positive effects were found however from peer support on personal recovery (( r = .40, p = .05 )). Furthermore decreases in internalized stigma after participating in peer support were found (( n = 18, M_{\text{diff}} = -0.05, SD_{\text{diff}} = 0.27 )).</td>
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<td>Engagement</td>
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<td>Behaviour/ Offending:</td>
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MacIness et al. (2016) (UK)

<table>
<thead>
<tr>
<th>55 patients &amp; 47 nurses (intervention)</th>
<th>6 medium secure in-patient</th>
<th>Therapeutic milieu/service level intervention:</th>
<th>Quality of Life:</th>
<th>Service evaluation</th>
<th>Theory validation.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Quality of Life:</td>
<td>The quality of life estimated</td>
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<td></td>
<td></td>
<td></td>
<td>Manchester Short Assessment of Quality of Life scale (MANSA; Priebe et al., 1999)</td>
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## Values and Recovery in Forensic Mental Health

<table>
<thead>
<tr>
<th>Study</th>
<th>Design</th>
<th>Participants</th>
<th>Setting</th>
<th>Intervention</th>
<th>Outcomes</th>
<th>Service Evaluation</th>
<th>Notes</th>
</tr>
</thead>
</table>
| Smith et al. (2010) (US) | N group, 57 patients & 45 nurses (control group) | 85% male and 15% female participants | Structured patient-clinician communication approach to increase active patient participation in discussions about their care with the aim of improving quality of life in secure settings (DIALOG approach). | Recovery:  - Process of Recovery Questionnaire (QPR; Neil et al., 2009)  
Treatment engagement/therapeutic milieu:  - Engagement with Services - Helping Alliances Scale (HAS; Priebe, 1993)  
- Ward Climate - Essen Climate Evaluation Schema (EssenCES; Schalast et al., 2008)  
- Patient Satisfaction - Forensic Satisfaction Scale (FSS; MacIness et al., 2010)  
Behaviour/Offering:  - Disturbed behaviour was recorded from the ward untoward incident forms and patient progress notes  
Staff measures:  - Nurse Stress - Maslach Burnout Inventory (MB; Maslach, 1981) | Staff measures:  - Nurse Stress - Maslach Burnout Inventory (MB; Maslach, 1981)  
Treatment effect was 0.2 (95% CI: -0.4 to 0.8) at 6 months and 0.4 (95% CI: -0.3 to 1.1) at 12 months.  
There were good response rates and low withdrawal rates.  
Furthermore, a reduction in "disturbed behaviour" was found compared to the control group, including: number of seclusions, physical restraints, attempts to self harm, and violence. | No control group |
| Walker & Paton (2015) (UK) | 73 adults (71 men and 2 women), adjudicated not guilty by reason of insanity (NRGI) | 42 Bed secure residential treatment facility | Direct intervention: “Stage progressive recovery model”. Recovery model based approach to build life skills, coping skills and community supports. A focus on successful transitions from secure care to the community. | Intervention outcomes:  - Recorded readmissions, abstinence, steady housing, and meaningful activity.  
Violence/risk:  - Observations of challenging behaviour | Service evaluation:  
No control group  
Attendance at the recovery-based music group was associated with a reduction in PRN medication use in the day following attendance, indicating a reduction in distress. | No control group |

### Additional Notes
- **Smith et al. (2010) (US)**
  - The study showed positive outcomes with 90% of participants who completed the program meeting criteria for “overall success”. Therefore for 90% there were no readmissions to state hospital; and no rearrests following re-entry.
  - Furthermore, 49% were rated as “highly successful”, indicating that for 49% of participants there were no rearrests; no readmission; maintained abstinence; steady housing and meaningful activity in community.
  - Further statistical analysis was not completed on the outcome data.

  - Adults, MDOs, forensic inpatients (number Low secure forensic unit (13 bed))
  - Direct intervention: Recovery based music therapy group: Lifemusic.
  - Intervention outcomes:  - Qualitative feedback post group (verbal and questionnaires)  
Violence/risk:  - Observations of challenging behaviour | Service evaluation:  
No control group |
### Values and Recovery in Forensic Mental Health

| Ward & Attwell (2014) [UK] | 10 Adults, MDO’s, Forensic outpatients (gender not specified) | 2 community outreach forensic psychological services | Therapeutic milieu/service level intervention: Services guided by principles of the Good Lives Model | Intervention outcomes:  
- Semi-structured interviews  
Rating scale constructed for the study to measure effectiveness of the service | No statistical analysis | Service evaluation | No control | Semi-structured interviews and rating scale results indicated that both services were found to improve psychological well-being, general quality of life and to manage risk of re-offending. Furthermore, service engagement was found to help form and maintain positive relationships and social integration.  
No statistical analysis was undertaken on rating scale data. |
|---|---|---|---|---|---|---|---|---|
| Wiglesworth & Farnworth (2016) [Aus] | 8 Adult females, MDOs, forensic inpatients | Forensic mental health hospital | Therapeutic milieu/service level intervention: Recovery approach at a service level, focusing on the introduction of a sensory room rather than the use of seclusion | Intervention outcomes:  
- The Adult/Adolescent Sensory Profile (SP) assessment (Brown and Dunn, 2002)  
- The sensory room evaluation form, based on Novak et al. (2012) which captured ratings of stress.  
- Focus group with staff. | No statistical analysis | Service evaluation | No control | A reduction in stress was documented following the use of the sensory room.  
A higher mean change in stress was found for patient initiated use of the sensory room \( (M = 2.81, n=16) \) as opposed to staff initiated use \( (M = 2.66, n = 32) \).  
Further statistical analysis was not completed on the outcome data. |
4.4. Outcomes

Eight domains of outcomes were reported across the studies. Five studies reported recovery-based outcomes; five reported quality of life outcomes; four reported violence/risk outcomes; one study reported recidivism outcomes; five studies reported mental health symptoms outcomes; two reported outcomes for therapeutic milieu; and 3 studies reported engagement outcomes.

4.4.1. Recovery

Seven recovery outcomes were recorded by five studies. No single measure of recovery was used by more than one study. Service users’ personal recovery was measured by four measures across four studies: Milestones to Recovery Scale (MTRS); Recovery Journey Questionnaire (RJQ); Mental Health Recovery Questionnaire (MHRM); and Process of Recovery Questionnaire (PRQ). Outcomes were found to vary regarding the intervention’s effect on recovery. A significant association was found from attending at least one peer support group on personal recovery in Livingston et al.’s (2013) study, however evidence was not found that the wider service level intervention improved the service users’ personal recovery. Moreover, the introduction of a structured patient-clinician communication approach to increase patient involvement in their care in a medium secure unit, did not find evidence of improved recovery outcomes in service users (Maclness et al., 2016).
Across the studies, it was reported that increased levels of therapeutic engagement and increased opportunities for structured activities and treatment were found to improve individual recovery. Furthermore, recovery was found to correlate positively with quality of life and negatively with social problems. In Gudjonsson’s (2011) study, recovery was not found to correlate significantly with disturbed behaviour in an inpatient setting.

Two studies measured how well a service implemented a service design that was aligned with the recovery model (Corlett & Miles, 2010; and Livingston et al., 2016). It was found that the intervention did not have a significant effect on perceptions of recovery orientation services in both patients and staff (Livingston et al., 2013). In Corlett and Miles’ (2010) paper, staff and patient perceptions of how well a recovery approach had been implemented differed, with staff consistently rating it as better implemented across ratings on 24 recovery elements, using the Developing Recovery Enhancing Environments Measure (DREEM). Furthermore, MDOs forensic history was found to be predictive of success of implementation of recovery approach, with differences found between sexual and violent offenders; and between MDO’s detained under a Section 41 Restriction Order than those on a civil section.

4.4.2. Quality of Life

Five studies reported quality of life outcomes using two different measures: the Lancashire Quality of Life Profile (LQoLP) (Bouman et al., 2009) and the Manchester
Short Assessment of Quality of Life (MANSA) (Gudjonson et al. 2011; and MacInness et al., 2016). Two studies did not use a formal measure of quality of life but gathered clinical data related to quality of life (Smith et al., 2010; and Ward and Attwell, 2014).

In a randomised control trial, positive effects were found on quality of life from recovery focused service level intervention, as compared to controls. The study reports however, that a full trial would be required to estimate the effect with better certainty (MacInness et al., 2016). A further study reported an improvement in quality of life for patients in a community forensic team with a good lives model informed service design (Bouman et al., 2009). This was however a self-rated item on a unvalidated rating scale developed for the study. Based on these two studies, it seems that quality of life improves from a strength-based approach, however, the evidence is somewhat limited currently.

Other studies explored how quality of life related to other outcome domains. There was a positive correlation found between QOL and recovery with a medium effect size found (Gudjonsson et al., 2011). Quality of life and subjective well-being were related to recidivism data, with a modest relationship found with violent reconvictions. Furthermore, satisfaction with health and life fulfilment were found to predict significantly decreased levels of self-reported offences (Bouman et al., 2009).
4.4.3. Violence/ Risk

Four studies reported on outcomes related to violence and risk. Outcome measures were used in two of the studies: the Self-reported Delinquent Behaviour Inventory (SRDB); and the Disruptive Behaviour and Social Problem Scale (DBSP) (Bouman et al., 2009; Gudjonsson et al., 2011). Two further studies used clinical data: clinical notes, untoward incidents forms, and recorded PRN use (MacIness et al., 2011; and Walker & Paton, 2015).

Three of the four studies reported a reduction in violence and risk from strength based interventions. As reported previously one study found a significant association between quality of life and self-reported violent offences, suggesting that as quality of life improves, violence and risk decreases (Bouman et al., 2009). MacIness (2011) found a reduction in challenging behaviour and violence from patients in the treatment group as compared to controls. This included a reduction in recorded seclusions, physical restraints, self-harm attempts and violence. Furthermore, patients who attended a recovery-based music group had a reduction in PRN medication use and challenging behaviour (Walker & Paton, 2015). In one of the studies however, a significant relationship was not found between disruptive behaviour and recovery or quality of life (Gudjonsson et al., 2011).

4.4.4. Recidivism

Bouman et al. (2009) recorded rates of recidivism, by obtaining it from the Central Judicial Documentation register at the Dutch Ministry of Justice. No other studies
Values and Recovery in Forensic Mental Health reported recidivism data. Recidivism data was collected at follow up at a time between 28 and 46 months. It was found that 24.5% of those that completed the intervention, were convicted of a new offence committed after the engagement with a Good Lives Model informed service. The study found a modest negative relationship between subjective wellbeing and recidivism. The data suggested that satisfaction with health was significantly correlated with recidivism in relation to violent offences.

4.4.5. Mental health symptoms

Four studies reported outcomes related to mental health symptoms, recorded with two outcome measures: the Beck Hopelessness Scale (BHS); and internalised stigma of mental illness scale (ISMI). A negative correlation was found between recovery and BHS (medium effect size), suggesting that as a recovery approach progresses, feelings of hopelessness reduce (Gudjonsson et al., 2011). In Livingston et al.’s (2013) study, the intervention was not found to have a significant effect on internalised shame with the exception of patients who had used peer support, which appeared to reduce internalised stigma.

4.4.6. Therapeutic Milieu

Two studies reported the therapeutic milieu outcome using the EssenCES (Livingston et al., 2013; MacIness et al., 2016). In both studies, the intervention did not have a significant effect on staff and patients’ perceptions of therapeutic milieu.
4.4.7. Engagement

Five different types of engagement outcomes were recorded by three studies. Across the three studies, engagement outcomes varied. In Livingston et al.’s (2013) paper, the recovery informed service level intervention, did not have a significant effect on levels of service engagement. In MacInness et al.’s (2016) study it was found that there was a small increase in engagement as the intervention progressed. Furthermore, it was found that there was not a significant treatment effect on reported service user satisfaction. A positive relationship was however, found between recovery and treatment motivation (medium effect size) and treatment engagement (large effect size) in Gudjonsson et al.’s (2011) study of the application of the recovery model in NHS medium and low secure units.

4.5. Quality of included studies

Ratings for all included papers on the 11 quality criteria are given in table 2, which allows for the consideration of each paper’s relative strengths. MacInness et al (2016) is the methodically strongest study. Fluttert et al. (2010) was of average quality, however the other eight studies were found to be of low quality overall. Nine of the ten studies were not able to be rated on the first three quality criteria, which assessed the internal validity of the studies as these criteria were not applicable to these studies.
Table 2. Quality assessment of included studies

<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Randomisation</th>
<th>Allocation</th>
<th>Attrition</th>
<th>Outcome measures</th>
<th>Measure Relevance</th>
<th>Power</th>
<th>Analysis</th>
<th>Intervention Definition</th>
<th>Fidelity</th>
<th>Routine</th>
<th>Follow up</th>
<th>Overall score (/33)</th>
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<tbody>
<tr>
<td>Bouman et al. (2009)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>AA</td>
<td>WC</td>
<td>NR</td>
<td>WC</td>
<td>PA</td>
<td>NR</td>
<td>WC</td>
<td>WC</td>
<td>15</td>
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<tr>
<td>Corlett &amp; Miles (2010)</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>PA</td>
<td>WC</td>
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<td>Doyle et al (2012)</td>
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<tr>
<td>Gudjonsson et al. (2011)</td>
<td>NA</td>
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<td>NA</td>
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<td>Livingston et al. (2013)</td>
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<td>WC</td>
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<tr>
<td>Smith et al. (2010)</td>
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<td>NA</td>
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<td>AA</td>
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<td>PA</td>
<td>WC</td>
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<td>Walker &amp; Paton (2015)</td>
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<td>AA</td>
<td>NA</td>
<td>WC</td>
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<td>Ward and Attwell (2014)</td>
<td>NA</td>
<td>NA</td>
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<td>Wiglesworth &amp; Farnworth (2016)</td>
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<td>AA</td>
<td>NA</td>
<td>WC</td>
<td>NA</td>
<td>9</td>
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(WC) Well covered = 3, (AA) Adequately addressed = 2, (PA) Poorly addressed = 1, (NA) Not addressed = 0, (NR) Not reported = 0 and (NA) Not applicable = 0.
5. Discussion

5.1. Main findings

A systematic review of strength-based approaches with mentally disordered offenders (MDOs) was conducted. It was demonstrated that MDOs benefited from strength-based approaches, with some improvements noted in the domains of quality of life, recovery, engagement, violence/risk, recidivism and mental health symptoms. The findings suggest that strength-based approaches are positively applicable in forensic mental health settings, however the conclusions that can be drawn from this are limited as the overall quality of the studies was poor and the outcomes were not consistent across the studies.

5.2. Strengths of the papers

A strength of the papers is that all were conducted in clinical settings as part of routine clinical practise across a range of forensic mental health environments. The sample of participants and the outcomes found are therefore likely to be reflective of the challenges of working with this population and carrying out research with good external validity.

Furthermore, six of the papers were rated as having “well covered” analysis of outcome measures and reporting of results, therefore providing clear and meaningful results. Across the papers, the outcomes measured and recorded in the papers were also mainly very relevant to the intervention and evaluation, with six
Values and Recovery in Forensic Mental Health

papers rated as “well covered” and two papers as “adequately covered” on ratings of quality criteria.

5.3. Limitations of the papers

Overall, the quality of studies was reasonably poor. Only one study employed a randomised controlled trial design and the nine other studies did not utilise any control groups. It is not clear therefore, whether the results may have been confounded by factors outwith the strength-based approach which may have had an influence on the therapeutic outcomes reported. The lack of use of controls is acknowledged by many of the papers and moreover, is a wider issue within forensic mental health populations (Hockenhull et al., 2015). The use of control and withholding treatment from patients raises ethical considerations and human rights issues (Smith et al., 2010). Furthermore, priority is given to security and risk consideration over the needs of research (Fitspatrick et al., 2010). This, therefore, contributes to a general lack of randomised controlled trials in forensic mental health. Moreover, it is likely that the heterogeneity of the service users included in the study, impacted on the outcomes recorded. There were a range of mental disorders, personality disorders, substance misuse and offence history recorded. Furthermore, the included studies had small samples and power was not reported in any of the studies.

Furthermore, the outcomes were often inconsistent across the studies. There was a lack of follow up in the studies with only three of the ten studies recording follow
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up data. There was also little overlap of the same measures used across studies. Only two measures, the Manchester Short Assessment of Quality of life (MANSA); and the Essen Climate Evaluation Schema (EssenCES), were used in multiple studies. Both outcome measures were used in two papers each. This limitation has been acknowledged in previous forensic mental health research with a previous review of interventions of MDOs reporting 345 different measures from 300 trials (Cure et al., 2005).

A further limitation of the papers is the lack of clarity regarding the interventions used. All can be categorised as strength-based interventions at a service and a direct intervention level; however it is not clear as to how this has been operationalised within the service. It is difficult therefore to be confident in making comparisons across these studies. This is a problem and a criticism of the research that has been found in the wider strength-based literature (Ibrahim et al., 2014).

Many of these criticisms are also criticisms of research within forensic mental health generally. It is difficult to standardise outcome measures with this population, due to the multiple targets for intervention and multiple problems, including mental health and substance misuse difficulties. Furthermore, research has focused more on public safety rather than clinical and rehabilitation outcomes (Fitzpatrick et al., 2010). Forensic populations also frequently move through different health and custodial settings and clinically there is a priority for security and duty of care to the individuals, that limits the possibilities of undertaking
Values and Recovery in Forensic Mental Health

randomised controlled trials in forensic mental health research (Fitzpatrick et al., 2010).

5.4. Strengths and limitations of review

The use of an interrater who was independent of the research helped limit the potential subjective bias of the methodological analysis.

A criticism of the review is that it excluded qualitative studies, despite their being a number of qualitative studies undertaken in both forensic mental health and in strength-based approaches (Roychowdhury, 2011; O’Sullivan et al., 2013). Future reviews may benefit from a consideration of taking a mixed research methods approach, for example utilising the mixed methods appraisal tool (MMAT) (Pluye et al., 2011), which would allow for a consideration of qualitative, quantitative and mixed methods studies. Furthermore, given the low quality of included studies and lack of RCTs, future research should consider using a different a quality criteria scale or making further adaptations to that used in this review.

A further limitation of this review is that only studies in English language were included in the review, which could potentially have caused biases in sampling and potentially limited the studies included in the review. Moreover, the inclusion of two service evaluations with no statistical analysis, may limit the findings of this review.
Values and Recovery in Forensic Mental Health

5.5. Implications for further research and clinical practice

Strengths based approaches show promise as a model for service design and direct interventions within forensic mental health. Strength-based and recovery orientated approaches have been increasingly welcomed by policy makers (Tse et al., 2016). Future research and clinical practice would benefit from developing a clearer framework to inform service design and therapeutic milieu. These approaches would benefit from clear definitions and being operationalised or manualised and helping to inform how the recovery model and Good Lives Model compare to each other. This would be assisted from a more consistent and standardised approach to outcome measures across studies.

Operationalising this approach would also aid with staff training. This is important as it is clear that this approach is regularly used at a staff level to inform service design and the therapeutic milieu. This was apparent in the review, with 8 of the 10 included papers reporting a service design methodology. In these papers it is not clear what training that staff have had to implement this and to move away from a deficit and risk focus. Within general mental health settings, a fidelity scale for the strength-based approach has been developed and used in studies to measure the adherence of staff to the elements of this model (Fukui et al., 2012). It could be helpful to adopt the use of this fidelity measure within forensic mental health settings and may assist in implementing and evaluating the effectiveness of this approach.
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There is a need for more high-quality studies to further explore the effectiveness of strength-based approaches within forensic mental health. The care of MDOs and the development of strength-based approach approaches would benefit from larger scale studies. Studies that are conducted across multiple forensic services and environments would reduce the heterogeneity of the existing literature. This would help develop the external validity of these studies, which is likely to develop more informed guidance for a range of services that work with this population. It would also benefit from a standardised framework for study protocols, for example using the CONSORT (consolidation standards of reporting trials) guidelines. The use of controls is needed in future studies as only one randomised controlled trial was found in this review.

6. Conclusions

This is the first review to explore strength-based approaches in forensic mental health. Future research within forensic mental health needs to further balance the concerns of public safety, clinical, rehabilitation and humanitarian outcomes, whilst striving to explore more strength-based outcomes. Limited evidence was found and there was also a lack of consistent significant findings. Despite these limitations, strength-based approaches appear to be a promising approach to managing the care and treatment of mentally disordered offenders across a range of forensic and health environments. Moreover, it appears to be a growing approach to service design and for direct interventions. The current, although limited evidence, seems to suggest that a strength-based approach will facilitate outcomes in quality of life,
Values and Recovery in Forensic Mental Health

recovery, mental health symptoms, violence, risk, recidivism, and engagement.

Further consideration of the long-term impact of such an approach is needed as only one study looked at longer term rates of recidivism. There is a clear need therefore, for further high-quality research of this approach with mentally disordered offenders to establish its effectiveness and develop evidence based interventions and structured clinical care.
7. References


Values and Recovery in Forensic Mental Health


* Doyle, M., Logan C., & Ludlow, A. (2012). Milestones to recovery: Preliminary validation of a framework to promote recovery and map progress through the
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Part B: Empirical Research Study

Searching for the self and belonging

An exploration of values of men in medium secure units

Prepared for submission to the

Journal of Qualitative Health Research

(See Appendix 11 for the journal’s guide for Authors)
Values and Recovery in Forensic Mental Health

Searching for the self and belonging

An exploration of values of men in medium secure units

Stuart Cooney, Louise Tansey, Ethel Quayle

Abstract

There is an increasing emphasis on values and recovery in health settings and in forensic mental health services. There is currently a paucity of research into values and mentally disordered offenders (MDOs). In this study, we explored the values of men in a medium secure unit who have offended. The study employed Grounded Theory Methods to build a theory of values of men in a medium secure unit who have offended. Interviews were conducted with nine inpatients in a medium secure unit in Scotland.

The model that emerged involves four conceptual stages that captures the dynamic nature of values and the experiences of MDOs. The expressed values of MDOs was made up four separate categories relating to: (1.) connecting with others; (2.) living a healthy life; (3.) being productive and contributing; and (4.) having agency and being in control. The model depicts a process of values across the lifespan in an individual from the: (1.) early development and consolidation of values; (2.) the way in which these values are expressed through behaviour and goals; and (3.) the fluctuating balance and expression of values throughout an individual’s life. Each of these components in the lifespan of values are proposed to be sensitive to and influenced by various barriers, restrictions and opportunities that an individual must navigate in life. Participants discussed the impact that their (1.) interpersonal
Values and Recovery in Forensic Mental Health

relationships; (2.) environment and culture; (3.) health challenges; and (4.) the consequences of offending, had on them and their values throughout their lifespan. This dynamic process, which appears to be vulnerable to change throughout people’s lives, contributed to the individual’s sense of their self. This sense of self appears to be fragile and there is uncertainty regarding the self and how they fit in with the world around them (Searching for the self and belonging). The implications of this model are considered in relation to existing theories of values with MDOs and the clinical applications of this study are explored.

Keywords

Values; forensic; mentally disordered offender; medium secure; qualitative; grounded theory method; United Kingdom
8. Introduction

8.1. Values and the political and health context

Recent national health and political campaigns, such as the Well Scotland Initiative, NHS England’s RightCare programme and the Recovery model have highlighted the importance of the role of individuals’ values and the benefits of pursuing them in addressing mental well-being. There is an increasing emphasis on values and recovery in health settings (Centre for Mental Health, 2011; Hayes, 1999) and in forensic mental health services (Forensic Mental Health Matrix, 2011).

As part of the drive to improve mental wellbeing, the Scottish Government have developed and supported a range of strategies and measures to “help create a fairer Scotland”. The Mental Health Strategy 2017-2027 (Scottish Government, 2017) sets out commitments to accessing mental health services that reflect the importance that is attached to “realising the right of every individual to the highest attainable standard of physical and mental health”. Good Mental Health for All (NHS Health Scotland, 2016) aims to improve mental wellbeing through promoting values of good mental wellbeing. Within criminal justice, The Justice Strategy: Justice in Scotland: Vision and Priorities (Scottish Government, 2017-2020) further developed a recovery based approach within forensic settings. This states that one of the priorities of the justice system in Scotland is that prison is to be used only when necessary to address offending or to protect public safety. Furthermore, this provision should focus on wellbeing, recovery, rehabilitation and reintegration.
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There is clearly an increased and more prominent discourse around values across the media, politics, health care, criminal justice and business domains. This is apparent in health and criminal justice systems through the use of “value statements” in their organisation’s mission statements. This is a means of shaping what is most important to the organisation, how it strives to conduct itself and is a way of communicating this to its staff and the public (Day & Casey, 2009). It can be seen therefore, that there is a growing consideration of values at an individual, organisational, national and political level and this both reflects and informs behavior and strategy.

8.2. Conceptualising values

Values are defined as what are important to an individual and guiding principles to live by. They are understood as action guiding and relate to specific goals. Furthermore, values are also considered to provide norms and standards which can be used to evaluate specific actions against these norms (Ward & Heffernan, 2017). There have been various ways of conceptualising values within the literature including Sadler (2005); Schwartz’s (1992) structural model; and a contextual, behavioural model from Acceptance and Commitment Therapy (ACT) (Hayes, 1999).

An ACT based conceptualisation of values was used in this study to inform the interview and research approach. The ACT based conceptualisation of values, states that values are verbal constructions of “organising principles for action” and this provides a long-term framework for an individual’s decisions and actions.
Values and Recovery in Forensic Mental Health (Hayes, 1999). From a behavioural perspective, decisions and actions that are carried out in line with their values are positively reinforced (Powers et al., 2009).

In Acceptance and Commitment Therapy, metaphors are used to help clients understand values and also to differentiate between values and goals. The compass metaphor proposes that values are like directions that one wants to move to in life; and goals are the things that they want to achieve (Hayes et al., 1999). The following quote is a way that this is communicated to clients in ACT based therapy:

“Values are like a compass. A compass gives you direction and keeps you on track when you’re travelling. And our values do the same for the journey of life. We use them to choose the direction in which we want to move and to keep us on track as we go.” (Harris, 2009)

8.3. Mentally disordered offenders and medium Secure Units

There is an increasing focus placed on values based interventions in forensic mental health and working with Mentally Disordered Offenders (MDOs). MDOs are defined as people with a mental illness, personality disorder or learning disability and have a history of significant offending behaviour, and/ or represent a significant risk to others (Forensic Mental Health Matrix, 2011). They are a complex group and diverse population who present with a range of chronic, complex and co-morbid mental health difficulties (Palijan et al., 2010), are subject to compulsory measures under mental health legislation, and are often regarded as difficult to treat (Barnao & Ward, 2015). The treatment and management of mentally disordered offenders is informed by two distinct institutions: the criminal justice and the mental health system, and therefore has to balance risk centered and psychopathology
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approaches. This requires care and management by specialists with forensic expertise with increased security. This creates difficult conceptual, clinical and ethical issues in forensic populations as the patient’s well-being is balanced with a focus on protecting the public through the reduction of risk and recidivism. Balancing the aims of these two distinct institutions is considered problematic (Barnao & Ward 2015) and may be a barrier to care. A recent critical review found evidence that offenders with a mental disorder were not able to access the equivalent mental health care to that available for non-offenders with a mental disorder (Grounds, 2019).

The challenge of working with MDOs is further compounded by a small evidence base for interventions and paucity of theories and rehabilitation models to guide clinical practice (Robertson et al., 2011). Strength-based approaches to working with MDO’s move from a focus just on mental disorder and risk to a wider consideration of the individual that considers their strengths, personal priorities and competencies. The recovery approach is one of the most prominent of strength-based approaches, which has been used in mental health services and extended to forensic based populations. Through the recovery approach and strength-based approaches there is greater acknowledgment of the difficulties of dual recovery from mental illness and offending behavior and an effort to balance risk management and restoring a meaningful and satisfying life in patients (Drennan & Alred, 2010). There is a paucity of empirical research to guide the rehabilitation of MDOs in a forensic mental health context and the majority of published literature
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has focused on the application and evaluation of specific interventions rather than
on the development of overarching models of care.

8.4. Mentally disordered offenders and values

As discussed, there is an increasing focus on values informed interventions,
however there is a paucity of published research in this area, particularly with
MDOs. Being detained in a medium secure unit (MSU) presents many challenges in
pursuing goals in line with a number of values including, freedom, autonomy and
intimate relationships (Mezey, 2010). Furthermore, MDOs within secure facilities
and in the community, may be more limited in their pursuit of relationships and
employment due to the double stigma that MDOs face of mental illness and
offending (Roskes & Feldman, 1999). Moreover, a focus on risk to self and others in
medium secure units can limit the pursuit of values and goals (Mezey et al., 2010).
Legal restrictions can also be a barrier to achieving goals, for example a goal of
being close to family but being unable to pursue this due to restrictions on
movement (Stuart, 2015).

Across the literature there is not an agreement on the nature of mentally
disordered offenders’ values and how these compare to the general population.
Within the strengths-based approach, The Good Lives Model (GLM) moves from a
previous primary focus on the management of risk, to balancing this with promoting
the goals of the individual, their recovery and positive risk taking. This approach
was initially used within a sex offender population but is also thought to be a
promising intervention with mentally disordered offenders (MDOs) (Barnao et al., 2016). This model makes an assumption that offenders have the same needs and aspirations as everyone else, whereas previously it was assumed that offenders did not have the same set of values as the general population (Ward, 2002). The aim of the GLM is to build resources for the individual to live a life that is meaningful, fulfilling, in line with their values and to reduce risk. In this model, 11 “primary goods” are proposed, which are an individual’s values, needs and aspirations. The primary goods are defined as: life; knowledge; excellence in play; excellence in work; excellence in agency; inner peace; relatedness; community; spirituality; pleasure; and creativity (Purvis, 2010). It is posited that criminal behaviour, for example psychotically driven violence may be a method for an individual try to obtain their primary goods (Barnao, et al., 2010). Applied to sexual offenders for example, the Good Lives Model suggests that sexually abusive behaviour may be motivated to achieve the value of intimacy. From this perspective, offenders’ values are thought to be congruent with the general population, but it is the way in which they attempt to enact their values that is problematic (Day and Casey, 2009). There have however, been conflicting ways to conceptualise values in MDOs. Research into the narrative roles of MDOs, propose that MDOs have a distorted set of values and an acceptance of antisocial behaviours, as compared to the general population (Spruin et al., 2014).
8.5. The present research

There has been little research into values and mentally disordered offenders previously, and there appears to be conflicting views on how offender’s values relate to non-offenders. Furthermore, values based approaches, like the Good Lives Model have assumed a set of values based on non-offending populations but there has been little work done to identify the values of this population directly. This study strives to address this limited and conflicting literature, and a qualitative study may be able to offer further insight into the values that are personally meaningful to this population and the barriers to pursuing these values. Qualitative methods have been found to help explore such issues and elicit the personal narratives within the recovery model (Roy Chowdhury, 2011; O’Sullivan et al., 2013).

There may be an additional clinical benefit of conducting this research, as discussions of values have been found to be a positive part of recovery and can also improve engagement with therapy and identification of therapeutic goals (Stuart, 2015; Tansey, 2010). Research that seeks to increases engagement in this population is valuable. This has the potential to benefit the care and treatment of this group of patients and additional benefits may be a reduction in risk, which benefits the safety and welfare of the general public also.

1.6. Objectives

The objective of this study was to develop a grounded theory of the values of men in medium secure units. The purpose was to gain an understanding of (a) the values
that are personally meaningful to this population; and (b) the barriers to pursuing these values.

9. Methods

Design

The research used a qualitative design to explore the values and goals of mentally disordered offenders (MDOs) in a medium secure psychiatric unit. Semi structured interviews were undertaken with MDOs at a medium secure unit in Scotland, to gather data. The study adopted a grounded theory methodology to develop an understanding of the values and goals from the patients’ perspective to assist in the development of a theory. The research proposal and consent process received approval from NHS Research Ethics (Reference: 12/SS/0219, Appendix 6).

Participants and recruitment

Participants were current residents in a NHS medium secure unit in Scotland, who have severe and enduring mental health problems and have offended. All participants were 18 years old or over, able to give informed consent to participate, fluent in English, and were not currently experiencing acute symptoms of mental illness. Potential participants were excluded if they had significant communication difficulties, an intellectual disability, or were engaged in individual psychotherapy with the researcher. For the purposes of homogeneity and due to the majority of MDOs being male (Gow et al., 2010), the sample was of male MDOs only.
Recruitment was sought initially through the patient’s Responsible Medical Officer (RMO), a Consultant Psychiatrist. They advised whether or not someone had capacity to consent to research and those without consent were excluded. Members of the clinical team then discussed the research with their patients who were deemed to have capacity, acting as gatekeepers for the research. The researcher then met with those interested in participating. At this meeting, the patient information sheet (Appendix 7) was reviewed and the patient was given the opportunity to discuss any questions they had. Participants were then given at least 24 hours to decide if they wished to participate in the study. Interviews were undertaken in a clinic room at the medium secure unit. All participants completed a consent form (Appendix 8) immediately before beginning the interview.

11 were approached by the researcher with information on the research study. Two declined to participate, stating that they felt uncomfortable with the interview being recorded. Nine people agreed to participate in this research and completed the interview process. To ensure anonymity, due to the small recruitment population, demographic and diagnostic information will be reported minimally, and details of participants’ offences will not be reported. Participants were aged between 28 and 55 years old and the average time spent in the MSU was 40 weeks. All had a diagnosis of psychotic illness and they had been admitted to forensic secure care after a crisis event. Additionally, some participants had a diagnosis of personality disorder, autism spectrum disorder (ASD) and a history of substance abuse. Patients had been transferred to medium secure from three routes: court,
prison and high-security care. The participants who took part in the study were at varying stages in their forensic secure care journeys, with some close to discharge to low secure units, prison or to the community; whilst others had no immediate plans for discharge.

Procedure

All patients identified as suitable and who consented to participate met with the researcher for a face to face interview. This meeting, lasted approximately one hour and took place within the MSU in a quiet and private room. The interview explored values and goals within this population, their valued daily activities; and the impact of offending and mental health on attaining their values. The interview schedule is included in appendix 9. The interviews were audio recorded and stored securely on an NHS computer. Using a grounded theory method, notes were taken during the interview and a preliminary and ongoing analysis of the interviews altered the questions asked in later interviews.

Data Analysis

Anonymised transcripts of the interviews were analysed using Dedoose data management software (Dedoose, version 8.1, 2018). This software was used to organise and order data. The data was evaluated using grounded theory methods. This qualitative approach is a systematic, inductive and comparative method used to understand and evaluate human behaviour with the aim of constructing a theory (Charmaz, 2014). More specifically Charmaz’s (2014) version of a constructivist
Grounded Theory approach was used to explore values and goals within MDOs. The main characteristics of grounded theory as outlined by Glaser and Strauss (1967), include the simultaneous collection and analysis of data, making use of memos taken during data collection and the interview transcript. Memoing was used to help increase the awareness of and monitor the researcher’s own preconceived ideas and minimise the impact on the analysis and theory. Techniques were then used such as coding and categorisation, to identify categories in the data, make links and to establish the relationship between categories. Efforts were made to use a non-linear method and used a “constant comparative method” throughout the data collection and analysis. This was not always possible to adhere to due to the constraints of working in a clinical setting and the need to respond to tight time scales for recruitment of some participants who were due to be discharged imminently. As much as possible, the researcher moved backwards and forwards between the two, until the categories reached theoretical saturation, when there was no new information or insights reported in the data. At this stage in the process, a theory that was generated from the data was formed (Charmaz, 2014).

10. Results

We begin this section by describing a grounded theory of values and their development in mentally disordered offenders (MDOs). This model, informed by patient interviews, is an attempt to capture the dynamic nature of values and is made up of four conceptual stages. The conceptual stages are as follows:
1. Expressed values

2. The lifespan of values: consolidation, expression and change

3. Navigating barriers, restrictions and opportunities

4. Searching for the self and belonging

In Figure 1, a model is presented of the main components of MDO’s experience of values. In the following sections, a grounded theory of values in MDOs will be elaborated on with quotations from patients to illustrate the components of the theory.

**Figure 1.** Searching for the self and belonging: A model of values of men in medium secure units
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The expressed values of men in medium secure units were made up four separate categories relating to: (1.) connecting with others; (2.) living a healthy life; (3.) being productive and contributing; and (4.) having agency and being in control.

The model depicts a process of the values across the lifespan in an individual from the: (1.) early development and consolidation of values; (2.) the way in which these values are expressed through behaviour and goals; and (3.) the fluctuating balance and expression of values throughout an individual’s life.

Each of these components in the lifespan of values are proposed to be sensitive to and influenced by various barriers, restrictions and opportunities that an individual must navigate in life. Participants discussed the impact that their (1.) interpersonal relationships; (2.) environment and culture; (3.) health challenges; and (4.) the consequences of offending, had on them and their values throughout their lifespan.

This dynamic process, which appears to be vulnerable to change throughout people’s lives, seems to contribute to the individual’s sense of their self. This sense of self appears to be fragile and there is uncertainty regarding the self and how they fit in with the world around them (Searching for the self and belonging).
Core Category 1: What matters to me? The expressed values of mentally disordered offenders

All participants were asked about their values in the interviews. Most spoke about their values in the context of the difficulties living in line with their values due to the various barriers and restrictions in their lives. The core category of expressed values, “What matters to me” is comprised of four subcategories. Participants identified values relating to: (1.) connecting with others; (2.) living a healthy life; (3.) being productive and contributing; and (4.) having agency and being in control. These values shall be detailed below but will explored further in later sections in the context of how they relate to the other core categories.

Subcategory 1: Connecting with others

All participants discussed the importance of “connecting with others” throughout the interviews. Being connected to others and having meaningful relationships was something that was important to people across different environments: including the community, forensic and mental health settings. Participants described a number of different means of connecting with others: from peers in the MSU; friendships; family relationships; romantic relationships; professional relationships with staff or others in authority; religion and spirituality; and relationships with pets and animals.

Connecting with others appeared to be important to people for a number of reasons. Many discussed that relationships with peers, fellow patients and
members of staff allowed them to feel as part of a community and provided “a real big sense of belonging” (P.7.). Connections with others, can also help normalise difficult experiences or emotions for others:

P.8.:”I try and think of something positive, so I think of the other patients and say, Oh it’s not that bad, we’re all in here together. So it cheers me up and I’ll talk to the nurses... Aye, that’s what brings me up again, then I’ll see my pals and I feel better after that.”

A connection with others seemed to also facilitate caring and nurturing relationships with others. Being in a position of both giving and receiving care, was reported to be something that they valued. This care often came from families, as is shown in the following example:

P1: “It’s so important because of the support and love that they’ve given me through everything. Obviously, eh, I was at (High Secure Hospital) for a very serious index offence and I mean I was pretty much at rock bottom. Em and they stood by me the whole time and also not just stood by me but kept me up on my feet emotionally and with them I was like able to cope.”

For many, the experience of losing the support and close relationships with others as a consequence of their offending, was difficult to come to terms with. This process however, appears to have emphasised just how important and valued their relationships with others are, both when they consider relationships that they have lost and ones that they have maintained in the aftermath of their index offence.

P1: “I lost quite a lot of friends. Not all of my friends stood by me. Em, it still troubles me, it’s quite sad but a lot of friends did stick by me and I’m so grateful for that. I appreciate it’s not an easy thing for someone to still care for me as a friend. It’s a difficult thing to grasp, people getting mentally ill and doing these things but thankfully a lot of my friends have understood and I’m grateful for that.”
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With many having lost contact or strained relationships with friends and family, they spoke of developing relationships with fellow patients. It seemed that peoples’ shared difficult experiences, for example, experience of psychosis, substance misuse, or being in secure environments was helpful in developing connections between patients and also appeared to facilitate the development of informal peer support or mentoring roles.

P7: “Hope. That’s what the guys give you in here. The encouragement. They will always give you hope. You might think, aw fuck I’m never getting anywhere but the boys always try and pick you up and give you that sense of hope like. Ken there’s a lot of the boys like that in here. Give you that sense of hope.”

Moreover, an additional factor in connecting with others as being an important value, was that it can be a means of protecting oneself and being safe. People described feeling safer, being part of a social group or also from connecting with a religious organisation or set of beliefs.

P8: “I’ve been going to church quite regularly and I say my prayers two or three times a day. Em... And eh, I just pray that God has me in his hands and will keep me safe. It’s a big bad world out there, I don’t trust people”

Subcategory 2: Living a healthy life

All participants identified being healthy as an expressed value. They discussed the importance of their physical, mental health and general wellbeing throughout the interviews. All spoke about the importance of physical health and considered that being healthy and keeping in good physical health was important.

P9: “I’m not gambling with my life or my physical health. I don’t want to be on my arse, I want to be how I am now.”
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Eight participants spoke about their mental health as being highly important to them. They discussed the steps they had taken to maintain this, through engaging with health professionals, psychological therapies, ward and community-based activities and medication.

Living a healthy life appeared to be something that was important to them as they described past experiences of poor physical and mental health as having significant negative consequences on their lives and making it more difficult to live a life in line with their values, impacting on their autonomy and ability to form and sustain relationships.

P1: “I suppose, I would say that what happened eh, the index offence was a massive barrier. It was a terrible thing but my family and friends stood by me. I’d say that, if I wasn’t able to cope through that. If I was to continue to be depressed through the whole thing it would be difficult for my family to keep me on my feet. So I suppose em, I suppose that I just need to come back to the priority of making sure my mental health remains well, otherwise that could be a potential barrier, you know.”

Subcategory 3: Being productive and contributing

Being productive and contributing to a wider community was discussed throughout the interviews by all nine participants. This was expressed in relation to working hard independently or for the greater good of the community. Moreover, this appeared to contribute to self-esteem through achieving tasks; developing structure and purpose to their day; and also being creative.

P6: “They had their own kiln and everything was done in house there. They had paint racks and small tubs of paint. Every colour, every shade of ever colour. Everything you needed. I loved it because I treated it like work. I went every day am and pm. See if it was open, I went... That’s what I like to do. Be busy. I was
Many spoke about the perceived benefits and motivation from contributing to their community. For some this appeared to be related to the value of connecting with others, as contributing to society was a means of fitting in and being “normal”. Furthermore, for many contributing to their communities and environments was motivated by hopes of reparation for their past offences or behaviour, or to pay back a debt to society to alleviate being a “burden”.

P1: “I have goals to... my goal would be to start my own landscape gardening company. A small landscape gardening company and eh, be successful with that. Make my money in that. Em... and eh you know, support myself financially, independently. Em... no longer be a burden on society. That’s something I feel, I felt like I had been, you know being in the hospital, the cost on tax payers of hundreds of thousands pounds of money being in hospital. Also through all this being on benefits as well, not being able to support myself but. Eh. Pay my taxes, support myself financially, all this, is important for me to be able to say, you know, I’m now a contributing member of society.”

Related to themes of reparation and paying back to society, this appeared to link to long standing values in individuals to be a successful, reliable and contributing member of society:

P8: “As a member of society, if you want the help you join.... And part of that is by getting in the fold. It might sounds nuts but when I got out of hospital last time I really wanted to be a pillar of the community. And eh, try and help where it’s needed. You know, em, just want to do it to help out and stuff like that.”

Participants spoke about earning money in relation to hard work. Many held the view that having wealth would allow them to live a happier life, by being more able
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to engage in valued activities. Furthermore, it seems that there was a relationship between earning money and connecting with others, as it was perceived that that they could more easily acquire material possessions that were valued by society and perceived as a sign of status, success or wealth, thus allowing them to fit in and be seen as “living a normal life (P4)”.

**Subcategory 4: Having agency and being in control**

All participants considered the importance of agency and independence and how their experience of these concepts has varied throughout their lives. This subcategory came up in the interview mainly in the context of participants discussing the impact of losing agency and control. This appeared to be primarily related to themes of being “free” or being “safe”.

*P2: “Having control over my own actions and doing what I want to do. Freedom basically”*

It seems that having agency and control over life and the environment is also important to provide security. This was achieved by some through developing “strength”, through altering their physical appearance to intimidate others or to ward off potential threats.
Core Category 2: The lifespan of values: Consolidation, expression and change

In addition to discussing what matters to them, participants spoke about the way in which their perception of their values and goals has fluctuated throughout their lives. The following section explores the early development of values; and considers the way in which peoples’ behaviour and goals can be either congruent or incongruent with their values at different points in their lives. Individuals’ values and the balance of what is important in life also appears to shift throughout life, which shall also be considered in this section.

Subcategory 1: Early development of values

Throughout the interviews, many participants considered the ways in which their values may have developed and the factors involved in this process. Participants were not asked directly about this in the interview but this subcategory emerged in discussions with five of the nine participants (P: 1, 2, 7, 8, & 9). They reflected on their early relationships with caregivers and the influence of their home environments and communities as having a role in shaping their sense of what is important and developing their values.

Behaviours that were described as pro social were modelled by individuals, with some viewing these people as a role model to themselves and others in the wider community.
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P8: “He would basically try and fix out all my worries. He was a pillar of the community, everyone looked up to him”.

In addition to the influence from direct care givers, peoples’ environments and communities were important in the development of values. Participants described the acquisition of knowledge and morals from the wider community in which they lived.

P7: “I value what the old people have done for us. Pass on their knowledge and experience or looked after me when I was younger.”

It appears therefore that there is an important relational role in the development of values, and that the formation of values is informed by others in their interpersonal network. In contrast to the direct modelling of pro social behaviours in the development of values, it appears that in some more difficult interpersonal relationships, that this can motivate an individual to act in the opposite way. This may be in relation to a parent, family member or someone within the wider community whom they perceive as acting in a way that is not congruent with their values. It may be therefore, that by observing others whom they believe have been unsuccessful, made mistakes or acted in ways that they disagree with, can motivate them to act and live their life in a way that is different from this other person.

P5: “my laddie he actually said to me, he said eh... ‘the reason I’m such a success is because I didn’t want to end up fuck all like you’.”
Subcategory 2: Values directed behaviour

Participants discussed behaviours and goals that appeared to be congruent or incongruent with their values. This appeared to alter throughout the lifespan and was influenced by values that had previously been developed; and by a number of barriers, restrictions and opportunities faced throughout their life (as shall be explored further in core category 3).

All participants considered the various influences on their behaviour and goals throughout their lives and that this could have either a negative or positive effect on their actions. For many, interpersonal relationships with others that were associated with substance misuse or criminal behaviour, had a negative impact on an individual’s behaviour. Associating with these people and being part of theses social groups may have been an attempt to meet values associated with connecting with others, however, participants reflected that this led them to act in a way that they now view as being wrong and that this was at the expense of their meeting their other values.

P2: “I’m never going back near it (drugs) because it’s too hard a life and leads you all the wrong ways. You end up hanging out with the wrong people. People with no dignity left, no values at all and they just want to waste their life away. And I can’t go back to that route. I’m too old now I’m, it’s time for me to get my act together and get on with my life.”

Furthermore, having past relationships with these types of social groups also appear to make it difficult for individuals to pursue an offence free life, with some expressing concerns about recidivism. The quote below demonstrates the struggle
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faced between people trying to act in a way that fulfils the legal restrictions placed on them after leaving a secure unit or prison whilst trying to protect themselves from threat or being taken advantage of in the community. This highlights the difficulties for MDOs with regard to autonomy in their lives after leaving secure care, with their actions and goals being shaped by legal and medical restrictions and orders but also being shaped by the environment that they are placed in and the people within their interpersonal network. It seems that these two factors are at odds with each other. The participants described that this made it difficult to understand themselves and how they fit in with the world. This links to core category 4 and will be explored in further detail in a later section.

P5: “there would be people coming up all the time saying aw you done this to your misses and bang they would try. They would have me and I’m on a license so I’m going to have it for about 2 year and they’ll say this and I’ll need to take a kicking. I said that to her I’ll just need to take a beating but if it gets too bad then I’ll need to hit back but what happens when the police come and even though there’s witnesses, they’ll just say that the two people that have been fighting: me and somebody, oh (names self) he’s on license from the jail. Straight back to jail.”

In contrast to the above, there appears to be times when MDOs have considered that when faced with a situation that clashes with their values and morals, that they have not followed their peer group into further offending behaviour. For example, a participant reflected on abstaining from stealing to fund his heroin addiction, despite his peers doing this and the knowledge that this would lead to distress and intense physical symptoms from experiencing withdrawal symptoms.
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P2: “It made me feel a letdown and a junkie basically. I don’t like the word junkie, I prefer drug addict. ‘cause I still kept my dignity, I wouldn’t steal, I wouldn’t do anything bad. I would just buy it with my own money. If I had no money, I’d just lie there strung out until I got money. It was a bad existence…

I: What do you think stopped you from doing that?

P: I just wouldn’t do that, I’m not a thief, it’s the way I was brought up, I was brought up to never steal.”

Many also described their goals and actions as being shaped by their current environment in a medium secure unit as they had to “abide” by the “system” and “jump through hoops” in order to meet the requirements of the legal and health systems.

In the interviews, many spoke about the struggle that they faced of acting in a way that was in line with their values but that was also appropriate to their environment and was congruent with the values and goals set by health and legal systems. For some, to pursue their values of connecting with others or of having agency and being in control, resulted in them offending further. The following example shows the illegal means that an individual took to increase his communication with his family at a difficult time, whilst in a medium secure unit. This action resulted in further restrictions being placed on him, and extending his time spent in a secure setting. Unfortunately, despite it being possible to understand actions like these as being motivated by values of contacting others and supporting family. The consequences of this can result in further and extended barriers to connecting with others and reduced agency in life.
P9: “Me being a bit of a wimpo, I’d smuggled a mobile phone in. At the time it helped because I could speak to people. This was round the time of my dad and my gran (dying). I had to phone then and I was chatting to friends and family but I was obviously breaking a major rule so that responsibility was on me.”

**Subcategory 3: Shifting balance of values**

Throughout the interviews a theme of changes in the expression of values emerged. They considered how the balance of their values shifted throughout their life, particularly after significant life events. This category was identified by 6 of the participants and is explored below.

During the interviews, some reflected that at times in their lives, particularly during difficult and stressful periods, that they had a narrower focus of values. At more settled times, however there appeared to be a broader view and greater balance in their values.

P1: “But I think that the balance I had was maybe not right because it was sacrificing a lot of other things that’s important and now to have a more rounded balance in your life… I suppose what I’m trying to say is that eh. I think that values that anyone has can shift over time… All these values combined are what kinda make me who I am today, not just one individual like rock climbing and the obsessional attitude I had before.”

These shifts in the balance of values appeared to be prompted by a number of significant life events, which shall be considered in the following section (core category 3). Some participants also described that a shift to a more balanced and broader range of values came as they got older.
P3: “It’s just... I need to prioritise what I’m doing with myself because I’m 50 now. I don’t have time to just... I’ve need to try and make good what time I’ve got left.”

**Core Category 3: Navigating barriers, restrictions and opportunities**

The participants in our study faced a multitude of challenges, barriers and restrictions that impacted on their ability to live and behave in a way that was in line with their values. Many of these acted as barriers and restrictions, however some of these challenges also appeared to help facilitate behaviours that were congruent to their values. This suggests that these parts of life are likely to cause a change in direction with regard to living a valued life. Therefore these areas seem to cause a change in course in individual’s actions which can be either congruent or incongruent with their values.

**Subcategory 1: Interpersonal relationships**

As has been discussed, there appears to be an important interpersonal component to the development of values. Furthermore, there were a number of values expressed by participants that related to connecting with others across the interviews. In addition to discussing the importance of this, they considered the impact interpersonal relationships had on them. Many considered the negative impact that others had had on their life:

P 9: “Realising that I was just being used by guys that didn’t want to get their hands fucking dirty” P.9.
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It seems that some interpersonal relationships have had a negative impact on their lives and took them away from the things that they valued. This appears to create a tension between the negative influence of others and values of connecting with other people. Some described being taken advantage of by others. This seems to suggest that others can influence their actions in a way that is not congruent with an individual’s expressed values:

P8: “Being with the wrong people was detrimental to my progress and as a human being.”

Subcategory 2: Environment and culture

The environment and culture that participants were in appeared to present various barriers, restrictions and opportunities. Participants spoke about the negative impact that their environments had on their lives and behaviour. In the main, this category refers to the barriers and restrictions posed whilst living in the community, being in secure care, and experiencing an unsettled home life. However, some also discussed the opportunities that their environment could provide, for example, from being in a medium secure unit.

Being in a secure unit appeared to have a negative impact on values relating to connecting with others; and having agency and being in control. Being in a secure unit creates physical barriers for connecting with others, as visits and pass plans in the community are dictated by restrictions placed on them. This can make it
difficult to maintain relationships and some described using phone calls and social media if this was permitted as alternative ways to try and maintain interpersonal relationships. Although this appeared helpful in maintaining contact with families, it appeared to be difficult to sustain or develop romantic relationships through these means. Furthermore, extended periods of time in secure units have also caused them to miss significant life events within the family, which can exacerbate feelings of being disconnected from friends and family and losing agency and control in their lives:

P2: “It was the first time that it happened to me. That I’ve missed out on anyone that’s important in my life, for going to their (referring to brother’s) funeral. I can’t believe I was the only one that missed it.”

Being in a restricted and controlled environment in a medium secure unit results in a loss of autonomy. Participants described having to “abide” by the “system” in order to make progress.

P2: “That’s when I start to feel a bit uneasy. Mostly to do with not being in control as well. Not that I’m a control freak, it’s just that I can’t be in control of what I’m doing in here. I have to go by the system. Do what I’m told and stick by, adhere to the rules. But eh, I just don’t like being like that. I can’t wait until that changes... It’s not having control I don’t like. It’s not having control over my own actions and doing what I want to do. Freedom basically.”

To progress through the secure setting, they are required to act in a way that is consistent with the “system’s” values and goals. Attempting to act in a different
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way and overcome barriers to live a life that is congruent with their values, can be challenging to the individual.

Participants also discussed the impact that unstable and threatening homelives and communities had on their values and were barriers to living a life in line with their values, particularly connecting with others, and having agency. Many described the difficulties faced by the separation of parents, bereavements, inconsistent care from care givers and frequent house moves. This also had an impact on the ability to maintain relationships, for example friendships were lost when they moved home or school and furthermore, these changes were out with their control so were at odds with values related to autonomy.

For some, who had periods in their life when they were homeless, they described the threat that they faced from living in this environment. This had an impact on his physical and mental health and on values related to autonomy and health.

P8: “My dad sent us, 250 quid and I got it cashed in at a post box and eh, that night my bag was stolen in the street. Late one night. And there was £250, my passport, all my clothing, my utensils for cooking and all I had was a vest on. So I was starting from scratch then. I was raking the buckets for food.”

Some participants also considered the opportunities that their environment gave them. Despite the restrictions imposed by secure care, some described this environment as being stable, safe, consistent and gave them an opportunity to live a life that was more congruent to their values of being healthy, and also being
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creative and contributing. It has also allowed some gradual increase in autonomy as have successfully progressed through pass plans, gaining further time and independence in the community. It appears that for some this was an opportunity for safety and stability in their lives that they had not had previously.

P2: “I: And what impact has being here (MSU) had on you being able to fulfil these values then.

P: Well I’ve been able to think clearer about what I want to do with myself. I’ve been to abstain from taking drugs so that’s... being in here has helped me get better and helped me realise the things I need to do with my life.”

Subcategory 3: Facing Health Challenges

Participants identified a number of issues regarding health that impacted on their pursuit of values, including: mental health, physical health, and substance misuse.

All nine participants discussed the impact that mental health had on their lives and identified with the category of this being a barrier in life and to their values. Difficulties with mental health was identified as a barrier to being a parent. Participants spoke of their experience of psychosis, and associated breakdowns in relationships and offending. The example below demonstrates the individual and his son’s anguish at being separated when he was unwell:

P3: “I think about him every day... Eh, I remember when they came to take me away that night. I wasn’t drunk, I wasn’t on drugs, I was just wired up. And I gave the wee one. He didn’t want me to let him go... He went crazy as I was taken away and that’s it. That night was a horrible night. It was a horrible night”
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Participants also discussed the impact that their mental health and experience of psychosis had on employment. They discussed the impact that poor mental health had on their ability to cope with their jobs, or impaired decision making by taking on too many jobs and being unable to organise workload. Another patient reported that they found mental health to be a stigma which may impact on their ability to get a job. This stigma can be compounded by the additional label of being an offender or criminal, as shall be discussed in the following section.

A number of patients spoke about the impact that their mental health had on connecting with others and their relationships. Difficulties regarding sustaining a relationship with friends, partners and family were discussed as barriers.

P1: “you know people have good days and bad days but you know if it’s a prolonged bad spell, that can be, em that can be difficult for a relationship.”

Three patients identified that unwanted side effects of medication were difficult to manage and impacted negatively on their lives.

P6: “So the barriers are me being in here. Well the obvious barriers are being in here but the barriers to me moving along at any speed are the medicines I’ve been given at the moment. They’re making me feel hellish. They’re really impacting on the passes you know. And I really don’t feel like (pause) and I don’t feel like I can do my passes at all... I feel right down about it.”

Many participants discussed a deterioration in their health prompting them to reassess the importance of physical health. This appears to be prompted by fears
that they would become significantly unwell or incapacitated. It is possible that this could lead to a further loss of autonomy. The example below illustrate this:

P3. “Aye, I had a bit of a health scare last year there. I came down with type two diabetes and I had problems with angina and stuff. I was overweight by one hundred and twenty kilos. So I’ve gradually made positive steps there too as I’m down to 107 now. A good 16 kilos. Slowly...Less portions, more fruit. I’ve gave up smoking. I’ve not smoked for the past two years. I don’t feel tempted to take it up again. Eh, all the benefits are... I was in some state the last couple of years, health wise.

Many spoke about the costs of substance misuse on their lives and the impact this had on their values. Many described using this as a coping mechanism to deal with difficulties in their life but as some reflected during the interviews, this led to further difficulties and this coping mechanism was instrumental in creating further barriers in their lives.

P2: “I’ve lost my two hour pass to the (Hospital activity centre). I lost all my passes yesterday... I never done it through anything apart from the way I was feeling. I couldn’t handle it, the way I was feeling on Monday. Deep down I also knew that I would feel more depressed after it and that’s exactly what’s happened. I feel very low at the moment and that’s because of the alcohol and the hangover and that fact that I’ve done it. I feel a bit silly about it as I’m 45 and I’m in here waiting to get released and I shouldn’t have done it. It will make it hard for my progress of getting out of here.”

The use of substances within medium secure settings, resulted in further restrictions being placed on an individual and often prolonged their time spent in secure settings, resulting in a further reduction in autonomy and control over their lives. Participants described the impact of substance misuse as being a barrier to all of the areas of their values. Substance abuse was reported to have resulted in a
deterioration in physical health, with one participant describing the dramatic change he experienced to his physical appearance and health: P5: “I was like a walking skeleton, my hip bones were sticking out, my ribs were sticking out, I was fucked... I never ate.” Furthermore, difficulties were identified in being able to sustain work, thus impacting on values based on being productive and contributing. Some also considered that there was a link between their drug use and deteriorating mental health and offending, therefore limiting their ability to live a life in line with values around living a healthy life.

P9: “obviously the index offence was through cocaine abuse and amphetamine abuse. I was up for nights, working for them, clubbing, just fucking about.”

**Subcategory 4: Consequences of Offending**

Offending was discussed as having a number of consequences. In addition to the impact of being in a secure environment, as discussed previously, participants considered the wider consequences they experienced from offending and the impact this had on their attainment of their values. This included the impact on one’s reputation, relationships with others, parenting, occupation, being able to contribute to society and on their autonomy.

P9: “It makes you think, I could have spent that energy making something of my life and having a family and an honest day’s wage if that was the case. But I chose that route because it was fun.”
All reflected that their offending had taken them off course from their values and from living a meaningful life. During the interviews, participants reflected on the impact on their reputation and how they and others perceived them after their offences. Patients identified feeling shame and guilt over the past offences and finding this difficult to live with after an improvement in their mental health. One participant described this as “something I can’t change so just kind of, just a burden I have to live with, you know.”

P1: “the index offences is something that lives with me for the rest of my life. Eh I mean there’s not a waking hour, eh, I don’t think about what happened and how much regret, remorse, guilt I feel about that, the pain, em eh. Em it’s the most difficult thing that’s ever happened to me, eh the biggest regret of my life easily”

Furthermore, this impact on reputation and efforts to repair this lead to many considering what this meant for their sense of self, as shall be discussed in core category 4. Many discussed the impact of their offending and resulting legal restrictions, on their relationship, limiting their ability to maintain or engage in romantic relationships.

P3: “I was married in all for about four years. Got a divorce because my status is a life sentence, I’m really eh... it’s detrimental to relationships”

For mentally disordered offenders with children, past offending was also attributed as making it difficult to be a parent. Many described their chaotic lifestyles, past, drug use and offending behaviour as preventing them from being able to be a father
that they would wish to be. Furthermore, they were unable to be present in their lives due to prolonged periods spent in prison and secure hospitals.

P5: “I got my 7 years when he (son) was 5 years old, em... 5 weeks old. I’ve been a pure fuck up with them all (In reference to all of his children).”

For some, legal restrictions prevent them from being able to have contact with their children. Many found this barrier difficult as this prevented them from being able to live a life in line with being connected to others or being a good parent.

As has been discussed, offending has consequences on one’s autonomy due to the more restricted environments that men in medium secure units find themselves in. Furthermore, some discussed the impact of ongoing offending within a medium secure setting, which could result in a loss of passes, seclusion, prolonged time in secure settings or a move to higher security. This resulted in further restrictions and control being exerted over them. One participant reflected on his recent use of computers for offending based behaviour and the impact this had on his access to technology and lengthening his time spent in a medium secure unit. This resulted in further loss of autonomy and limitations on being able to connect with others.

P6: “Well I had a bit of a hiccup with my internet IT stuff, you know. It was taken off me and I had lost my passes you know... I do miss it a heck of a lot, I mean you miss your phone and things like that, don’t you.”
Men within medium secure settings also considered that the prospects for their careers may be limited by their previous offences, length of time spent in prison or hospital, the legal restrictions associated with this and how others may perceive them. This can result in the loss of careers or narrowing their options for future jobs, thus being a potential further loss of autonomy.

P1: “I would say that in the past, my ambition was to do well in a job. Maybe I had higher expectations of myself in the past before my index offence. You know I graduated with a chemical engineering degree and I was thinking of doing something like that but now with the history that I’ve got a realise that I kind of, that would be a difficult career path. And I’m thinking I would need to go about things myself and if I’m going to do well at the gardening then maybe I need to make my own business.”

Core Category 4: Searching for the self and belonging: Who am I and how do I fit in?

From participants’ interviews and this paper’s proposed model of values of men in medium secure units, it seems their values are a significant part of their identity and sense of self. Furthermore, how congruent an individual’s life and actions are to their values also appears to contribute in an important way to the sense of self. This is developed from a young age, from a range of external influences and is shaped by a number of barriers, restrictions and opportunities throughout their life. However, as discussed this seems vulnerable to change and many describe the various factors that can cause a shift in balance of values or impact on how congruent their behaviour and goals are with their values. In the MDO population, it seems that this sense of self and the unstable and fluctuating external factors that
they face, contributes to a sense of self that is particularly vulnerable to change. This appears to establish and perpetuate an uncertain view of the self, with MDO’s struggling to establish who they are and to also find a place or a social group that they fit in with.

Participants described being uncertain of their identity at times in their life. At times of difficulty, it appears they question who they are but that family can be grounding and help them fit in.

P8: “Em, there was at one point a fast and loose attitude. Em, so it was being out there, taking drugs and really living in the fast lane. But as they say, you’ve got to come back to yourself after a while. So I came back and it was all the same eh, catalysts, you could say, like my family to remind me who I was but for a while I was out there on my own.”

Many described them of being critical of themselves for their past and current offending behaviour and for being in a forensic setting. Moreover, some noticed that they were at times judgemental of fellow MDOs for their past offences or mental health difficulties.

P9: “they think that because of my past, I’m a scum bag. And the fact that I (describes further breach of restrictions that is removed for purposes of anonymity), I don’t think that they like that. Obviously major breach of this but that was a long time ago. But because of that I see myself as not a nice... I got judgemental and started looking down on people. But it was always at the back of my mind that I am just as bad.”

As has been discussed MDOs described the difficulty of having a clear and stable understanding of the self. To understand who they are, it appears that they
compared themselves to their peers and those in their environment, and this seemed to emphasise and reinforce that they did not fit in:

P9: “Finding your place in life is what I need to do and find a way to do that without upsetting anyone or taking on too much.”

Six participants spoke about the concept of “normal” and considered what this meant to them and how they believed that they were not “normal” and struggled to fit in throughout their lives. Furthermore, many discussed hopes that by engaging in support offered from the medium secure unit and therefore trying to live a life in line with the values of the system that they would be “fixed” and become “normal”. Others considered feeling a pressure from society regarding expectations on what it means to be “normal” and how they were unable to meet this.

P4: “P: You need friends, you need family support. You need a girlfriend or a wife. If you want to be a decent man. Have children and a family. If you don’t make a child, a girl or a boy, don’t have a girlfriend or wife. People think you are a failure in life if you don’t have a son or daughter”

When fitting in with individual’s environments and to form connections with peers, many of the participants discussed the costs of doing this. Participants described making efforts but finding it difficult to assimilate themselves into their surrounding cultures and environments:

P9: Aye to fit into that culture you had to be loyal and if someone told you, one of the people that you are trying to impress and fit in with, tells you to do something that’s illegal and violent and gruesome, I had to do that to fit in. And once you’re
into that you can’t get out. Or if you do get out, you’ve not got the skills to mix with normal society. It’s... I don’t want a reputation anymore, I just want to have a quiet life.

I: It sounds like throughout life, you’ve tried to fit in with the environment like at school, there was the private school...

“I went to private school for a little while. I didn’t mix, I didn’t fit in. Like I said mud blood. I only got in through a scholarship. Eh and that was at (names school). I kept buggering off. Going home. So they ended up kicking me out the school.”

P: Yeah I didn’t fit in there and then I went to the local school. I fitted in there alright but that’s because it was just a breeding ground for criminals”

This difficulty to fit in with social groups was also apparent for some in medium secure settings as some felt caught between multiple social groups or environments and were therefore not able to fully integrate. For example, one participant described being caught between his immediate environment of a high secure hospital and his desired future environment of a pro social life in the community with his wife. He described that to move towards his desired future and forging connections with his family, that he felt that he had to isolate and distance himself from his immediate environment, from other patients in high security. The example below illustrates the struggle with connection that individuals can face in secure care:

P9: “Usually I would be in the mix of it, like climbing on the roof, doing silly stuff like smuggling drugs in or whatever, when I was married I couldn’t do that, I wanted to try and get out for my wife. So that meant excluding myself and making myself a bit of an outcast.”
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It seems this relationship with “normal” and “fitting in” with society is further complicated as others described times when they lived in the community, in what could be considered a “normal” life, but struggling with this as they were self critical of themselves and did not think that they deserved to live this sort of life.

P8: “I feel like a fat cat when I’ve got a nice place. To be honest with you, I don’t feel like I deserve it.”

A further way of connecting with others and fitting in was through religion with two of the participants describing that being part of a church was helpful to individuals who were trying to make a change in their life, to find a purpose and be part of a community. For those that pursue religious interests, it appears that this not only helps them feel a sense of community and fitting in, but is also done with the hope of understanding themselves better.

P7: “I feel a belongingness in the church I do. And you feel a true commonness with... you don’t have to be a Christian or you might just be trying to figure out what you want in life and what you’re trying to do in life. You’re not quite sure about what you’re trying to do in life. What sort of journey or path you’re wanting to go on or that. So you can go to church and just see how you feel but I am telling you, you’ll feel a real big sense of belonging.”

We discuss the theoretical and practical implication of these findings below.
**11. Discussion**

The aim of this study was to develop understanding and build a theory of the values of men in medium secure units. The model that emerged from the data suggested that values are sensitive to various barriers, restrictions and opportunities. These factors appear to have impacted on the make-up of an individual’s values throughout the lifespan, from their initial development to significant life events. The model suggested that these experiences and an individual’s values contribute to their sense of self. The model proposes that this sense of self is fragile, which can create and contribute to uncertainty as to who they are and how they fit in with their environment. The findings of the study will be discussed in relation to the existing research and theories of values. Furthermore, clinical and further research recommendations will be considered, and the limitations discussed.

**Extending Values Research to MDOs**

The values that emerged from the data in this study do not appear to support the proposal that mentally disordered offenders have a “distorted set of values” (Spruin et al., 2014). Indeed, there seems to be a shared set of values with the general population. The model suggests that there can be a tension however, between expressed values and behaviours that for some, can be enacted in maladaptive or antisocial ways. For example, substance misuse and criminal behaviour may be underpinned by shared values related to connecting with others or having agency, in particular social groups and environments.
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There appears to be an overlap of findings of the values of mentally disordered offenders from the present study and the “primary goods” identified in the Good Lives Model (Ward, 2002). This research was undertaken independently of the Good Lives Model literature, using a grounded theory method to develop an understanding of values of MDOs in a MSU. This paper proposes four categories of values, that emerged from the data: connecting with others; living a healthy life; bring productive and contributing; and having agency and being in control. Generally, the 11 categories of the Good Lives Model (GLM) appear to map onto the categories proposed here. The category “connecting with others” appears to relate to the following GLM primary goods: relatedness; and community. “Living a healthy life” is similar to the primary goods: Life; inner peace; and spirituality. The third category of values in this study, “Being productive and contributing” is similar to the GLM’s: excellence in play; excellence in work; and creativity. Furthermore, the final category of “having agency and being in control” relates to the GLM’s primary goods of excellence in agency. The primary good, pleasure, does not directly relate to any of the categories identified in this study. Overall, this research appears to be in support of the GLM literature and the primary goods that the model proposes. This also supports the view that the forensic population, specifically MDOs share the same values as non-offenders.

Clinical Implications and Recommendations

The model of values in MDOs indicates some practical and clinical implications for working with MDOs. Using the structure of the model may provide a framework to
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help inform assessments and formulations for this patient group. It may provide a useful way of to help better understand the values of the individual and the barriers that they have faced throughout life and are currently facing within medium secure care. This model may also help discussions with the patient and the team to consider how the patient’s values and goals fit with their current circumstances, current restrictions or opportunities available within the unit. Using this model may be a way of facilitating both the patient and MDTs expectations of goals and helping the patient work in a way and set goals that are congruent with their own values but fit with the wider values or restrictive paths set on them by health and criminal authorities.

Metaphors are frequently used within Acceptance and Commitment Therapy (ACT) to explain values, goals and other concepts to patients; and as tools for cognitive defusion (Hayes et al., 1999; Foody et al., 2014). The model proposed in this paper has the potential to inform and develop existing and new metaphors for values-based work, as part of an ACT based approach. A preliminary metaphor was developed from the model that emerged from the data of this study. A script written for use with patients is included in appendix 11 for consideration in future clinical use.

It is proposed that using this model may have additional uses in clinical settings for assessment and formulation. As previously discussed, there is a tendency for treatment planning for men in medium secure units to focus on risk and psychiatric
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issues and less on individual preferences and values. There have been recent attempts to focus more on the individual client and their values in approaches such as the Good Lives Model and Recovery Model (Barnao et al., 2015). The model provided in this paper may provide a framework to help explore this with patients and contribute to formulation and treatment planning with this client group that helps explore and determine what is important to the individual and to appreciate the course their life has taken with regard to their values. Furthermore, it may be helpful to consider the role of avoidance and individual values from an ACT based perspective. Within the ACT literature, a tension is proposed between avoidance and values, with emotional pain leading to avoidance, which may take them away from valued activity (Soriano et al., 2004). Using the model proposed in this paper, experiential avoidance can be specifically related to the barriers and restrictions that this population faces and this impacts on the congruence of behaviour and goals with values.

It seems moreover, that this model could be applied to different populations and different clinical settings. In the population interviewed, a number of the restrictions and barriers were specifically related to forensic and hospital environments and populations, however many of the barriers, restrictions and opportunities appeared to be universal themes that could apply to anyone in any population or clinical setting, for example: interpersonal relationships, environment and culture and health challenges. It is proposed therefore that this model and findings could be applied to wider populations and clinical groups. Further research
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exploring the utility of this model in other settings and with other populations would be helpful.

Limitations and Research Recommendations

Despite this study making important contributions to research and developing theories of values in mentally disordered offenders, there are some limitations. The study recruited a small sample from one medium secure unit in Scotland. Caution is therefore needed to generalise these findings to other medium secure settings or mentally disordered offenders. Within this one unit all participants were white, British males, whom were either Christians or atheists. It is not clear therefore, how these findings would generalise to females, and people of different nationalities, cultures and faiths. A consideration of cultural values could benefit future research (Ward & Fortune, 2013). Despite the mentioned limitations in diversity of this sample, a strength of this sample was that participants in the study had a range of ages, socio-economic, education and work history backgrounds. A further limitation of the study was that it was not possible to discuss categories with the participants after the formation of a model.

Adverse Childhood Experiences (ACEs) were not asked about directly with the participants in the interviews. There is evidence to support the role of ACEs in the development of mental health difficulties, substance abuse and offending behaviour (Bileas et al., 2016). The model proposed in this paper considers values across the lifespan and considers the formation and development of values. It may
be helpful for future research to focus on the development of values and to explore
the role of ACEs and the impact that this has on the development of values and the
barriers to living a life congruent with their values.

Further qualitative work is needed to establish the validity of this model within the
mentally disordered offender population and with other populations. Future work
could use larger samples across medium secure units or consider participants from
high secure and community settings also. It may also be helpful for future research
to conduct interviews with individuals outwith the MDO population to better
explore how this population’s values fit with the general populations.

12. Conclusions

The model that emerged from the grounded theory method study creates a
framework for understanding values in mentally disordered offenders. MDOs
identified four broad categories of values relating to: connecting with others; living
a healthy life; being productive and contributing; having agency and being in
control. The understanding of MDO’s values that emerged from the data in this
study do not support the proposal that mentally disordered offenders have a
“distorted set of values” as compared to non-offenders. Moreover, the findings of
this study fits with the predominant conceptualisation of values of offenders in the
Good Lives Model.
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As part of the model, participants reflected on their values throughout their lifespan from the initial development, to times in their life when the balance of values fluctuated. This appears to be sensitive to and influenced by a number of barriers, restrictions and opportunities. Moreover, there appears to be a connection to individual’s values and their sense of self. The model proposes that this sense of self appears to be vulnerable and there is uncertainty regarding the self and how they fit in with the world around them. Further research is required to explore this topic further, to consider other forensic settings, with larger samples and to also evaluate the utility of this model in non-offending populations.
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Appendix 1. Quality Criteria for Systematic Review

Adapted from Ross et al. (2013):

A: Study design and potential bias (internal validity)

1. Patients were randomly allocated and this process was sufficiently concealed
2. Participants, facilitators etc. were blind to the allocation
3. Attrition rates were reported

B: Choice of outcome measure

4. Outcome measures are valid, reliable and standardised
5. Outcome is relevant and meaningful to the intervention and the evaluation

C: Statistical issues

6. Study is adequately powered to detect the effect of the intervention
7. Appropriate analysis for outcome measures used and p values and effect sizes reported where appropriate

D: Quality of the intervention

8. The intervention has been appropriately defined
9. Intervention was delivered as planned (good fidelity)

E: Generalisability (external bias)

10. Intervention has been implemented in a way that would be considered ‘routine practice’
11. Follow up evaluation undertaken
Appendix 2. Scoring of quality criteria

1. Patients were randomly allocated and this process was sufficiently concealed

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<thead>
<tr>
<th>Score</th>
<th>Description</th>
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<tbody>
<tr>
<td>Well covered</td>
<td>The process of random allocation and concealment are well described so as the method of both are clear</td>
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<tr>
<td>Adequately addressed</td>
<td>The process of random allocation and concealment are mentioned but without great detail so as the actual method of each is unclear</td>
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<tr>
<td>Poorly addressed</td>
<td>The process of random allocation or concealment are mentioned but not sufficiently described or non-randomisation to groups</td>
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<td>Not addressed</td>
<td>The process of random allocation and/or concealment are not addressed</td>
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<tr>
<td>Not applicable</td>
<td>The process of random allocation and/or concealment not applicable in this instance</td>
</tr>
</tbody>
</table>

2. Participants, facilitators etc. were blind to the allocation

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well covered</td>
<td>Those who administered the outcome measures were blind to the allocation of participants or different people were involved in the administration of the measures and delivery of intervention. The method of this being ensured is clearly define</td>
</tr>
<tr>
<td>Adequately addressed</td>
<td>The process of how researchers were blinded to allocation is described but there is not sufficient detail to fully understand the method by which this was ensured.</td>
</tr>
<tr>
<td>Poorly addressed</td>
<td>Blinding of researchers is mentioned, however, no details about how this was done are provided</td>
</tr>
<tr>
<td>Not addressed</td>
<td>The issue of blinding the researchers was not discussed.</td>
</tr>
<tr>
<td>Not reported</td>
<td>The blinding of researchers to allocation was not reported.</td>
</tr>
<tr>
<td>Not applicable</td>
<td>The blinding of researchers to allocation is not applicable in this instance.</td>
</tr>
</tbody>
</table>

3. Attrition rates were reported

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well covered</td>
<td>Attrition rates are described for both intervention and control groups and are similar, and where differences exist, intention to treat analyses are described and carried out</td>
</tr>
<tr>
<td>Adequately addressed</td>
<td>Attrition rates are described, although differences exist between groups. Where these differences exist, intention to treat analyses are carried out, although they are less clearly described.</td>
</tr>
<tr>
<td>Poorly addressed</td>
<td>Attrition rates are described, differences exist between groups, and however, it is less clear whether intention to treat analyses were carried out.</td>
</tr>
<tr>
<td>Not addressed</td>
<td>The issue of attrition rates are mentioned but not clearly described and the issue of intention to treat analyses are not discussed.</td>
</tr>
<tr>
<td>Not reported</td>
<td>The issue of attrition rates and intention to treat analyses are not reported.</td>
</tr>
<tr>
<td>Not applicable</td>
<td>The issue of attrition rates and intention to treat analyses are not applicable in this instance.</td>
</tr>
</tbody>
</table>

4. Outcome measures are valid, reliable and standardised

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well covered</td>
<td>The psychometric properties of the outcome measures used are clearly described along with details of their validity and reliability within the forensic or clinical population utilised in the study.</td>
</tr>
<tr>
<td>Adequately addressed</td>
<td>The outcome measures are described but less well so and details around their validity, reliability or standardisation within the particular population are less clear. The measure is less well standardised with forensic populations.</td>
</tr>
<tr>
<td>Poorly addressed</td>
<td>The use of outcome measures are mentioned but little information is given about the tools used or their properties in terms of validity and reliability or the tool used is not standardised with the forensic or clinical sample nor has poor reliability or validity.</td>
</tr>
<tr>
<td>Not addressed</td>
<td>The use of outcome measures are mentioned but not further information is given.</td>
</tr>
<tr>
<td>Not reported</td>
<td>The use of outcome measures are not reported.</td>
</tr>
<tr>
<td>Not applicable</td>
<td>The use of outcome measures are not applicable in this instance.</td>
</tr>
</tbody>
</table>

5. Outcome is relevant and meaningful to the intervention and the evaluation

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well covered</td>
<td>The rationale for working towards a particular outcome is explained in terms of the relevance to the intervention being delivered and the evaluation of this in the broader context of strengths</td>
</tr>
</tbody>
</table>
Values and Recovery in Forensic Mental Health

Adequately addressed
The outcome is described but is less relevant either to the specific intervention being delivered or to the field of clinical or forensic practice with strength based approaches.

Poorly addressed
The outcome is mentioned but is less well covered and its usefulness to the evaluation of the intervention or broader improvements in practice are less clearly described.

Not addressed
The overall outcome is not related to the intervention specifically or the broader context of violence reduction sufficiently.

Not reported
How the outcome is related to intervention and evaluation is not reported.

Not applicable
How the outcome is related to intervention and evaluation is not applicable in this instance.

6. Study is adequately powered to detect the effect of the intervention

Well covered
Power calculation was completed using a reasonable effect size estimation and is clearly reported along with sufficient sample size within each group.

Adequately addressed
Power calculation is carried out, however, arbitrary effect size estimation used.

Poorly addressed
Power calculation is completed, however, effect size estimation not mentioned and no evidence of this having informed the sample size in each group.

Not addressed
Power calculation not completed or paper failed to meet the power calculation with sufficient sample size meaning any difference is not statistically significant.

Not reported
Power calculation not reported.

Not applicable
Power calculation not applicable in this instance.

7. Appropriate analysis for outcome measures used and p values, confidence intervals and effect sizes reported where appropriate

Well covered
Method of quantitative analysis used provides meaningful results of outcome and the confidence intervals, p-values and effect sizes are reported where appropriate. The analysis is described in sufficient detail so as statistical significance as well as descriptive information is clearly presented.

Adequately addressed
The quantitative analysis used provides meaningful results, however, the details of this such as the p-values, confidence intervals and effect sizes are less well covered.

Poorly addressed
The method of analysis used has not been well considered and does not provide the best presentation of results from the study. The p-values, effect sizes and confidence intervals may have mentioned but are not sufficient in this case.

Not addressed
There has not been any quantitative analysis used in this case, rather inconclusive findings have been provided.

Not reported
The methods of analysis have not been reported.

Not applicable
The methods of analysis are not applicable in this instance.

8. The intervention has been appropriately defined

Well covered
The intervention is covered in sufficient detail including reference to the theoretical underpinnings and the potential impact on level of violence within the target population. The content and procedures of the intervention are clearly described so as it could be replicated by the reader, as are any ‘rest periods’.

Adequately addressed
The intervention is described in relatively sufficient detail, although is less well covered. The theoretical underpinnings and impact of intervention are discussed but in less detail. The content and procedures are also mentioned but lack the acute detail necessary for the intervention to be accurately replicated.

Poorly addressed
The intervention is described; however, there is a lack of reference to the theoretical underpinnings and potential impact within sample. The content and procedures are not discussed.

Not addressed
The overall aim of the intervention is mentioned but the underpinnings and procedures of the intervention are lacking.

Not reported
Details of the intervention itself are not reported.

Not applicable
Details of the intervention are not applicable in this instance.

9. Intervention was delivered as planned (good fidelity)

Well covered
Details of how the intervention should be operationalised are provided and adhered to, as are
<table>
<thead>
<tr>
<th>10. Intervention has been implemented in a way that would be considered ‘routine practice’</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Well covered</strong></td>
</tr>
<tr>
<td><strong>Adequately addressed</strong></td>
</tr>
<tr>
<td><strong>Poorly addressed</strong></td>
</tr>
<tr>
<td><strong>Not addressed</strong></td>
</tr>
<tr>
<td><strong>Not reported</strong></td>
</tr>
<tr>
<td><strong>Not applicable</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>11. Follow up evaluation undertaken</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Well covered</strong></td>
</tr>
<tr>
<td><strong>Adequately addressed</strong></td>
</tr>
<tr>
<td><strong>Poorly addressed</strong></td>
</tr>
<tr>
<td><strong>Not addressed</strong></td>
</tr>
<tr>
<td><strong>Not reported</strong></td>
</tr>
<tr>
<td><strong>Not applicable</strong></td>
</tr>
</tbody>
</table>
Appendix 3. Aggression and Violent Behaviour Journal

TABLE OF CONTENTS

- Description
- Impact Factor
- Abstracting and Indexing
- Editorial Board
- Guides for Authors

DESCRIPTION

Aggression and Violent Behaviour is a multidisciplinary journal that publishes substantive and integrative reviews as well as summary reports of innovative ongoing clinical research programs in a wide range of topics germane to the field of aggression and violent behavior. Papers encompass a large variety of issues, populations, and domains, including homicide (legal, social, and mass murder; sexual homicide); sexual assault and incest; rape; sexual rape (child molestation, pedophilia); child and youth violence (hijacking, gang violence, and sexual offending); family violence (child, physical and sexual abuse, child neglect, mastrubatory and elder abuse); general psychopathology, and the psychopathology at its extremes.

The emphasis will be cross-disciplinary and cross-theoretical. Indeed, papers will emanate from numerous disciplines, psychology, psychiatry, criminology, criminal justice, law, sociology, anthropology, genetics, social work, ethnology, and physiology.

Papers describing the study of aggression in normal, criminal, and psychopathological populations are acceptable. Reviews of analog investigations of aggression and related topics will be considered if they point to the development of theory or practical changes in the field. The emphasis, however, will be on innovativeness of presentation and clarity of thinking.

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To find out more, please visit the Preparation section below.

Submission checklist
You can use this list to carry out a final check of your submission before you send it to the Journal for review. Please check the relevant section in this Guide for Authors for more details.

Ensure that the following items are present:
One author has been designated as the corresponding author with contact details:

- Email address
- Full postal address

All necessary files have been uploaded:
- Manuscript
- Include keynotes
- All figures (include relevant captions)
- All tables (including titles, description, footnotes)
- Ensure all figure and table citations in the text match the files provided
- Indicate clearly if color should be used for any figures in print
- Graphical Abstract / highlighter file (where applicable)
- Supplements file (where applicable)

Further considerations:
- Manuscript has been spell checked and grammar checked
- All references mentioned in the Reference List are cited in the text, and vice versa
- Permission has been obtained for use of copyrighted material from other sources (including the Internet)
- A competing interests statement is provided, even if the authors have no competing interests to declare
- Journal policies detailed in this guide have been reviewed
- Refer to suggestions and contact details provided, based on journal requirements

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Figures and tables embedded in text

Papers are divided into sections, and the contents of each section are placed near the bottom of the page. The corresponding section should be placed directly below the figure or table.

Revised Submissions

Use of word processing software

Regardless of the file format of the original submission, all revision must provide a clearly written text in the English language. The document should be submitted in a single-column format and should be adhered to the guidelines provided by the journal.

Artistic structure

Subsections numbered sections

You should consider dividing your paper into clearly defined and numbered sections. Subsections should be numbered 1.1, 1.1.1, 1.1.1.1, etc. (the abstract is not included in section numbering). Any cross-referencing within the text should appear in the same sequence throughout the text.

Introduction

State the objectives of the work and provide an adequate background. Avoid discussing your methods in the introduction.

Material and Methods

Provide sufficient details to allow the work to be reproduced by an independent researcher. Methods that are already published should be summarized, and indicated in the reference list. Where possible, use descriptive terms rather than abbreviations. Avoid overly technical jargon.

Results

Results should be clear and concise.

Discussion

Discuss the significance of the results of the work, not repeat them. A combined Results and Discussion section is often appropriate. Avoid extensive citations and discussion of published work.

Conclusion

Summarize the main conclusions of the study. They may be presented in a short Conclusions section, which may stand alone or form a subsection of a Discussion or Results and Discussion section.

Acknowledgments

If there is more than one appendix, they should be identified as A, B, etc. Formulas and equations in appendices should be given separate numbering (e.g., (A.1), (A.2), etc.) and a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures (Table A.1), Fig. A.1, etc.

Essential title page information

Title: Conclude with informative titles. Avoid abbreviations and formulas wherever possible.
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If no funding has been provided for the research, please include the following sentence:

This research did not receive any specific grant from funding agencies in the public, commercial, or non-profit sectors.

Math Formulas:
Please submit math equations as editable text and not as images. Present simple formulas in line with normal text where possible and use the solidity (\) instead of a horizontal line for small fractional terms. e.g., \( XX \). In principle, variables are to be presented in italics. Review of a pre-formula note is conventionally denoted by a \( \) number consecutively any equations that have to be displayed separately from the text (if referred to explicitly in the text).

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Electronic artwork

- Make sure you use uniform lettering and sizing of your original artwork.
- Preferred fonts: Arial (or Helvetica), Times New Roman (or Times), Symbol, Courier.
- Number the illustrations according to their sequence in the text.
- Use a logical naming conversion for your artwork files.
- Indicate per figure if it is a single, 1.5 or 2-column fitting image.
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- TIFF (or JPEG): Color or grayscale photographs (halftones); always use a minimum of 300 dpi.
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- JPEG (or PNG): Compressed bitmaps of photographs (color or grayscale); a minimum of 300 dpi.

Please do not:

- Supply files that are optimized for screen use (e.g., GIF, JPEG, PICT, WPG); the resolution is too low.
- Supply files that are too low in resolution.
- Submit graphics that are disproportionately large for the content.

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Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in tables do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

References:

Citation in text:

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list, they should follow the standard reference style of the journal. The appropriate author for any reference should be clearly indicated and the reference should be included in the reference list. The reference should be followed by the date, if known. All references should be listed in numerical order within each section of the reference list. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted or proof stage for the author to correct. If you do wish to format the references yourself, they should be arranged according to the following examples:

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For supported data repositories a repository banner will automatically appear next to your published article on ScienceDirect.

In addition, you can link to relevant data or entities through identifiers within the text of your manuscript, using the following format: Dataset, v.x, (e.g., TAIR: AT1G53500; CCDC: 714853; PDB: 1KYN).

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Appendix 4. Thesis Proposal Form:

Doctorate in Clinical Psychology

Thesis Research Proposal

(Research 1 Assessment)

This form should be completed and submitted as the assessment for Research 1. It will then be reviewed by a member of the academic team and will receive a grade and detailed feedback. The feedback will include an evaluation of the viability of the project and any recommendations. If there are significant concerns about viability, the project will be flagged to the research director and the research committee will decide whether the project can proceed in its current form.

<table>
<thead>
<tr>
<th>Exam Number</th>
<th>B082138</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provisional Thesis Title</td>
<td>Exploring Values and Goals in a Mentally Disordered Offender Population within Medium Secure Psychiatric Units: A Qualitative Study.</td>
</tr>
<tr>
<td>Proposed Setting</td>
<td>The Orchard Clinic, Royal Edinburgh Hospital, Morningside Terrace, Edinburgh, EH10 5FH</td>
</tr>
<tr>
<td>Allocated Thesis Project Supervisors</td>
<td>Clinical: Dr Ethel Quayle</td>
</tr>
</tbody>
</table>
Values and Recovery in Forensic Mental Health

<table>
<thead>
<tr>
<th>Academic 2</th>
<th>N/A</th>
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<tbody>
<tr>
<td>Others Involved</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Anticipated Month / Year of Submission
Must be final year for full-time trainees. For flex trainees, the month and year of submission will depend on the individual Training and Development Plan. Trainees from 2011 intake onwards must submit in May. Trainees who started in 2010 or earlier are advised to submit in May to reduce potential for HCPC registration difficulties.
May 2018

Please Note: Whilst this is not an ethics review process, where questions have some similarities to questions contained in the NHS IRAS Research Ethics form, the corresponding IRAS question numbers are given in parentheses. This is intended to facilitate completion of NHS ethics where such approval is needed.

Section 1: Introduction
1.1 Provide a brief critical review of relevant literature, which should clearly demonstrate the rationale and scientific justification for the research
1000 – 1500 words
Relevant to IRAS A12

Values and the political and health Context
Recent national health and political campaigns, such as the Well Scotland Initiative and the Recovery model have highlighted the importance of the role of individual’s values and the benefits of pursuing them in addressing mental well-being across Scotland. There is an increasing emphasis on values and recovery in health settings (Centre for Mental Health, 2011; Hayes, 1999) and in forensic mental health services (Forensic Mental Health Matrix, 2011). Within the recovery approach, The Good Lives model moves from a previous primary focus on the management of risk, to balancing this with promoting the goals of the individual, their recovery and positive risk taking. This approach was initially used within a sex offenders population but is also thought to be a promising intervention with mentally disordered offenders (MDOs) (Barnao et al., 2016). Its aim is to build resources for the individual to live a life that is meaningful, fulfilling, in line with their values and to reduce risk. Despite the endorsement of values based approaches, values have not been clearly defined or operationalised in clinical settings (Tansey, 2010). Moreover, it is not clear if similar values are shared across populations (Tansey, 2010; Stuart, 2015), despite the Good Lives Model assuming that the values of the MDO population are the same as the general population (Sellen et al., 2006). In light of this increased focus on values in MDOs and in the development of clinical interventions, a greater understanding of values within this population is required to ensure that interventions are evidence based.
Conceptualising values
There are currently two main approaches used within the literature to conceptualise values: Schwartz’s (1992) structural model; and a contextual, behavioural model from Acceptance and Commitment Therapy (ACT) (Hayes, 1999). Schwartz’s model proposes that values are guiding beliefs, which are transsituational and represent desirable end states (Schwartz and Bilsky, 1987). Within this model, values are thought to be a product of their upbringing, social and cultural environments (Schwartz and Bardi, 2001). Schwartz’s (1992) model of universal values, proposes ten value types, which can be separated into four higher-order value groups: conservation, openness to change, self-enhancement, and self-transcendence. The ACT based conceptualisation of values, states that values are verbal constructions of “organising principles for action” and this provides a long term framework for the individual’s decisions and actions (Hayes, 1999). From a behavioural perspective, decisions and actions that are carried out in line with their values are positively reinforced (Powers et al., 2009).

Quantitative measures of values, such as the Valued Living Questionnaire (Wilson et al., 2010) and the Portrait Values Questionaire (Scwartz et al., 2001) are used clinically and in research. There are criticisms however, using these measures to explore values, particularly with MDOs. It can be argued that reducing values to a limited number of options will not capture everything that is important to an individual, and may limit the meaning of this. Furthermore, this restricted list will fail to capture any anti-social values, if these are present in an individual, as the values in these measures are mainly pro-social based (Tansey, 2010).

Mentally disordered offenders and medium Secure Units
Mentally Disordered Offenders (MDOs) are defined as people with a mental illness, personality disorder or learning disability who have offended and are involved in the criminal justice system (Jacques, Spencer, & Gilluley, 2010; Scottish Office, 1999).

The Orchard Clinic is one of three medium secure units in Scotland and was the first to open in 2000. Prior to this, the State Hospital at Carstairs was the sole high secure unit for MDOs in Scotland. A change to the management and treatment of MDOs was prompted by a number of government and health led reviews of services and risk. The Mental Health Act (2003), reviews by the Scottish Office (1997, 1999), and the State Hospital survey (Thomson et al., 1997), highlighted the need for medium and low secure units and also community resources. The Orchard Clinic is 40 bed unit and provides inpatient facilities for the assessment, treatment and rehabilitation of people with complex needs, who are involved in the criminal justice system. MDOs at the Orchard Clinic are thought to be a risk to themselves or others but they do not require high security care (Crichton, 2009). Recent reviews of the Orchard Clinic’s admission have highlighted that the majority of patients are male and aged under 40 and have a primary diagnosis of schizophrenia.
Many also had a secondary diagnosis of personality disorder or substance misuse (Gow et al., 2010). The average length of admission was 40.7 weeks and admissions were predominantly from legal establishments, with an increasing proportion admitted on treatment orders pre trial (Stuart, 2014).

**Mentally disordered offenders and values**

As discussed, there is an increasing focus on values informed interventions, however there is a paucity of published research in this area, particularly with MDOs. A previous doctoral thesis (Tansey, 2010) was undertaken with the same client group at the Orchard Clinic, suggesting that a values based approach can assist with treatment planning, therapeutic engagement and goal setting. In this research, it was found that living in accordance with values was positively related to quality of life and negatively related to psychological distress. It also found some similarity in values of MDOs with the general population, however MDOs are often not able to live in accordance to these values. There were also some differences in personally meaningful values between populations, with greater importance placed on the values concerning safety, freedom and independence for MDOs. Furthermore, different goals were also identified, for example the goal of recovery and stability in mental health. It is thought that these differences in goals and values may be due to their current environment in the medium secure unit (Tansey, 2010).

Being detained in a medium secure unit presents a number of challenges in pursuing goals in line with a number of values including, freedom, autonomy and intimate relationships (Mezey, 2010). Furthermore, MDOs within secure facilities and in the community, may be more limited in their pursuit of relationships and employment due to the double stigma that MDOs face of mental illness and offending (Roskes, 1999). Moreover, a focus on risk to self and others in medium secure units can limit the pursuit of values and goals (Mezey et al., 2010). Legal restrictions can also be a barrier to achieving goals, for example a goal of being close to family but being unable to move to be with family in another part of the country due to restrictions on movement (Stuart, 2015).

There has been little research into these areas previously, therefore a qualitative study may be able to offer further insight into the values that are personally meaningful to this population; the barriers to pursuing these values; and to explore the differences between MDOs and the general population. Qualitative methods have been found to be important in exploring these issues and facilitating personal narratives within the recovery model (Roychowdhury, 2011; O’Sullivan et. al., 2013). A discussion of values has been found to be a positive part of recovery and can also improve engagement with therapy and identification of therapeutic goals (Stuart, 2015; Tansey, 2010). Furthermore, this research is important as attempts to increase engagement with therapy and management of offending behaviour will add to the evidence base and help inform current clinical practice, which has the potential to reduce the risk of this client group, impacting on the safety and welfare of the public.
Section 2: Research Questions / Objectives

2.1 What is the principal research question / objective?

What role do values and goals play in the lives of mentally disordered offenders?

The research question will be kept generic inline with a grounded theory methodology (Charmaz, 2014).

2.2 What are the secondary research questions / objectives, if applicable?

What are the barriers in pursuing these values?

Section 3: Methodology

3.1 Give a full summary of your design and methodology

Design

This research will use a qualitative design to explore the values and goals of mentally disordered offenders (MDOs) in a medium secure psychiatric unit. Semi structured interviews will be undertaken with MDOs at the Orchard Clinic to gather data. The study will adopt a grounded theory methodology to develop an understanding of the values and goals from the patients’ perspective to assist in the development of a theory. It is hoped that this will help facilitate the development of future interventions with this client group. There is a current paucity in the literature and a qualitative approach was chosen to develop an understanding of what is important in this population. Specifically, grounded theory was chosen as it is a good fit for the aims of this research as will be discussed later. Furthermore it is a well established method and is often used in offender populations (Hinsby & Barker, 2004; Mezey et al., 2010).

Participants and Recruitment

Participants will be recruited from the Orchard Clinic, a medium secure unit. The sample will be current residents of the clinic who have severe and enduring mental health problems and have offended. They will be 18 or over, able to give informed consent to participate, and not currently experiencing acute symptoms of mental illness. For the purposes of homogeneity and due to the majority of MDOs being male (Gow et al., 2010), the sample will be of male MDOs only.

Recruitment will be sought initially through the patient’s Responsible Medical Officer (RMO), a Consultant Psychiatrist, who is in charge of the patients care. Plain-English patient information sheets will be developed and a clinical
A psychologist in the team will present an overview of the research to the clinical team meeting. At this meeting the RMO will say whether or not someone has capacity to consent to research and those without consent will be excluded. Members of the clinical team will then discuss the research with their patients who are deemed to have capacity, acting as gatekeepers for the research. If the patient is interested in participating, the researcher will then meet with them. During this meeting, the patient information sheet will be reviewed and the patient will have the opportunity to discuss any questions they may have. If they wish to participate in the study, they will be given at least 24 hours to review and sign the consent form.

Procedure
All patients identified as suitable and who have consented to participate will meet with the researcher for a face to face interview. This meeting, lasting approximately one hour, will take place within the Orchard clinic in a quiet, private and secure room. The interview will explore values and goals within this population, asking open ended questions. In particular, patients will be asked what is important in their life; their valued daily activities; and the impact of offending and mental health on attaining their values. These interviews will be audio recorded and secured securely on an NHS computer. Using a grounded theory method, notes will be taken during the interview and a preliminary analysis of the interviews may alter the questions asked in later interviews.

Data Analysis
All interviews will be transcribed and Dedoose software used to manage the anonymised data. The transcribed interviews will be analysed using a grounded theory method (Charmaz, 2014) as described below. Once theoretical saturation is reached, this will be used to generate a theory. This process will be reviewed in supervision and guidelines and checklists such as Chenail (2011) and Spence et al. (2003) will be used to ensure methodological rigour and help reduce researcher bias.

3.2.1 In which aspects of the research process have you actively involved, or will you involve, patients, service users and/or their carers or members of the public? Highlight as appropriate.
IRAS A14-1

<table>
<thead>
<tr>
<th>Design of the research</th>
<th>Analysis of results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Management of the research</td>
<td>Dissemination of findings</td>
</tr>
<tr>
<td>Undertaking the research</td>
<td>None of the above</td>
</tr>
</tbody>
</table>

3.2.2 Give details of involvement, or if none, please justify the absence of involvement
The researcher will meet with peer support workers in the Orchard Clinic to discuss the planning and design stages of the research. It will not be possible to have further service user involvement in the project, at other stages due to time restraints, nor at the stages of management of research or analysis of results due to the confidential nature of the raw data.

3.3 List the principal inclusion and exclusion criteria

<table>
<thead>
<tr>
<th>Inclusion criteria:</th>
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<tbody>
<tr>
<td>● Fluency in English</td>
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<tr>
<td>● Over the age of 18</td>
</tr>
<tr>
<td>● Considered able to provide informed consent as judged by the Responsible Medical Officer (RMO)</td>
</tr>
<tr>
<td>● Male</td>
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<table>
<thead>
<tr>
<th>Exclusion Criteria:</th>
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<tbody>
<tr>
<td>● Considered unable to provide consent by the Responsible Medical Officer (RMO)</td>
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<tr>
<td>● Decline to hear more information when asked directly by the “gatekeeper”</td>
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<tr>
<td>● Are currently acutely psychotic, as assessed by the RMO</td>
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<tr>
<td>● Are engaged in individual psychotherapy with the researcher</td>
</tr>
<tr>
<td>● Have a learning disability</td>
</tr>
<tr>
<td>● Have significant communication difficulties</td>
</tr>
<tr>
<td>● Female</td>
</tr>
</tbody>
</table>

3.4 How will data be collected?

If quantitative, list proposed measures and justify the use of these measures. If qualitative, explain how data will be collected, giving reasonable detail (don’t just say “by interviews”).

As discussed above, all participants taking part in the research will meet the researcher for individual face to face semi-structured interviews. The interviews will last approximately one hour using open ended and non judgemental questions to explore the values and goals of this group and barriers to achieving them. After the interview, participants will be given the opportunity to ask any questions in a post interview debriefing. Notes will be taken during the interview, in line with a grounded theory method, as will be discussed below. The interview will be audio recorded using encrypted digital audio recorders and the data will be transcribed, stored securely on a NHS computer in the Orchard Clinic, and anonymised data managed using Dedoose software. Each interview will be analysed and new questions formulated using grounded theory prior to the next interview.

Section 4: Sample Size

4.1 What sample size is needed for the research and how did you determine this?

For quantitative projects, outline the relevant Power calculations and the rationale.
for assuming given effect sizes. For qualitative projects, outline your reasoning for assuming that this sample size will be sufficient to address the study’s aims

IRAS A59 and IRAS A60

It is estimated that I will be able to recruit approximately 8 to 12 patients from the Orchard Clinic for this study. In grounded theory, it is difficult to estimate accurately beforehand, the size of a sample required, as it is difficult to predict when saturation of the data will occur (Stern, 2007). An average of eleven participants, with a range of six to sixteen participants were found to be used in qualitative studies using grounded theory with this population (Mezey et al., 2010; Krishnan & Evans, 2004; Van Hout & Phelan, 2014). Moreover, a recently completed thesis using grounded theory, had a sample of seven participants and found the saturation of categories after six interviews (Picton, 2013).

4.2 Outline reasons for your confidence in being able to achieve a sample of at least this size

E.g. give details of size of known available sample(s), percentage of this type of sample that typically participate in such studies, opinions of relevant individuals working in that area

I have met with my academic and clinical supervisors for this research to discuss sample size and they agree that this sample size is achievable given experience of past researchers at the Orchard Clinic. Of the 40 patients at the unit, it is estimated that 20 will fit inclusion criteria and a longer time frame for patient recruitment should allow for adequate recruitment, making it highly likely that I will be able to recruit 8-12 participants. Moreover, an unpublished thesis undertaken in the Orchard Clinic with the same client group (Tansey, 2010) was able to recruit a sample size of fifteen participants.

Section 5: Analysis

5.1 Describe the methods of analysis (statistical or other appropriate methods, e.g. for qualitative methods) by which the data will be evaluated to meet the study objectives

IRAS A62

The data will be evaluated using grounded theory methods. This qualitative approach is a systematic, inductive and comparative method to understand and evaluate human behaviour with the aim of constructing a theory (Charmaz, 2014). More specifically Charmaz’s (2014) modern version of constructivist Grounded Theory approach will be used to explore values and goals within MDOs. The main characteristics of grounded theory as outlined by Glaser and Strauss (1967), include the simultaneous collection and analysis of data, making use of memos taken during data collection and the interview transcript. Memoing is used in Charmaz’s (2014) constructivist grounded theory to increase awareness of and monitor the researchers own preconceived ideas and minimise the impact on the analysis and theory. Techniques are then used such as coding and categorisation, to identify categories in the data, make links and establish the relationship between
Values and Recovery in Forensic Mental Health

categories. This method is non linear and uses a “constant comparative method” throughout the data collection and analysis. The researcher moves backwards and forwards between the two, until the categories reach theoretical saturation, where there is no new information or insights reported in the data. At this point a theory that is generated from the data can be formed (Charmaz, 2014).

A qualitative approach was considered most suitable for this study as there is a current paucity of research with this population (Tansey, 2010). A qualitative approach is useful for exploring individual’s personal experience (Strauss & Corbin, 1998), which fits with the subjective nature of this research, exploring individual’s values. More specifically a grounded theory methodology was chosen as: it is systematic and transparent in its approach to data collection and analysis, in contrast to other qualitative methods which use more broad principles (Starks & Trinidad, 2007). This adds rigour and credibility to the product of this method, the theory (El Hussein, 2014). A grounded theory method is consistent with the aim of the research, to develop an explanatory theory from patients’ perspective which will help to shape future research and interventions for this client group. It is also the most widely applied qualitative methodology with client group (Mezey, et al., 2010; Hinsby & Barker, 2004). Furthermore, grounded theory is a good fit for these goals as it does not begin with an existing hypothesis or a priori assumptions (Charmaz, 2014) but that categories and the resulting theory emerges naturally from the data.
### Section 6: Project Management / Timetable

#### 6.1 Outline a timetable for completion of key stages of the project

E.g. ethics submission, start and end of data collection, data analysis, completion of systematic review

<table>
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<tr>
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<tbody>
<tr>
<td><strong>July 2016</strong></td>
<td><strong>January – November 2017</strong></td>
<td><strong>January 2018</strong></td>
</tr>
<tr>
<td>Submit Thesis Proposal Form to university</td>
<td>Ongoing interviews, transcription and analysis of interviews</td>
<td>Complete data analysis and write results section</td>
</tr>
<tr>
<td>Submit Substantial Amendment for IRAS</td>
<td><strong>January – February 2018</strong></td>
<td><strong>March 2018</strong></td>
</tr>
<tr>
<td>Visit Orchard Clinic and meet team</td>
<td>Write Discussion section</td>
<td>Completion of systematic review</td>
</tr>
<tr>
<td><strong>August 2016</strong></td>
<td><strong>November 2017</strong></td>
<td><strong>May 2018</strong></td>
</tr>
<tr>
<td>Meet with academic and clinical supervisors. Complete Patient information Sheet, Patient Consent Form and Interview Schedule and submit to IRAS</td>
<td>Complete semi structured interviews</td>
<td>Completion of write up and submission</td>
</tr>
<tr>
<td><strong>September 2016</strong></td>
<td><strong>December 2017</strong></td>
<td><strong>June –July 2018</strong></td>
</tr>
<tr>
<td>Once receive IRAS approval, meet with clinical team and begin recruitment</td>
<td>Complete systematic review draft</td>
<td>Viva</td>
</tr>
<tr>
<td>Begin semi structured interviews</td>
<td></td>
<td><strong>July 2018</strong></td>
</tr>
<tr>
<td><strong>October 2016</strong></td>
<td></td>
<td>Corrections</td>
</tr>
<tr>
<td>Begin write up of methods section</td>
<td></td>
<td><strong>September 2018</strong></td>
</tr>
<tr>
<td><strong>November 2016</strong></td>
<td></td>
<td>Submit systematic review and research papers for publication in relevant journal</td>
</tr>
<tr>
<td>Begin literature search for systematic review</td>
<td></td>
<td></td>
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<tr>
<td><strong>December 2016</strong></td>
<td></td>
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<tr>
<td>Complete draft methods section</td>
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### Section 7: Management of Risks to Project

#### 7.1 Summarise the main potential risks to your study, the perceived likelihood of occurrence of these risks and any steps you will or have taken to reduce these risks. Outline how you will respond to identified risks if they should occur

There are not any anticipated risks or burdens for the individuals taking part in this research. The interview should not include any topics that are upsetting or embarrassing for the individual. In previous work exploring similar topics (Tansey, 2010 and Gannon et al., 2011) participants have found it enjoyable and a positive experience to speak about their values. A potential risk for this research would be a participant disclosing risk of harm to themselves, others, or previous offending that was not known about. In this instance the researcher would disclose the risk and relevant information to the clinical psychologist on the team who would ensure that
Further potential risks for this research include failure to recruit enough people or to get rich data. To maximise the potential numbers of participants, I plan to begin recruitment early in the research process to increase the time of the recruitment window. This is helped as this project has previously received ethical approval through IRAS, so recruitment can potentially begin in late summer 2016. I will review participant numbers regularly with supervisors and will consider contacting other medium secure units in Scotland if this looks to be problematic. If there is failure to get adequately rich data, for example vague or irrelevant responses from the interview, the option for supplementary interviews will be explored.

Another potential risk in this research is the potential for loss of data, including interview recordings and transcripts. I plan to use Dedoose software to manage and backup my data which will reduce the likelihood of data loss. Furthermore, I will use two audio recorders for the interviews and test them prior to use to minimise the impact of equipment malfunction.

A final risk that must be considered, is the researcher failing to adequately facilitate semi structured interviews. Interviews will be carefully planned with supervisors and Chenail’s (2011) interviewing the investigator approach will be considered. Using this approach, the researcher will role play the role of interviewer and interviewee during supervision to develop interview skills and highlight any biases or assumptions about the client group. Furthermore, as mentioned previously, guidelines and checklists will be used to ensure methodological rigour and reduce research bias.

Section 8: Knowledge Exchange

8.1 How do you intend to report and disseminate the results of the study?

This research will be written up as a doctoral thesis in line with the requirements for the University of Edinburgh Clinical Psychology Doctorate Programme. I also intend to submit sections of this thesis, for example the systematic review and the research study, to relevant peer-reviewed journals for publication. The findings will also be presented to the Orchard Clinic and other local forensic units. Furthermore, participants in the study will be given the opportunity to receive a summary of the results. This will be done by meeting with the individual to give general feedback or by sending a written summary of the research findings to the individual.

8.2 What are the anticipated benefits or implications of the project?

E.g. if this is an NHS project, in what way(s) is the project intended to benefit the NHS?
This research aims to fill a gap in the existing understanding of values and goals within an MDO population. This is hoped to help inform future research and therapeutic directions for this client group. This will be of benefit to MDOs as developing an understanding of the values of this group will help professionals work in ways that are respectful of the individual and congruent with what is important to them. Further benefits to engaging in values based work have shown an improvement in quality of life and reduction of psychological distress (Tansey, 2010). It is hoped that this will facilitate engagement in therapy and also reduce stigma.

8.3 Are the any potential costs for the project?
Outline any potential financial costs to the project, including the justification for the costs (why are these necessary for the research project?) and how funding will be obtained for these costs (how will they be met?) Please separate these into potential costs for the University and potential costs for your NHS Board and note that you should ask your NHS Board to meet stationery, printing, postage and travel costs.

Printing costs for information leaflets and consent forms which will be covered by NHS Lothian. Dedoose software will be used for data management, coding and analysis. The monthly subscription fee is $10.95 when used and I will apply for funding for this through the university.

Section 9: Any Other Relevant Information
This research was previously approved by IRAS in 2012 but not started. At the time of submission for the Thesis Proposal (R1), a resubmission for a change of name is currently in progress.

Section 10: Key References


Values and Recovery in Forensic Mental Health


Values and Recovery in Forensic Mental Health


<table>
<thead>
<tr>
<th>Section 11: Confirmation of Supervisors’ Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I confirm that both my Academic and Clinical Supervisors have seen and approved this research proposal and have both completed the supervisors’ appraisal forms below.”</td>
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<td>Delete as appropriate</td>
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<td>Yes</td>
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Appendix 1

**Main Academic Supervisor’s Appraisal of Project Risk**

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<thead>
<tr>
<th>Supervisor’s Name</th>
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<tbody>
<tr>
<td>Ethel Quayle</td>
</tr>
</tbody>
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<table>
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<tr>
<th>Date</th>
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<tbody>
<tr>
<td>13/07/16</td>
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</table>

| Do you consider that the project should proceed in broadly its current form? |
| Delete as appropriate |
| Yes | Yes, subject to the revisions outlined below | No |

<table>
<thead>
<tr>
<th>Outline the reasons for the above response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highlight any areas of risk to the completion of the project that have not been fully addressed within the proposal and any steps that could be taken to reduce risks</td>
</tr>
<tr>
<td>This proposal relates to an earlier research project which was not started but was reviewed, has IRAS approval which has been submitted for a change of name and has been sponsored by the University. It fits well with the Orchard Clinic’s portfolio of research and, as it requires a relatively small sample, should be achievable.</td>
</tr>
</tbody>
</table>
## Appendix 2

### Clinical Thesis Supervisor’s Appraisal of Project Risk

<table>
<thead>
<tr>
<th>Supervisor’s Name</th>
<th>Dr Louise Tansey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Position</td>
<td>Clinical Psychologist</td>
</tr>
<tr>
<td>Date</td>
<td>13/07/16</td>
</tr>
</tbody>
</table>

**Do you consider that the project should proceed in broadly its current form?**

*Delete as appropriate*

| Yes | Yes, subject to the revisions outlined below | No |

**Outline the reasons for the above response**

Highlight any areas of risk to the completion of the project that have not been fully addressed within the proposal and any steps that could be taken to reduce risks

This is an interesting project which fits with department and Orchard Clinic interests and objectives. A sample size of between 8 and 12 seems achievable, especially because of a lengthier period available for recruitment due to the project already having ethics approval.
Appendix 3

Lay Summary

Provide a summary of your project in language suitable for a layperson
500 words

This research aims to explore values and goals of mentally disordered offenders (MDOs) within the Orchard Clinic, a medium secure psychiatric unit. This group consist of people with a mental illness, personality disorder or learning disability who have offended and are involved in the criminal justice system. This research will explore ways to help this group of patients live a meaningful and fulfilling life as part of their recovery. Values are defined as what is important to the individual and give a sense of purpose, meaning and satisfaction to life. There can be a number of barriers that prevent individuals from living a meaningful life in line with their values, particularly in the mentally disordered offender population.

Recent health and political campaigns, such as the Well Scotland Initiative and the Recovery model, have highlighted the importance of individual's values and that living consistently with one's values may enhance well-being, quality of life and reduce psychological distress. Values based approaches have been used clinically and early research suggests that this can assist with treatment planning, therapeutic engagement and goal setting within this client group.

Despite this recognised importance for mentally disordered offenders and increasing use of values based treatments, there has been little research exploring individual values and what is personally meaningful and relevant to this client group in medium secure psychiatric units. A greater understanding of values within this population is therefore required to ensure that interventions are evidence based. Furthermore, values have not been clearly defined in clinical settings and it is not clear if values are the same in mentally disordered offenders as with the general population.

A qualitative approach is useful to explore individual personal experiences. Semi structured interviews with MDOs at the Orchard Clinic will be used to explore individual values (what is important in their life) and barriers to pursuing these. A grounded theory methodology will be used to explore to explore these topics and to construct a theory, which is hoped will contribute to future research in this area and clinical practice. This is important as it is hoped that this research will inform ways to improve engagement with therapy with MDOs, by making it more meaningful to the individual and better manage offending behaviour. This has the potential to reduce the risk of this population, impacting on the safety and welfare of the public.
Appendix 5. Caldicott Approval

Lothian NHS Board
Waverley Gate
24 Waverley Place
Edinburgh
EH1 2EJ
Telephone 0131 651 5252
Fax 0131 651 5494
www.lothian.scot.nhs.uk

Dr Stuart Cooney
The Orchard Clinic
The Royal Edinburgh Hospital
Morningside Terraces
Edinburgh

Date: 8th March 2017

Dear Dr Cooney

CALDICOTT APPLICATION 16155

Thank you for the information supplied

<table>
<thead>
<tr>
<th>Request received from</th>
<th>Dr Stuart Cooney</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary of proposal</td>
<td>Exploring values and goals in a mentally disturbed offender population with medium secure psychiatric unit: A qualitative study.</td>
</tr>
<tr>
<td>Patient identifiable information requested</td>
<td>CM1, Gender, Other: patient audio recording, length of time as important at clinic, number of total admissions, reason for admission</td>
</tr>
<tr>
<td>Approved</td>
<td></td>
</tr>
<tr>
<td>Advice</td>
<td></td>
</tr>
</tbody>
</table>

Yours sincerely

Professor Alison McCallum
Director of Public Health & Health Policy
Appendix 6. Ethical Approval

University Hospitals Division

Queen’s Medical Research Institute
47 Little France Crescent, Edinburgh, EH16 4TJ

25 August 2016

Mr Stuart Cooney
The Orchard Clinic
Royal Edinburgh Hospital
Munrohouse Terrace
Edinburgh
EH10 5RH

Dear Mr Cooney,

REC No: 13/S0/0218
R&D Project ID No: 2013/PSY/01
Amendment: Substantial amendment No 1 dated 26 June 2016
Title of Research: Exploring values and goals in a mentally disordered offender population within medium secure psychiatric units: A Qualitative study

I am writing in reply to recent correspondence in relation to an amendment(s) to the above project as follows:

- Change of Principal Investigator and Chief Investigator from Miss Marie Watson to Mr Stuart Cooney

We have now assessed any consequential changes and can confirm that NHS Lothian management approval is extended to cover the specific changes indicated.

Yours sincerely,

Mr Kenny Scott
NHS Generic Review Manager
Appendix 7. Patient Information Sheet

“An exploration of the values of people in a medium secure unit”

- We are inviting you to take part in a research study.
- We want to make sure that you understand what it is, and what it would involve.
- Please take time to read the information sheet. If you have any questions you can speak to the psychologist on your team, or speak to Stuart, the Trainee Clinical Psychologist who is running the study.

What is the research about?

The Orchard Clinic wants to help patients to live a meaningful life as part of their recovery. Part of this is about discovering your values (what is important to you) and helping you to achieve them. We hope that this study finds out more about what you value and the things that might stop you from living a life that you find meaningful.

Why have I been asked to take part?

We are asking all men who are staying in the Orchard Clinic to take part in this study.

Do I have to take part?

No, it is up to you. To help you decide, Stuart will describe it to you. You will have the chance to ask questions. After this you will be asked if you want to take part.

If you decide to take part, you can change your mind at any time. You do not have to give a reason for this. Your decision will not affect the care that you receive or your legal rights.

What will happen if I take part?

Stuart, the researcher will meet with you. He will ask you about your values and what’s important in your life. The meeting will last around 45 minutes. You can leave at any time or spend longer discussing this if you wish. It can also be split into more than one meeting.

The discussion about your values will be recorded. This is so that Stuart will have an accurate record of your views. This interview will be stored securely in his office at the Orchard Clinic. It will then be typed up as soon as possible. The recording will be destroyed. Following this meeting, your part will have finished.
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What do I do if I want to take part?

After reading this information sheet, ask Stuart any questions that you have. You will be asked to sign a consent form to say that you agree to take part. The consent form is a way of making sure you know what you have agreed to. You will be given a copy of this. A copy of it will be kept in your medical notes.

What are the benefits of taking part?

Taking part may help you to think about your recovery and what is important to you. This study is about listening to people’s experiences and views. This will help us understand what is important to people and the difficulties they may face. We hope this can help improve the care the NHS offers in future. It will also help with future research.

Are there any disadvantages to taking part?

It is not thought that taking part in this study will make anyone upset or unhappy. However, if you feel you need to discuss anything after the interview, you can let Stuart or another member of staff know. They will make sure that the right person provides you with support.

Will my taking part in the study be kept confidential?

Yes. All the information we collect will be kept private. Details of what you say will not be saved with your name. Members of your clinical team will know you are taking part but not what we discuss. All documents will be anonymous and stored securely. No one reading it will be able to identify you. The recordings will be destroyed at the end of the study.

A copy of this information sheet and your consent form will be kept in your medical notes. Your answers will not be written in your notes. The only time that the Clinical Team will be told what you say is if the researcher is concerned about risks to yourself or to others.

What will happen to the results of the research study?

Stuart is happy to provide you with a summary of the results. This study is being carried out as part of his training to become a Clinical Psychologist. Once it is finished, a copy of the study will be held at the University of Edinburgh. The results may also be published in a journal or presented at a conference.

Who has reviewed the study?

The University of Edinburgh, the Research Ethics Committee, NHS Lothian and The Orchard Clinic have approved the study.

Who do I contact if I have any questions?

If you have any questions, you can ask the team at the Orchard Clinic to put you in touch with Stuart, the researcher: Stuart Cooney, Trainee Clinical Psychologist; or Dr Louise Tansey, Clinical Psychologist.

If you would like to discuss this study with someone independent of the research, please contact: Dr Shauneen Porter, Clinical Psychologist, who works at the Orchard Clinic.

If you wish to make a complaint about the study please contact: Patient Experience Team, NHS, Lothian, 2nd Floor, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG. Tel: 0131 536 3370, Email: feedback@nhslothian.scot.nhs.uk

Thank you for reading this information sheet.
PARTICIPANT CONSENT FORM

“An exploration of the values of people in a medium secure unit”

1. I confirm that I have read and understood the information sheet dated 18th April (version 2) for the above study. I have had the chance to think about the study and to ask any questions.

2. I understand that taking part is voluntary. I understand that I am free to withdraw at any time, without giving a reason. This will not affect my medical care or my legal rights.

3. I understand that taking part in the research will involve a conversation being recorded. This conversation will then be typed up and the recording destroyed. I give permission for this to happen.

4. I understand that the data collected during the study may be looked at by individuals from the Orchard Clinic or the University of Edinburgh. This data will be anonymous. I give permission for these individuals to have access to this.

5. I understand that the anonymised findings of the research may be published or shared with other professionals. This does not include any details that identify you personally.

6. I would like to receive a summary of the results.

7. I agree to take part in the above study.

Name of participant ___________________________ Date ______________ Signature ___________________________

Name of person taking consent ___________________________ Date ______________ Signature ___________________________

1x copy to the participant
Appendix 9. Interview Schedule

Semi-Structured Interview Schedule v2, 18/04/2017, page 1 of 1

Semi-Structured Interview Schedule
An exploration of the values of people in a medium secure unit

What is important to you in your life/ What really matters in your life?
• Have the same things always been important to you, or has it been different things at different times?
• Do you think you have achieved this?
• How have you gone about achieving this?
• What have you done in your life that meets this value?
• If participant struggles to discuss values or focuses on goals use ACT techniques for clarifying values:
  o Magic wand
  o Childhood dreams
  o Character strengths
  o Role models
  o Disapproval

What holds you back/ What has got in the way of you fulfilling (insert previously discussed value)?
• What impact has being in here (The Orchard Clinic), had on you fulfilling (insert value)?
• What impact has your offending had on you fulfilling (insert value)?
• What impact has your mental health had on you fulfilling (insert value)?
• How does that make you feel?
• How do you cope when you feel that way?

We’ve talked about what has happened in your life and where that fits with what you value most. How do you see your life moving forward?
• How does (insert value) relate to your goals for the future?
• How does doing what you value, fit with the way you see yourself or feel about yourself?

Ending:
• Is there something else I should know to understand (you/ your experience) better?
• Is there anything you would like to ask me?

General prompts throughout interview:
• Can you tell me more about that?
• Can you explain what you mean by that?
Appendix 10. Interview Transcript Example

Interviewer: It sounds like it can impact on you being able to engage with the things that are important to you.

P1: Yes and then you question how much you value that. Just like you can have eh, if you were to have a fight with one of your family members, like... a long time ago me and my brother had a bit of a fight I suppose you could say and it kind of lingered. You know you'd... you questioned how much you wanted that relationship if you are always arguing but thankfully it settled down and we're back to being on very good terms but I suppose what I'm trying to say is that eh. I think that values that anyone has can shift over time.

Interviewer: It certainly sounds like that from what you're saying. You've said how these values can move up and down in terms of the ranking of your values.

P1: Yeah

Interviewer: and is that true that as well as moving up and down in terms of ranking that those specific values have always been there but the extent to which they are there has changed?

P1: Yes, I think so

Interviewer: Or have some new ones emerged over time.

P1: I don't think new ones have. Actually, I would say that before I didn't have much bearing on my mental health. I didn't think about it much, well before the index offence. And the same with the physical health. I maybe didn't take great care of myself. I smoked cannabis and stuff like that, that obviously not good for either mental or physical health.

Interviewer: Ok

P1: I think they've been newer things to emerge.

Interviewer: So mental health and physical health, they've been ones that have emerged then more recently.

P1: Yeah
Interviewer: But then the others: family and friends; occupation; having fun; keeping busy...

P1: Yeah, they’ve been there. Just trying to think if there’s any other... *em*... say *em*... creativity

is quite important to me now. I do... At the state hospital I did a lot of painting. I really enjoyed that and I’ve done art therapy here and hoping to do some more art therapy. And *em*... I mean, *em*, that side of things have... also helps with your emotions and mental state as well. I would say I didn’t really have that in my life before. Being in a therapeutic setting I suppose.

Interviewer: So that’s is it that creativity has been something that’s new or is it just something that’s new in a therapeutic sense or something that’s been there previously...

P1: I would say it’s new in a therapeutic sense. Definitely. I’ve never had like art therapy before. And I mean I did do art in school to like standard grade but I wasn’t really doing much. Just doing it in the class and that would be it. Maybe did a few sketches and stuff but I mean I’d never done it to the extent that I’ve done it now; the *art work*... I would say it’s something that I value because of all that it gives me and with the finished product, I mean I can give art pieces to family and friends and that makes me feel good as well. And all that good stuff.

Interviewer: So having that finished product, being able to give it people that you care about is important to you.

P1: Yeah
Appendix 11. All at Sea: A metaphor of values of men in medium secure units:

Metaphors are frequently used within Acceptance and Commitment Therapy (ACT) to explain values, goals and other concepts to patients; and as tools for cognitive defusion (Hayes et al., 1999; Foody et al., 2014). The model proposed in this paper has the potential to inform and develop existing and new metaphors for values-based work, as part of an ACT based approach.

A preliminary metaphor was developed from the model that emerged from the data of this study. As previously discussed, The Compass Metaphor (Hayes et al., 1999) is a way of communicating values and goals to clients and relating this to navigating with a compass. Further metaphors such as the “Demons on the Boat” (Harris, 2007) and “Passengers on the Bus” (Hayes et al., 1999) are also used to communicate values and other aspects of the ACT Hexaflex to patients. In line with this theme of journeys and navigation, this paper proposes a related metaphor called “All at Sea”. This takes into account individual’s relationships with values, and is informed by the model proposed of values in men in medium secure units that emerged from the data. This new metaphor aims to capture the participants’ values but also the relationship with these across the lifespan; the impact of barriers, restrictions and opportunities; and the impact this has on the understanding of the self and how they fit in. Below is an explanation of this metaphor written as if spoken to a patient, in line with the compass metaphor detailed previously:

All at Sea: A metaphor of values of men in medium secure units:

“Imagine you are on a boat at sea. On board the ship are a number of crew members. Many of these crew members boarded at the dock when the ship was preparing to set sail. The crew members available were dependent on the environment that the boat was built and docked. Furthermore, the crew members that joined the boat were selected, trained and influenced by those in authority of
the boat: be it the captain or shipping company. Imagine that the boat is the self and each crew member is a different value, representing something important to you. Each crew member therefore, represents a value and influences the direction in which the boat is steered and the direction it is going in.

Throughout the journey, there may be several barriers, restrictions and opportunities that the boat (the self) may face. Stormy seas may knock the ship off course and in these more difficult sailing conditions, some crew members may be better able to weather the storm than others, resulting in them taking more control over the ship and the direction that it is heading. At times there may be conflict between the crew members with them placing conflicting demands to steer the ship in their desired direction. Unfortunately, this is likely to mean that the boat may shift between directions, go off course or become lost at sea under these conflicting demands. Some seas may be calm and others dangerous. Furthermore, the boat may be vulnerable to the influence of others that they meet on their journey. Other boats may try and influence the direction that the boat is headed, perhaps assisting the crew members chart a better and more successful journey in their chosen direction. They may be able to offer a map, help maintain and upgrade the boat’s engine or get on board and help steer the ship. Just as stormy seas can knock the boat off course, other boats could attack or seek to take over the boat for their own purposes.

Moreover, there may be times where the ship may be steered into waters that are subject to strict regulations and prescribed shipping lanes, with severe penalties placed for deviations from these routes. At these times it may feel like the boat is being directed, guided or forced to follow a direction that is in line with and important to the waters and place that they are in but does not fit wholly with the crew members. At these times, the crew may have little control over the direction of the boat, having to be steered by external forces, perhaps escorted by other government boats in these areas. For some, they may try to deviate from these
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regulated and restricted shipping lines but this is likely to result in increased control and restrictions being placed on the boat. Perhaps presenting them with a limited choice of directions they can travel in or preventing them from sailing to specific destinations.

For some, who may have faced hostile and restrictive waters throughout their lives, the boat has had little freedom to safely explore the sea and to allow the crew members to take the lead and to develop a balance between the roles of the crew that take the ship in a direction that is true to the boat and the crew as a whole. Sailing in such a boat, may result in the boat drifting, perhaps with little purpose or direction, making it further vulnerable to the influence of the environment and a chaotic and disorganised crew. Being in this manner, all at sea, it is likely that the boat will not have a stable sense of what makes the boat itself and despite entering and sailing in different seas, oceans, docking at different ports, and meeting others on their journey, it may be hard to feel at home or able to fit in and maintain itself in any one situation or location.”
Appendix 12. Qualitative Health Research (journal)

Relevant information is included here, from the outline guides for authors: https://uk.sagepub.com/en-gb/eur/journal/qualitative-health-research#submission-guidelines; https://mc.manuscriptcentral.com/societyimages/qhr/QHR%20Author%20Submission%20Guidelines.pdf

Qualitative Health Research (QHR) is an international, interdisciplinary, refereed journal for the enhancement of health care and furthering the development and understanding of qualitative research methods in health care settings. We welcome manuscripts in the following areas: the description and analysis of the illness experience, health and health-seeking behaviors, the experiences of caregivers, the sociocultural organization of health care, health care policy, and related topics. We also consider critical reviews; articles addressing qualitative methods; and commentaries on conceptual, theoretical, methodological, and ethical issues pertaining to qualitative inquiry.

Article Format (see previously published articles in QHR for style):

- Title page: Title should be succinct; list all authors and their affiliation; keywords. Please upload the title page separately from the main document.
- Blinding: Do not include any author identifying information in your manuscript, including author’s own citations. Do not include acknowledgements until your article is accepted and unblinded.
- Abstract: Unstructured, 150 words. This should be the first page of the main manuscript, and it should be on its own page.
- Length: QHR does not have a word or page count limit. Manuscripts should be as tight as possible, preferably less than 30 pages including references. Longer manuscripts, if exceptional, will be considered.
- Methods: QHR readership is sophisticated; excessive details not required.
- Ethics: Include a statement of IRB approval and participant consent. Present demographics as a group, not listed as individuals. Do not link quotations to particular individuals unless essential (as in case studies) as this threatens anonymity.
- Results: Rich and descriptive; theoretical; linked to practice if possible.
- Discussion: Link your findings with research and theory in literature, including other geographical areas and quantitative research.
- References: APA format. Use pertinent references only. References should be on a separate page.

Additional Editor’s Preferences:

- Please do not refer to your manuscript as a “paper;” you are submitting an “article.”
- The word “data” is plural.
Journal layout
In general, QHR adheres to the guidelines contained in the Publication Manual of the American Psychological Association [“APA”], 6th edition (ISBN 10:1-4338-0561-8, softcover; ISBN 10:1-4338-0559-6, hardcover; 10:1-4338-0562, spiral bound), with regard to manuscript preparation and formatting. These guidelines are referred to as the APA Publication Manual, or just APA. Additional help may be found online at http://www.apa.org/, or search the Internet for “APA format.” 4.6 Reference style QHR adheres to the APA reference style. Click here to review the guidelines on APA to ensure your manuscript conforms to this reference style.
Full Reference List:


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