

Exploring the experience of community adjustment following discharge from a low secure
forensic unit

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Abstract

Low secure forensic services have been identified as a common interface between inpatient care and care in the community. However, to date, no research has specifically explored the lived experience of discharge from such units. The present study aimed to address this by using Interpretative Phenomenological Analysis (IPA) to explore experience and sense making around community adjustment up to a year after discharge from two low secure forensic units in West Yorkshire. Theories of change, transition and identity, which were identified as potentially relevant to understanding the adjustment experience were incorporated into a semi-structured interview schedule, which was used to interview six people about their experiences. Three key findings emerged from the study. First, adjustment was characterised by both change and continuity. While to some extent participants were able to disengage from an inpatient role granted on the units, which was characterised by a loss of autonomy and identity, in other ways they remained changed by their experiences and struggled to move on towards a preferred identity or towards valued life goals following discharge. Secondly, ambivalence existed between participants seeing adjustment as a personal journey whilst simultaneously feeling internal and external pressure to strive for 'normalcy.' Finally, in addition to presenting an adjustment challenge, discharge for many represented the first opportunity to work towards recovery, heightening the magnitude of the discharge experience. These findings have been discussed in relation to pertinent theories of identity and change. On the basis of the findings, recommendations have been made, including maximising retention of autonomy and valued aspects of service users' identities during inpatient care and ensuring service users are at the centre of discharge planning to facilitate the adjustment process. In the context of these findings, further directions for clinical practice are discussed.

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Personal Statement

My initial motivation for exploring this research area stems from my first Assistant Psychologist post where I worked in a low secure unit (not forensic) in London. Part of my role was facilitating groups with the aim of preparing service users for discharge. Common group topics were around rehabilitation and community reintegration. These groups were generally constructed around mine and my fellow professionals' ideas of successful rehabilitation and community reintegration rather than asking individual service users what reintegration meant to them or indeed what their own priorities were. These same notions of rehabilitation and reintegration surfaced in the three monthly care plan reviews where we often spoke of planning for the future and putting strategies in place around for example budgeting, involvement in social circles and seeking vocational opportunities, all with the ultimate aim of preparing people to 'move on' from the unit.

All of these plans and discussions took place in the context of an inpatient stay which, for many, had exceeded four years with minimal community leave. I particularly recall working with one young man who had barely left the unit grounds since his admission four years previous. I found that many of them understandably felt hopeless about ever being discharged and, for some, when they eventually faced with discharge they became highly anxious about re-entering the community. In some circumstances this led to 'sabotaging' discharge (a term we somewhat insensitively used to make sense of very natural concerns.)

When considering this paradox between focusing on rehabilitation and community re-entry while essentially deskilling people to manage outside the unit, I became increasingly frustrated and saddened by it. When I examined the research literature to try and identify whether this was a more generic experience of secure care and what the literature was on community adjustment in this field, I noticed how little research attention this area had been given. Later I met with another clinician who was interested in community adjustment specifically in low secure forensic settings so together we took our ideas forward and the final idea of exploring the experiences of community adjustment following discharge from a low secure forensic unit emerged. I am hopeful that this research will help to shed the first insights into the lived experiences of those who are faced with it allowing their own stories to be privileged. In turn I hope that it will provide some insight into how best to support people from the earliest stages of a low secure admission right through to the transitional phase of 'moving on' in order to maximise people's chances of enjoying a positive and valued quality of life in the community.

Introduction

Introduction to the Chapter

This study aimed to explore the experience of community adjustment following discharge from a low secure forensic unit. First I give a background to the focus on community care before discussing forensic mental health services in both inpatient and community settings in the context of relevant psychological theory. I then review existing literature into community adjustment in mental health. At the end of the chapter I state the specific research aims in more detail and introduce the research methodology.

Care in the community

In recent years, several organisational and societal shifts have resulted in a shake-up of mental health services and in particular the shift away from inpatient care to care in the community. One of the catalysts for change can be traced back to the Reed report, which was concerned with improving the care of offenders with mental health difficulties (Department of Health and Home Office, 1992). The report outlined that people with mental health difficulties who have committed offences need support and care rather than imprisonment. 276 recommendations were made in the report (Chiswick, 1992) with the key message of supporting people in the least restrictive environment possible, preferably in a community setting and with the ultimate goal of rehabilitation to the stage of being able to live independently (Chiswick, 1992).

A number of other reviews have documented past and more recent driving forces behind the focus on community care (e.g. Prior, 1991). These include pharmacological advances (the development of neuroleptic medication for psychosis) and financial concerns. Financial concerns exist because community care is presented as a more cost-effective alternative to inpatient care. Statistics from 2009/2010 showed that in-patient care in secure settings (defined below) alone cost £1.2 billion, which constituted 18.9% of spending in adult mental health (Department of Health, hereafter DoH, 2010). By contrast, dedicated community services are estimated at approximately a third of this cost (DoH, 2010).

While financial and pharmacological factors are clearly instrumental, arguably the central driver towards community care is the shift in knowledge and understanding of mental health. Whereas historically, people with mental health problems were defined by their difficulties and often seen as untreatable, mental health difficulties are no longer seen as completely disabling and the focus has instead shifted towards 'recovery' (Anthony, 1993) and to maximising people's chances to sustain a valued quality of life (Lester & Gask, 2006).

Consequently, in the last 10 years care has become increasingly centred on supporting service users to live an independent and fulfilling life in the community (DoH, 2000).

Recent amendments to the Mental Health Act (DoH, 2007) in particular the introduction of the community treatment order (CTO) have also facilitated the community care movement. The CTO is a legal provision under which service users sectioned under the Mental Health Act receive mandatory treatment in the community (DoH, 2007). In the event of noncompliance with treatment, deteriorating mental health and/or increased risk, they can be recalled to inpatient units (Snow & Austin, 2009; Burns & Dawson, 2009). Literature has suggested that the introduction of the CTO has increased the number of service users being treated in the community and reduced readmissions (Lawton-Smith, Dawson, & Burns, 2008).

Within the prison service, mental health in-reach teams and specialist healthcare units are now well established and closer links with general and forensic psychiatry now exist. Furthermore, developments such as Multi-Agency Public Protection arrangements (MAPPA, Criminal Justice and Court Services Act 2000; Criminal Justice Act, 2003) a multi-agency approach focusing on managing people with high risk profiles in the community have made it increasingly possible to move people out of inpatient settings into the community. Such organisational changes, alongside a gradual shift in public perceptions of mental health have largely contributed to an expansion of community care for mental health service users, particularly those with offending histories (Mohan & Fahy, 2006). Consequently, mental health inpatient facilities are now structured with a key aim of supporting service users to return to the community.

Summary of section

In this section I have highlighted the on-going focus within mental health of supporting service users to maintain a desired quality of life in the community, emphasising the need for research focusing on community adjustment. In the next section I introduce and describe forensic mental health services.

Forensic Mental Health Services

Forensic mental health services aim to provide appropriate treatment and care in a safe and secure environment for people experiencing mental health problems or psychological distress. Most have been in contact with the criminal justice system and are deemed too high risk to themselves and/or others to be supported in open wards or in a community setting

(Rutherford & Duggan, 2007; Beer, 2008). In addition to inpatient care, forensic services also offer specialist community and transitional support for service users with forensic histories.

Forensic services are structured by levels of security: high, medium and low. High secure services are set up for people who *'pose a grave and immediate danger to the public'* (Rutherford & Duggan, 2007, p.6). Medium secure services accommodate those posing a *'serious danger to the public'* (Rutherford & Duggan, 2007, p.6). Finally, there are also low secure services. In contrast to high and medium secure services which only treat people sectioned under the Mental Health Act, low secure services also accept informal admissions (people who are not sectioned). The admission criteria for low secure services are that people *'pose a significant risk to themselves and/ or others,'* (Rutherford & Duggan, 2007, p.6). Decisions about the level of security required are centred on providing the most appropriate care in the least restrictive environment (DoH, 2002; Pereira, Dawson, & Sarsam, 2006).

Recently it has been estimated that up to 3.5¹ thousand people are resident in low secure units in the UK (Centre for Mental Health, 2011). Despite this sizable number, research into low secure care has been extremely limited until recently. One possible reason for this is that definitions of low secure care have in the past been blurred with services often providing an overflow for oversubscribed medium secure wards (Beer, Pereira, & Paton, 1997). However, following the publication of national service framework guidelines recognising the importance of low secure care as its own distinct service specific guidelines have been issued for them (DoH, 1999; 2002). Since these publications, low secure services have started to receive more recognition in the research literature (Beer, 2008; Dix, 2005).

About Low Secure Services

Low secure care is divisible into two services: Psychiatric Intensive Care Units (PICUs) and Low Secure Units (LSUs). PICUs provide intensive, multidisciplinary treatment during an acute phase of illness to people posing a high level of risk to themselves or to others. Detention in a PICU is recommended for a maximum of 8 weeks (DoH, 2002). Conversely, LSUs provide longer-term care with a focus on rehabilitation for service users who are often chronically unwell. Support provided by LSUs is recommended for a maximum of 2 years (Beer, 2008; DoH, 2002).

¹ Figures are approximate because data is regional and is not standardised across the country

LSUs mainly provide care to those stepped down from higher secure settings although admissions are also accepted via the community. Others are transferred to LSUs from prison or court if they are assessed as being too mentally unwell or otherwise inappropriate for detention in prison (Rutherford & Duggan, 2007). While many have had contact with the criminal justice system, others without a forensic background may be admitted to an LSU because they display challenging behaviours in the context of their mental distress and are thereby judged as needing a secure environment to manage risk.

Given that LSUs have the lowest provision of security, they often form the interface between inpatient care and the community (Pereira & Dalton, 2006; Laidlaw, 2008; Davies, Maggs, & Lewis, 2010) and therefore have a vital role in terms of promoting social inclusion, integration and independence (Page, 2011) to maximise the chance of a successful community placement. However, given that the average (mean) stay in an LSU is 354 days (Pereira et al. 2006) and that the majority of service users have been stepped down from more secure environments (in a recent study of 200 service users in LSUs over 50% of them had previously been accommodated in another inpatient setting, Beer et al. 2005) it is likely that many will have experienced prolonged hospitalisation.

The impact of prolonged hospitalisation has been documented by the seminal work of Goffman (1961) who outlined the process by which service users become institutionalised over the course of a lengthy inpatient admission. Institutionalisation was said to occur because on admission to inpatient facilities, service users are dispossessed of their roles in the community and are instead through a period of acculturation socialised into an inpatient role characterised by a loss of autonomy (which has been defined as a loss of both agency and liberty, Beauchamp & Childress, 1994) and individuality where they become increasingly separated from their previous life. Researchers (e.g. Gilmartin, 1997) have understood this using social role theory (Sarbin and Allen, 1968; Sarbin & Scheibe, 1983). Social role theory posits that identity is constructed according to the roles people take in society and that one's self-concept is influenced by the valuations they make of these roles. Three dimensions are deemed pertinent to identity in relation to social roles; status (whether someone worked to attain a specific desired role or whether an role was granted for example a service user on admission to an LSU), involvement in matters relating to the role (simply how involved someone is in a role they undertake), and valuation (whether one has been demoted from a valued role or has attained a socially undesirable role), Gilmartin (1997). The studies of Goffman (1961) suggest that admission to an inpatient facility results in being granted the socially devalued inpatient role, being expected to become fully immersed in this role (because

they generally have no choice in the matter) and being demoted from valued social roles in the community. Moreover, it has been suggested that a lengthy inpatient admission can make it increasingly difficult to disengage from the inpatient role in order to regain valued social roles (and consequently one's preferred identity) following discharge (Gilmartin, 1997), a process known as disculturation (Goffman, 1961). Given the lengthy admissions to LSUs and higher levels of security highlighted above, it is possible that a similar process occurs for people admitted to LSU whereby they are assigned inpatient identity and, after many years of having to behave in accordance with this role may struggle to disengage from it on discharge (Wakefield, McGrath, & Holliday, 2005). However, while potential transitional difficulties have been highlighted, no research has actually explored the experience of the transition from low secure care to the community and the subsequent experiences of service users as they try and adjust to the transition.

Experiences of low secure care

Studies of service users' experiences during low secure care have lent support to the idea that admission to an LSU is associated with acculturation to the inpatient identity. For example, one mixed methods study conducted in an LSU found that many service users described how they were forced to become dependent on staff, representing a loss of agency (Baker, 2003). Similarly, a recent qualitative study exploring experiences and sense making in an LSU in West Yorkshire found group themes around powerlessness (people feeling like passive recipients of care), finding time on the units meaningless and feeling that their lives had been interrupted (Wilkinson, 2008). This suggests that in addition to being granted an inpatient role, the feeling of being cut off from life in the community also implies a loss of identity as a result of the granted inpatient role.

These experiences resonate with the writings of Goffman (1961) around institutionalisation, implying that theories of identity, specifically social role theory may be pertinent in making sense of community adjustment following discharge from an LSU.

Identity and the self

In the previous paragraphs, I discussed the potential impact of prolonged hospitalisation on one's identity. Given that identity is a largely misunderstood concept, being one that is often confused with that of the self and the self-concept (Owens, 2006) it is important to deconstruct identity and to situate it in relation to these other concepts before progressing.

Distinctions between identity and the self have been the source of much historical and current debate (Owens, 2006). However, identity and self-concept can be understood as two concepts that are subsumed under 'the self,' which has been broadly defined as '*a process and organisation born of self-reflection,*' (Owens, 2006, p.206).

While a number of theoretical frameworks of the self exist, from a phenomenological perspective the self is understood as developing from one's subjective experiences in the world via their interactions and relationships with people and objects they encounter (Stevens, 1996). Subsumed under this is the concept of identity, which, rather than a 'process' is defined as a '*tool by which individuals or groups categorise themselves*' (Owens, 2006, p.206) as a means of making sense of themselves within the world. Identities are constructed in numerous ways, including the roles they take (as in social role theory, outlined above) and according to the groups they affiliate with (as in social identity theory, discussed below).

Finally, the notion of the self-concept (used interchangeably throughout my thesis with 'sense of self') is defined as '*how we envisage or perceive our self*' (Owens, 2006, p.208) implying an evaluative aspect to the self-concept. The way in which we construct our sense of self is in turn strongly influenced by our identities; for example, if we value our identities this is in turn associated with a more positive self-concept (Jackson, Tudway, Giles, & Smith, 2009). For the purpose of my study, I have chosen to focus on concepts of identity and self-concept as opposed to the global process of the self as these are more tangible concepts able to be captured through an investigation of experience than the more abstract notion of the self. However, by presenting this discussion I hope that this will aid the reader in situating any discussion of identity and service user's self-concepts within the broader notion of self.

In the next session I now discuss experiences and the structure of support following discharge from an LSU.

Life after discharge from low secure care

Service users are discharged from LSUs to a range of residences. Decisions about housing are based on factors including risk, presenting difficulties and ability to manage both practically and emotionally the challenges of independent living (Macpherson, Shepherd, & Edwards, 2004). Some are discharged to supported living, an overarching term for residential services providing varying levels of staffing and support. While some are highly staffed, others with much smaller staff: service user ratios are more geared towards independent living (Macpherson et al. 2004). Supported accommodation 'bridges' the highly staffed secure

environment and the complete independence of private accommodation. While most are discharged to some form of supported accommodation, some are discharged to private residential accommodation, either their pre-existing address or a new residence.

There is little documented information concerning patterns of residence following discharge from an LSU. However, an idea about such transitions can be extrapolated from medium secure units. A recent review of patterns of discharge from medium secure units in South London revealed that 35% of 157 males were discharged to supported housing while less than 10% were discharged to their own homes (Brown & Fahy, 2009). The remainder of the sample were discharged either to higher or lower levels of security or to other, open psychiatric wards. It is likely that when discharged from LSUs, the proportions discharged to supported housing or independent residences may be even higher as LSUs are usually the lowest form of security from which people are discharged into community settings (Pereira & Dalton, 2006; Laidlaw, 2008; Davies, Maggs, & Lewis, 2010).

In another review of patterns of residence from a medium secure service, 71% of people moved to a different residence on discharge than they had lived prior to admission (Jones, 2009). This is pertinent to the adjustment experience given that service users will be contending with multiple changes when they first leave an LSU, and returning to an unfamiliar environment presents another change.

It has been highlighted above that the paths taken by people discharged from LSUs in terms of accommodation are varied. Similarly, there is no uniform pathway of care post discharge. Support varies between mainstream community mental health services (such as Community Mental Health Teams or Assertive Outreach Teams), forensic outreach services from the LSU base or dedicated Community Forensic Teams (Centre for Mental Health, 2011; Turner & Salter, 2005). Community Forensic Teams comprise professionals (such as Community Psychiatric Nurses, Social Workers and Support Workers) specially trained to support people with complex risk profiles and forensic histories. There is a current lack of consensus as to the relative advantages of specialist Community Forensic services over generic mental health provision (Turner & Salter, 2011; Mohan & Fahy, 2006.) However, despite the lack of demonstrated efficacy, it has been argued that specialist forensic services are vital in delivering a targeted service to forensic service users who present with a very unique profile and cannot be safely managed within generic services (Mohan & Fahy, 2006; Ozdural, 2006).

Concerns about low secure care

The three previous sections ‘about low secure care,’ ‘experiences of secure care’ and ‘life after discharge from low secure care’ have identified possible difficulties for service users on adjusting to changes following discharge. For example, it has been highlighted that admissions can be lengthy, particularly if time in other more secure settings is also factored in. It has also been highlighted that time in LSUs can result in the assignment of the inpatient role associated with compromised autonomy and a disconnection from one’s previous identity (Baker, 2003; Wilkinson, 2008.) These experiences could present challenges with post discharge adjustment in terms of being able to disengage from the inpatient role to reconnect with valued roles and life in the community. It is also likely that there will be further challenges post discharge as service users will have to adapt to new residences, either supported living, which involves adjusting to new people and procedures or independent living, which involves adapting to living alone again. These residences may also be in new geographical locations presenting a further adjustment challenge (Jones, 2009). When the issues of disculturation from the inpatient role and adaptation to change and novel situations are considered together, it seems that moving from such an environment back to a community setting involves a number of changes, which may present adjustment difficulties. When this is considered in the context of the current focus on community care in mental health (outlined above) this presents a potential dilemma, highlighting one of the key drivers behind this research.

In addition to the focus on identity and social roles, the present discussion has also highlighted how discharge from an LSU may present a number of changes and transitional challenges. In the next section, dominant theoretical frameworks concerning change and transition are therefore outlined.

Change and transition

A transition is defined as a process by which change occurs although generally, transitions are associated with major life changes as opposed to minor adjustments (Williams, 1999). It can be argued however that any event represents a transition if it is associated with change and adaptation. One dominant psychological model, which specifically maps the normative transitional process, is described below.

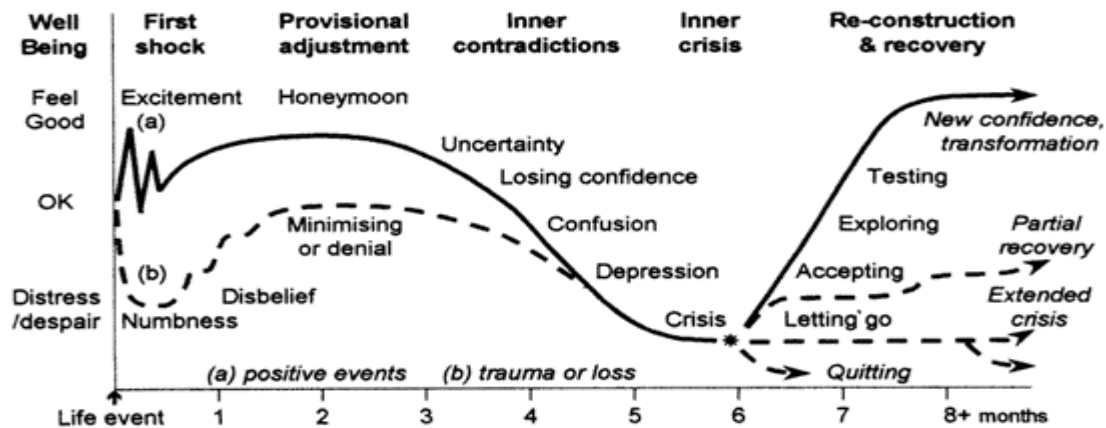
The transition cycle

Adams, Hayes and Hopson (1976) developed a transitional model termed the transition cycle (see Fig 1). They identified two main types of transition, transition associated with positive and negative events (see continuous and broken lines respectively). The model assumes that the

experience of transitions follows a predictable pattern beginning with initial shock and ending in reconstruction and recovery. Focusing on positive events, the initial shock occurs immediately after a life event followed by a 'honeymoon period' of prolonged excitement and positivity, which is generally accompanied by some unrealistic hopes and expectations. Following this the model states that people enter a phase of uncertainty and doubt, whereby wellbeing gradually deteriorates, resulting in crisis. Thereafter, it suggests that people gradually enter a phase of acceptance of a more realistic situation, which is associated with improved wellbeing. In the event that a new phase of acceptance and realism is not achieved, an individual may remain in prolonged crisis associated with either quitting or despair.

Given the above discussion about discharge presenting a potentially major transition, it is possible that this model may be of relevance to understanding the adjustment process following discharge from an LSU. However, several limitations of the model first warrant consideration. As with any stage model, the transition cycle posits that people experience transition in the same way, with each person having to proceed through each part of the process before being able to reach 'acceptance' and 'new confidence' (see Fig.1.) However, it has been criticised for failing to appreciate the personal nature of transition (Dixon & Hayden, 2008) and it has been argued that, for example, not everyone who undergoes a transition reaches a crisis stage. Furthermore, it has also been argued that different coping skills and resources available to an individual will impact on the time spent in different stages of the cycle and in how close to a 'crisis' people undergoing transitions get to (Roncaglia, 2010). It is also notable that while this model maps a possible process of adapting to change, it does not explain how change comes about for example how some people result in enhanced wellbeing while others end up in prolonged crisis. The following section addresses this limitation by presenting two dominant theoretical frameworks of change (Bowles, 2006).

Figure 1 The transition cycle (taken from Williams, 1999)



Self-efficacy

Self-efficacy (Bandura, 1977) is *'the belief in one's capabilities to organise and execute the courses of action required to manage prospective situations,'* (Bandura, 1995, p.2). According to the theory one's perceived self-efficacy will influence their approach or avoidance of a situation. For example, in the event of high self-efficacy one is more likely to approach a novel situation and try to cope with it whereas someone low in self-efficacy is more likely to avoid it. One's perceived self-efficacy will also influence the extent to which they try and cope with or persevere with a novel situation once they approach it and the amount of effort they dedicate (Bandura, 1977).

Factors said to influence self-efficacy include having mastered previous situations, observing other people master similar situations and receiving praise and encouragement (Bandura, 1994). Psychological responses can also influence self-efficacy; for example feeling particularly anxious in public situations can reduce one's sense of self efficacy in these environments. However, by learning to manage psychological responses differently this can improve self-efficacy, demonstrating that it is a fluid as opposed to a fixed concept (Bandura, 1994.)

Self-efficacy is likely to be pertinent to discharge from an LSU because as identified above, service users admitted to LSUs have reported feeling separated from their life in the community and experiencing a loss of autonomy on the units, which may compromise their self-efficacy in turn affecting their approach of certain situations in the community that they may not have been faced with or had to deal with independently for a long time. In line with the theory, reduced self-efficacy may also compromise overall wellbeing (see Schmutte et al. 2009 for details on the relationship between self-efficacy and wellbeing) and may therefore bear relevance to the success of the community placement.

The Theory of planned behaviour

The theory of planned behaviour (Ajzen, 1985; 1991) is concerned with how change comes about by focusing on how people form intentions that result in actions. It is based on the premise that behaviour can be predicted by intentions (motivation) and perceived behavioural control (how confident a person feels about their ability to perform a behaviour). The theory posits that two people with equal intention are likely to differ in their perseverance towards a desired behaviour according to the extent of their perceived behavioural control over the behaviour (how confident they feel that they will eventually be able to succeed). It is notable that the concept of perceived behavioural control shares many commonalities with that of self-efficacy and the two concepts have been deemed broadly compatible (Ajzen 1991).

The theory of planned behaviour also identifies three conditions that affect people's intentions towards performing a behaviour. These are 'perceived behavioural control' (discussed above), subjective norms (the perceived social pressure someone feels) and attitudes towards the behaviour (the degree to which someone already holds a favourable attitude to the behaviour, Ajzen, 1991). The degree to which each of these conditions are met is classed as determinate of the level of intention someone will have to perform an action and the likelihood therefore of an action being initiated. However, it also suggests that if any one of these conditions is sufficiently weighted, it can be sufficient to prompt intention and subsequent action even in the event that the other conditions have limited support (Ajzen, 1991). The theory of planned behaviour has received empirical support from a variety of sources (see Ajzen, 1991 for a review). However, it has also been criticised for assuming a direct link between intention and behaviour, as opponents of the model have argued that in many situations, irrespective of how strong an intention is, it may still not result in a behaviour being effected (Brandstatter, Lengfelder, & Gollwitzer, 2001).

The theory of planned behaviour is also relevant to the current discussion because as outlined above the discharge experience is likely to present a number of novel experiences that service users will have to navigate. The theory may help to understand service users' approach or avoidance of these novel situations as well as the relative effort dedicated to different tasks during the transitional process.

Summary of the section

In this section, three theoretical frameworks of change and transition have been presented, which along with theories of identity, namely social role theory (outlined above) may be

applicable in understanding experiences on discharge from low secure care to community given the significant transition this is likely to present. However, the lack of research attention in the field of low secure care (as identified above) makes it difficult at this stage to identify the extent of their applicability. Given the focus of the current research on exploring community adjustment, in the following section, existing literature relating to community adjustment is discussed.

Literature Review

Introduction to the section

For this literature review, I used the following search engines: Psychinfo, Google Scholar, and Pubmed. Initial search terms inputted to Psychinfo were: Low secure, discharge, and community, which produced only three hits, highlighting the relative lack of research into LSUs. More general terms were then inputted including combinations of the following: Discharge, community, reintegration, mental health, forensic, and psychiatric. Using more broad terms than those related purely to forensic services produced significantly more hits; for example, a combination of 'forensic', 'discharge' and 'community' produced 63 hits (Psychinfo, June 2011).

From conducting the literature review it emerged that the small amount of literature into forensic psychiatric services generally and LSUs in particular has largely focused on admissions, neglecting the potentially rich data on discharge and its impact (Maden, Rutter, McClintock, Friendship, & Gunn, 1999). Furthermore, the majority of literature that does examine transitions post discharge stems from general mental health (non-forensic) services, with much of the data emerging from the post-asylum era. The majority of the studies were also conducted outside the UK, which may limit the generalisability of the findings to low secure care in the UK. The majority of this literature measured adjustment using either structured quantitative quality of life measures (e.g. Prince & Prince, 2002; Pinkney, Gerber, & Lafave, 1991) or models of integration (Gerber, Prince, Duffy, McDougall, Cooper, & Dowler, 2003; Townley, Kloos, & Wright, 2009). Both quality of life and integration research are discussed in turn.

Quality of life research

Much of the research on community adjustment in mental health has focused on quality of life variables. While a number of definitions of quality of life abound, it is understood as broadly compatible with the concept of wellbeing (Lehman, 1983). In a large scale review of both

objective (quality of life measured against standard indicators such as employment and social status) and subjective (personal sense of wellbeing) quality of life of service users discharged from general mental health facilities, negative experiences were reported for various quality of life variables (Prince & Prince, 2001). Quality of life measures used included the Satisfaction with Life Scale (Deiner, Emmons, Larsen, & Griffin, 1985) and the Quality of Life Interview (Lehman, Ward, & Linn, 1982). Areas of discontent included dissatisfaction with financial situation, personal safety and in social and familial relationships (Prince & Prince, 2001), implying both interpersonal and practical difficulties. Similar results were reported in another quality of life study following service users through the transition from an inpatient rehabilitation programme to the community (Pinkney et al. 1991). Using the Uniform Client Data Instrument to measure quality of life, service users and informants (usually close relatives) on average reported their main difficulties as finding employment and relating socially to others (e.g. difficulty making conversation and mixing socially with people outside their homes). These results suggest that even following the completion of structured rehabilitation programmes, service users continued to experience both interpersonal (social) and practical (employment) difficulties, highlighting the extent of potential adjustment difficulties following a prolonged inpatient stay. This supports the work of Goffman (1961) who identified how after a lengthy admission it can be extremely difficult to separate from the inpatient role in order to move forwards post discharge.

Similar interpersonal difficulties were reported by another quality of life study conducted in Ireland, which followed the progress of long-stay mental health inpatients up to 5 years after discharge into the community (McInerney, Finnerty, Avalos, & Walsh, 2009). On a number of social and interpersonal measures (e.g. social relations, community skills and interest in activities) significant deterioration was reported across the five year study period. This suggests that interpersonal difficulties may be quite pervasive and stable for service users who have experienced prolonged hospitalisation, rather than being a transient experience. However, it is worth noting that no structured rehabilitation programmes were completed while in hospital or upon returning to the community, which may have contributed to the disappointing outcomes reported.

By contrast, another quality of life study following service users through the transition from a rehabilitation programme in hospital to the community revealed more positive results, particularly in terms of interpersonal outcomes, suggesting that there is scope to move forwards and disengage from the inpatient experience. Long-term hospitalised patients (average hospitalisation duration of 23 years) in Wales were discharged to various community

settings (including supported housing, care homes or independent houses) and followed up to a year post discharge (Barry & Crosby, 1996). Service users in the community reported higher subjective satisfaction on several quality of life measures (wellbeing, freedom, independence, and social communication) than in hospital, implying positive interpersonal experience. Notably, 72% described living in the community as 'better' than hospital, an evaluation which has been reflected elsewhere (MacGilp et al. 1991; Leff et al. 1994; 1996). However, the fact that care practices significantly improved over the course of the year, becoming more client focused and less restrictive may have positively influenced the results (Barry & Crosby, 1996).

The above studies are useful in informing possible themes that might apply to service users returning to the community after discharge from low secure care and in highlighting some of the complexities and inconsistencies in the adjustment experience. However, it is difficult to directly extrapolate from the above data given that LSUs are specifically geared towards providing rehabilitation for service users with forensic histories and complex risk profiles who often have a number of complex difficulties (Pereira et al. 2006; DoH, 2002). Consequently, such studies cannot be used to address the dearth of literature on discharge specifically from an LSU.

Integration research

Another common way of assessing service user's wellbeing in the community has been using measures of integration. Integration comprises 3 components: Physical integration (participation in activities of daily living in the community), social integration (social contact with neighbours and other community members) and psychological integration (sense of community and belonging, Aubry & Myner, 1999). Concerning physical and social integration, Kearns, Taylor, and Martin (1989) found that service users with chronic mental health problems residing in the community avoided most social events, only attending service-user led activities. In addition, Gerber et al. (2003) examined integration of forensic service users in Canada discharged to community outreach services. They found that many avoided activities with large groups of people and spent most of their time in their own homes, which reflects earlier findings by Nikkonen (1996) in which service users spent excessive amounts of time at home for fear of being stigmatised. Similarly, other researches examining social integration found that service users sought to associate with other service users rather than non-service user groups (e.g. Kearns et al. 1989). This also reflects the findings from the quality of life study by Pinkney et al. (1991) where service users avoided socialising outside their homes.

The above findings in terms of physical and social integration can be explained using two theories of social identity; labelling theory and social identity theory. Labelling theory (Goffman, 1963²) for example posits that people who are classified as deviant from dominant societal norms are assigned minority group status. This gives rise to stigma in that people are then judged on the basis of their 'virtual social identity' (stereotypical traits that minority or 'deviant' group members are expected to embody) as opposed to their actual social identity (Goffman, 1963). Labelling theory is pertinent in understanding the findings of Nikkonen (1996), Pinfold (2000), and Pinkney et al. (1991) as it provides an explanation for why service users avoided interacting with the majority group (wider society) or entering certain social spheres for fear of being subject to these stigmatising attitudes preferring instead to isolate themselves.

Social identity theory (Tajfel & Turner, 1986) can also explain aspects of these findings. In contrast to labelling theory which assumes that people are assigned minority group status by those in a relatively more powerful position (Owens, 2006), social identity theory posits that people actively choose to affiliate with groups and that group affiliation is central to one's self-concept. Furthermore, favourable comparisons of one's own group (the in-group) compared to other groups (relevant out-groups) is understood as protective of self-esteem (Ouwker & Ellemers, 2002). There is evidence from the integration literature described above that service users living in the community actively affiliate with the service user group for example, only attending activities organised by this group (Kearns et al. 1989). Consequently, it seems that both labelling and social identity theory may be of relevance in understanding social integration when considering adjustment following discharge from inpatient facilities.

Despite the reported issues with physical and social integration outlined above, in the study by Gerber et al. (2003) when asked for their own perspectives, service users described feeling psychologically integrated, describing a sense of belonging to the community and a satisfactory level of social adjustment and interaction with neighbours (Gerber et al. 2003). This contrasts with previous findings that service users with severe mental health difficulties struggle to experience psychological integration because they fear negative attitudes by the community (Prince & Prince, 2002). This highlights the individual nature of integration and how perceptions of integration vary significantly between people. Interestingly, despite such promising outcomes in the study by Gerber et al. (2003), the researchers concluded that

² Notably the origins of labelling theory are largely traceable to Becker (1963). However, while Becker assumed that the assignment of minority group status resulted in people reflecting the behaviours of that group, Goffman (1963) described a number of other possible reactions to the group status included deflecting stigmatising attitudes or actively fighting against the label.

service users were poorly integrated because many avoided immersing themselves in large groups. This issue underlines the disparity between service users perspectives and the norms adopted by clinicians and researchers as to what qualifies a 'successful' outcome as in this case, a sense of belonging described by service users was still deemed 'poor integration' by the researchers (see also Prince & Prince, 2002 for a discussion of the contrast between objective measures and subjective measures of wellbeing and quality of life). This emphasises the need to explore service user perspectives and experience as opposed to relying on researcher-defined outcomes in order to more fully understand personal experiences of community adjustment.

Qualitative research

In an attempt to distance research on community adjustment from researcher defined norms, a number of qualitative studies have sought to elicit service users own experiences of community adjustment. Several of these studies have focused on the impact of the inpatient experience itself on community adjustment. For example, Gilmartin (1997) explored the impact of psychiatric hospitalisation on the post discharge experience of two service users with the aim of examining how they had reconstructed their lives following their inpatient experiences (Gilmartin, 1997). One key finding was that participants forged a more positive identity through the attainment of more valued social roles for example in education and employment. This represented a divergence from the granted inpatient role, which was experienced as detrimental to their identity as it stripped them of valued roles held prior to admission. Gilmartin (1997) concluded from the study that this process of assimilating their experiences into their self-concept and of disengaging from the inpatient role to more valued social roles was beneficial for service users in re-establishing their identities and moving towards desired life goals. In turn this further emphasises the importance of social role theory in understanding community adjustment (see above).

A number of other qualitative studies have specifically examined the post discharge experience. Pinfold (2000) for example used qualitative methods to explore how service users re-housed in the community made use of the geographical space around them. Generally, it was found that many service users were socio-spatially isolated (having small activity spaces and small social networks); possibly reflecting the assignment of the minority group label outlined above (see above section concerning labelling theory). Interestingly, socio-spatial isolation was not always experienced negatively. Rather, for many service users the 'isolative' positions they adopted were functional for them. Furthermore, the results revealed that service users were not striving to 'integrate' according to practitioner-defined norms and

instead many took an active stance of positioning themselves between inclusion and exclusion and between independence and dependence. By these standards, service users would not be classed as 'integrated,' or indeed 'independent,' although service users actively chose this position (Pinfold, 2000).

In another qualitative analysis of community adjustment, Corin (1990) analysed the narratives of service users with a diagnosis of 'schizophrenia' discharged from psychiatric inpatient facilities into the community. Analysis of the narratives revealed that service users who were subsequently re-hospitalised tended to see themselves as forcibly excluded from society (which also seems to reflect their assigned social identity as a minority group as outlined above) whereas those who avoided rehospitalisation often adopted a more active stance of detachment from the external world. These findings raise similar themes to that of Pinfold (2000,) namely the concept that total inclusion is not the end goal of all service users; rather, the extent to which people define inclusion and seek to immerse themselves in communities is highly individual. Another interesting finding was that people who were not readmitted tended to view certain normative indicators of quality of life (for example securing a job that matched expectations) as less urgent or important. Interestingly, one such individual who viewed himself as successfully reintegrated was classed by practitioners as functioning poorly in society (Corin, 1990).

Similar discord between service users and practitioners was demonstrated in a recent study of supported housing services. The majority of service users found that their own goals contrasted highly with the goals the staff held for them (Fakhoury, Priebe, & Quraishi, 2005). This further highlights the importance of eliciting service users own perspectives about the transition from inpatient care to community rather than relying on social norms as to what people should be striving for. This is particularly important given the current socio-political climate where there is increasing emphasis on placing consumers at the centre of their care and ensuring that their own opinions and choices are respected (DoH, 2010a; 2011).

Finally, two studies conducted by Montgomery and Johnson (1998) and Johnson and Montgomery (1999) used a phenomenological qualitative method to explore the lived experience of service users with chronic mental health difficulties being discharged from inpatient care to community settings in Canada. In the first study, ten service users were interviewed pre and post discharge. A key theme emerged around discharge offering a new beginning, which was in turn associated with positive expectations; however, these were marred by concerns about coping in the community and an awareness of some on-going

difficulties that they felt could make the transition difficult (Montgomery & Johnson, 1998). A further theme emerged around the value placed on relationships and how for many, close relationships were seen as instrumental in managing the transition. However, positive relationships were not universally described and some spoke of on-going conflictual relationships and the fear of being discriminated against in the community.

In the next phase of the research Johnson and Montgomery (1999) followed up five service users discharged from inpatient care to a larger urban community setting in Canada. They found that living conditions were experienced as poor (examples included low paid employment and unsatisfactory living arrangements), aspirations and goals felt unattainable and many felt a sense of impermanence about their living situations believing they would be readmitted to the inpatient facility. As a consequence, many found it hard to fully embrace life in the community and make plans for their future (Johnson & Montgomery, 1999). These findings further highlight the potential involvement of self-efficacy in understanding adjustment as participants clearly showed reduced self-efficacy in relation to managing their community transition resulting in doubt about its success. Furthermore, social role theory is also pertinent here as the experiences described by participants reflected concerns about being able to successfully disengage from the inpatient role in order to reconnect with valued roles or move towards a preferred identity in the community. This further highlights the importance of theories of change and identity in understanding community adjustment.

Interestingly, the continued importance of the hospital in service user's lives was reflected in earlier studies of reintegration following prolonged hospitalisation. For example, Townley, Kloos, and Wright (2009) used a map drawing method with service users discharged from psychiatric services to identify their use of geographical space as a proxy measure of integration. This revealed that one of the most frequently visited and salient points on participants' maps was the psychiatric facility they were discharged from, reflecting the findings of Johnson and Montgomery (1999). Seemingly, for many the hospital continued to be central to structuring people's days even following discharge.

The themes in Johnson and Montgomery's (1999) paper yield interesting data about the complexity of community adjustment. In particular, the difficulty severing ties with the hospital highlights the complexity of functions served by the hospital environment and that the experience of leaving the hospital behind is far from a simple linear relationship between discharge and satisfaction and that there may instead be some continuation of the inpatient experience.

Summary of section

This section has highlighted a number of challenges adjusting to community living following an inpatient admission. Several possible theoretical reasons for this have been suggested. These include difficulties disengaging from the granted inpatient role implying continuation of the inpatient experience, undermined self-efficacy in relation to one's ability to remain in the community, the assignment of a stigmatised and devalued social identity resulting in avoidance of social situations and the active affiliation with service user groups restricting scope for inclusion in the wider community. Another key finding from the above research is that service users' own experiences and values concerning community adjustment often differ from what standardised measures of integration and adjustment infer, demonstrating the importance of research from the perspective of the service user. However, the above research has been carried out in non-forensic environments therefore the findings may not extrapolate directly to experiences of service users who have been discharged from secure environments. The next section therefore reviews existing literature on community adjustment specifically from secure facilities.

Discharge from secure services

As demonstrated above, multiple sources have documented the community adjustment of service users discharged from general inpatient facilities. However, very little data exists about such experiences following a period of residence in a secure unit; rather, research into secure services has instead focused on admissions data and experiences on the units (Alcock & White, 2009). The small amount of existing literature on discharge from forensic services has centred on risk, readmissions and reconvictions, therefore medium and high secure facilities have been at the centre of most of the literature, with LSUs receiving comparatively little attention.

A recent large scale outcome study examining community adjustment following discharge from a medium secure unit focused specifically on demographic measures such as mortality rates, reoffending and readmissions as proxy measures of adjustment. In this study, Davies, Clarke, Hollin, and Duggan (2007) found concerning evidence relating to the number of deaths post discharge. In the 20 year study period, 53 of the sample of 554 died post discharge, a mortality rate six times higher than expected. Furthermore, 37.6% subsequently spent time on one or more occasion in medium secure care and approximately half of those discharged were subsequently reconvicted at least once (Davies et al. 1997). Even higher readmission rates were observed in earlier studies of medium secure care; for example, Maden et al. (1999) reported a readmission rate of 74% and a number of other studies have found high rates of

reoffending behaviour and reconviction post discharge (e.g. Baxter, Rabe-Hesketh, & Parrott, 1999) suggesting that many service users continue to face multiple challenges post discharge.

More recently, similar outcome data have been collected for discharge from low secure services. Data were collected up to four years post discharge from an LSU (Akande, Beer, & Ratnajathy, 2007). Encouraging results were found for readmission and reconviction rates; none of the 33 people followed up were reconvicted and only five were readmitted during follow-up. Furthermore, all improvements made during admission on the global assessment scale and HONOS (Health of the Nation Outcome Scales³) were generally maintained at follow-up, demonstrating encouraging improvements in terms of levels of functioning as well as outcomes regarding criminality and risk (Akande et al. 2007). There were however a number of limitations to this study; no control group was included so it is difficult to compare outcomes with admissions from people not recently discharged from low secure care. Furthermore, the small sample size (compared to the approximately 3,500 people in low secure care at any one time, Centre for Mental Health, 2011) makes it difficult to draw any firm conclusions on the basis of the findings.

While the above research provides some statistical information about post discharge pathways, it lends little insight into the personal experiences of discharge from a secure environment (Wells, 1992). Furthermore, some of the limitations with existing research into discharge from secure environments precludes any firm conclusions from being drawn. This seems particularly problematic when considering LSUs where information about the experience of transitions and community adjustment is arguably crucial given the interface between LSUs and the community. Indeed, a number of practitioners have highlighted this transition as potentially difficult and numerous inpatient programmes promoting social inclusion and reintegration skills are prevalent across LSUs in the UK (e.g. Wakefield et al. 2002). However, these are largely based on normative concepts (objective and standardised notions) of 'social inclusion,' 'integration' and researcher/clinicians' perspectives on what constitutes successful adjustment. The drawback to this is that these perspectives may not match those held by service users themselves; rather, service users may hold quite contrasting goals and ambitions in terms of community adjustment.

The problem with being supported to achieve goals that are disparate from one's own could result in service users being unprepared for such a major personal transition. This contrasts

³ Nationally accredited scales for measuring health and social outcomes of people with mental health difficulties

with the current emphasis on community care and person-centred care (DoH, 2010a; 2011). By contrast, seeking to understand the nature of the experience for those actually experiencing it should be of benefit: a.) For service users in ensuring they receive support in the areas they struggle with, b.) To help guide forensic mental health practitioners provide appropriate interventions around community adjustment and c.) For commissioners and the tax payer by minimising hospital readmissions and so called 'revolving door' clients, thereby cutting financial costs.

Rationale

Aims and Objectives

This project aimed to address the identified gap in the research literature by exploring the experiences and meaning making of service users recently discharged from one of two LSUs in West Yorkshire, England. This study will hopefully provide the first insights into personal accounts of community adjustment following discharge from an LSU. While as outlined throughout this introduction there are several possible theories (of change, transition and identity) that are likely to be applicable in understanding community adjustment, the fact that it is the first research of its kind means that I have kept my research questions deliberately open (see below). However, existing literature and theories of transition, change and identity as discussed above will be incorporated when devising interview questions about participants' experiences to identify their possible relevance in understanding the adjustment experience.

Research questions

- 1.) What are the experiences of service users recently discharged from low secure forensic services in terms of community adjustment?
- 2.) How do service users make sense of their adjustment experiences?

In the context of the main research questions, several secondary research questions were developed that I felt may be of importance in relation to the main research questions. These secondary research questions reflect the potential influence of theories of change, transition and identity as well as potentially salient areas concerning adjustment that were outlined in the previous literature review. These are detailed below.

- 1.) In what way are service users' identities impacted on by their experiences and how does this in turn influence their adjustment?
- 2.) In what way can the adjustment experience be understood using theories of change and transition?

- 3.) How do service users' experiences impact on their relationships with themselves and with others?

What cannot be addressed by the current study?

The significant lack of research into low secure services generally and particularly in relation to post discharge experiences means that the present study cannot hope to entirely fill the research gap. However, I hope that exploring the research questions outlined above will lend valuable insights into people's experiences which will then direct and inform future research in this area. In turn, this research will hopefully highlight areas in which improvements can be made in the care provision for people experiencing similar transitions in future.

Rationale for choosing a qualitative methodology

The exploratory nature of the research led me to select a qualitative methodological approach. I felt that this would allow people's own perspectives of what is meaningful for them to emerge, which could then be used to inform and guide future research designed at quantifying aspects of reported experience. Another benefit of qualitative research is that it allows rich description of lived experience to be discovered rather than gathering data from pre-generated categories presumed to be important by practitioners or researchers, which reflects the need identified above to understand adjustment experiences from the perspective of the service user.

Rationale for choosing IPA

A number of possible qualitative methods are available; however I chose Interpretative Phenomenological Analysis (IPA). IPA is classed as phenomenological because of its focus on capturing and understanding experience (Smith, Flowers, & Larkin, 2009). In its consideration of experience, IPA is grounded in the philosophical principle of intentionality; that there is always a relationship between an object and one's experience or consciousness of the object (Landridge & Hagger-Johnson, 2009). In other words, objects and experiences are inseparable from the meanings they hold for the individual (Moustakas, 1994; Willig, 2009). This also means that people are likely to interpret future experiences according to their past experiences therefore their assumptions, values and other prior experiences are likely to influence their sense making. The principle of intentionality is integral to the 'interpretative' part of IPA, which is the focus on understanding how people make sense of/interpret the things that happen to them.

The concept of interpretation brings forward the principle of hermeneutics (the theory of interpretation), which is central to IPA. One of the key principles of IPA is the 'double hermeneutic,' the idea that the researcher is seeking to make sense of the ways in which the participant makes sense of his/her own experiences (Smith et al. 2009). In other words, there are two layers of interpretation, the researcher's interpretations of the participant's interpretations (hence the 'double' hermeneutic). The double hermeneutic principle highlights that the researcher is also influenced by prior assumptions and preconceptions. A major component of IPA is therefore for researchers to continuously reflect on how their own experiences may influence interpretations. In the first stage of analysis the researcher therefore seeks to transcend his/her own assumptions to try and get as close as possible to the lived experience of the participant. This reflects the philosophical concept of 'bracketing,' developed by Husserl, who was concerned with how people could try and move closer to capturing the essence of experience by bracketing off (separating) their own ideas and assumptions (Smith et al. 2009). It is now widely agreed that it is never possible to achieve perfect bracketing; however, by reflecting on one's own preconceived ideas and assumptions prior to meeting with participants it may be possible for a researcher to move closer to participants' own experiences. At a later stage in the analysis the researcher can reconsider his/her own ideas and integrate them with his/her new understandings of the world that have developed from meeting with the participant. At this stage the research process moves away from the sense making of the participant (the first part of the double hermeneutic) and more towards the researcher's own sense making (the second part of the double hermeneutic).

Finally, IPA is also idiographic, meaning it is concerned with depth of analysis and with eliciting rich accounts of experience. Consequently, in IPA the researcher initially analyses data on a case by case basis and only at the final phase of analysis makes comparisons across cases. This protects the depth of analysis and maintains focus on the particular as opposed to the general aspects of experience.

Considering the philosophy and principles of IPA described above, it seemed the most appropriate methodology for this study given its focus on exploring experience and sense making. However, before coming to this decision I considered alternative qualitative methods, particularly grounded theory. Grounded theory seeks to identify a phenomenon using minimal assumptions about the phenomenon as it seeks to develop a theory from the data that emerges (i.e. a theory that is grounded in the data). Grounded theory has also been identified as being largely similar to IPA (Willig, 2001). However, one of the main limitations of grounded theory is that it is arguably more descriptive than explanatory when applied to psychological

phenomena (Willig, 2009). In addition, IPA is one of the most well established qualitative approaches in psychological research (Willig, 2001) and therefore from a practical perspective it was also deemed appropriate for the present study.

Rationale for using semi-structured interviews

When using IPA, there are a number of possible methods of data collection. Two of the most popular methods are focus groups and semi-structured interviews. For the present study, I chose semi-structured interviews because I felt that focus groups might stifle people from expressing their true views or from divulging personal experiences for fear of stigma or ramification. Additionally, certain voices may dominate in a focus group leading to less dominant but equally valid stories remaining unheard (Smithson, 2000). Finally it is likely that at least some of the participants in the study would already know each other or share similar social networks or care workers. This would have presented issues around confidentiality and may have led to people censoring aspects of experience. Interestingly, in a previous study by Carrick, Mitchell & Lloyd (2001) where the authors sought to involve service users in the research, they were explicitly asked by service users to change their data collection approach from focus groups to individual interviews. While the authors give no reasons for this request, this highlights the potential concerns with using focus groups for mental health research with service users. I felt that semi structured interviews might avoid some of these concerns.

Summary of chapter

I began this chapter by highlighting the importance of focusing on community adjustment before providing a background to forensic mental health services in the UK, in particular outlining the structure of LSUs and how they are often a transitional point between inpatient care and community living. At the end of this section the possible challenges facing service users through the transitional period from low secure care to the community were highlighted and a discussion of theoretical models of change, transition and identity followed. I then reviewed existing literature in the field of community adjustment, which further highlighted the potential role of identity and change theories in understanding adjustment in addition to emphasising the relative lack of research into experiences of discharge from low secure services and the lack of focus on service users own experiences. I then identified how I hope to start addressing the current gap in the research by exploring lived experience and sense making around community adjustment following discharge from an LSU. Finally, I explained the rationale for using IPA to address my research aims.

In the next chapter I explain the research methodology in more detail including ethical considerations, details of participants, the procedure followed and the analysis conducted.

Method

Ethical Considerations

Approval

Ethical approval was granted by Leeds Central Research Ethics Committee (REC), reference **10/H1313/51** and by the Research and Development Consortium (R&D) for Leeds Partnerships Foundation Trust and West Yorkshire Partnerships Foundation Trust. In response to recommendations by R&D, amendments were made to the information sheet and consent forms for the study. These amendments were approved by Leeds Central REC. See Appendices A and B for a copy of the approvals.

Confidentiality

To protect confidentiality, all data were linked anonymous. To ensure this, identification numbers and later pseudonyms were assigned to each participant and all identifiable information was removed from interview transcripts. Where possible pseudonyms were chosen according to names that befitted an interest of the participants (for example a particular musician they liked). However, I ensured these were sufficiently modified to retain anonymity. Any documents containing personal information (such as consent forms and digital recordings) were stored in a locked cabinet and any data stored on computers was saved on a secure server.

Consent

All participants were given an information sheet and were encouraged to discuss this with me. If after reading the information they still wished to participate, they were given a written consent form to sign (see Appendix C and D for copies of the information sheet and consent forms respectively).

It was emphasised to participants that the research was separate from their care to minimise perceived pressure to consent. Participants were also given a minimum one week cooling off period between consent and participation to allow them the opportunity to reconsider their decision.

Questions about capacity to consent were discussed with a member of staff at the University of Leeds who has expertise in the Mental Capacity Act (Shickle, 2006). Mental and cognitive capacity was established by checking participants' understanding of the information at the time of consenting and by rechecking at the start of the interview. Anyone who lost capacity to

consent during the research would have had their data removed until such time as they regained capacity and were able to make an informed decision about the use of their data. However, this situation did not arise.

Risk

One possible risk to participants concerned distress at recalling potentially difficult experiences. This was outlined in the information sheet and discussed with participants. Their mental health workers were always available following the interviews to offer support in the event of residual distress. However, it has also been noted that having the opportunity to discuss past experiences can be cathartic for individuals (Minogue & Hardy, 2009). To minimise risk, interviews were conducted in safe environments in which staff involved in supporting participants were always available to intervene or offer support if necessary.

Payment

A £10 gift voucher was introduced as a 'thank you' to participants for giving up their time. However, the majority of participants explicitly stated that their motivation for participating was to share their experiences and contribute to some research rather than to receive the voucher.

Recruitment and Selection of Participants

Setting

Participants were recruited via two sites across West Yorkshire. Both sites have a low secure forensic facility forming part of a wider variety of forensic mental health services.

At both sites, a dedicated Community Forensic Team (CFT) supports service users through the process of discharge. At the first site, the team is made up entirely of Community Psychiatric Nurses. At the second site, the team comprises a variety of health professionals, including Community Psychiatric Nurses, Social Workers and Support Workers. Staff from the CFTs were approached as it was felt they would have knowledge about and provide access to the target sample.

Interviews were conducted in various locations, with the key stipulation that they had to be safe, confidential and accessible for researcher and participant. The most common interview location was the LSU site where participants had been resident.

Inclusion and Exclusion Criteria

People who had been discharged from one of two low secure forensic facilities in West Yorkshire to a community setting in the past 12 months were included.

A good standard of language fluency is required for IPA research and it was felt that the addition of interpreters may impact on the information elicited in the interviews as well as creating some pragmatic difficulties. Consequently, people who could not speak English fluently were excluded from participating.

People who did not have mental or cognitive capacity to consent were also excluded because of the need to obtain informed consent. Capacity was assessed by asking questions about understanding of the study and checking retention of this before proceeding with the interviews. In the event of residual uncertainty about a person's cognitive capacity to consent, the Mini Mental State Examination (Folstein, Folstein, & McHugh, 1975; Crum, Anthony, Bassett, & Folstein, 1993) was used as a screening tool although notably this was not required.

People with a diagnosis of a learning disability were not automatically excluded for two reasons. Firstly the criteria for defining a learning disability are often unclear and may have resulted in people being unnecessarily excluded. Secondly, excluding people on the basis of a learning disability may have resulted in the exclusion of people who could have provided useful insights into their experience and was deemed an unethical position.

Finally, given that the research questions were concerned with people's experiences of community adjustment, it was felt that a limit was needed where people were no longer classed as in the 'adjustment' phase. Consequently it was agreed that participants had to have been living back in the community for 12 months or less prior to recruitment. This also helped to maintain homogeneity of the sample, which is recommended in IPA research (Smith et al. 2009.) Given that the transition cycle (Adams et al. 1976) suggests that transitions take eight to nine months, the 12 month cut off also ensured that this time would have passed allowing me to identify the applicability of this model to participant's experiences.

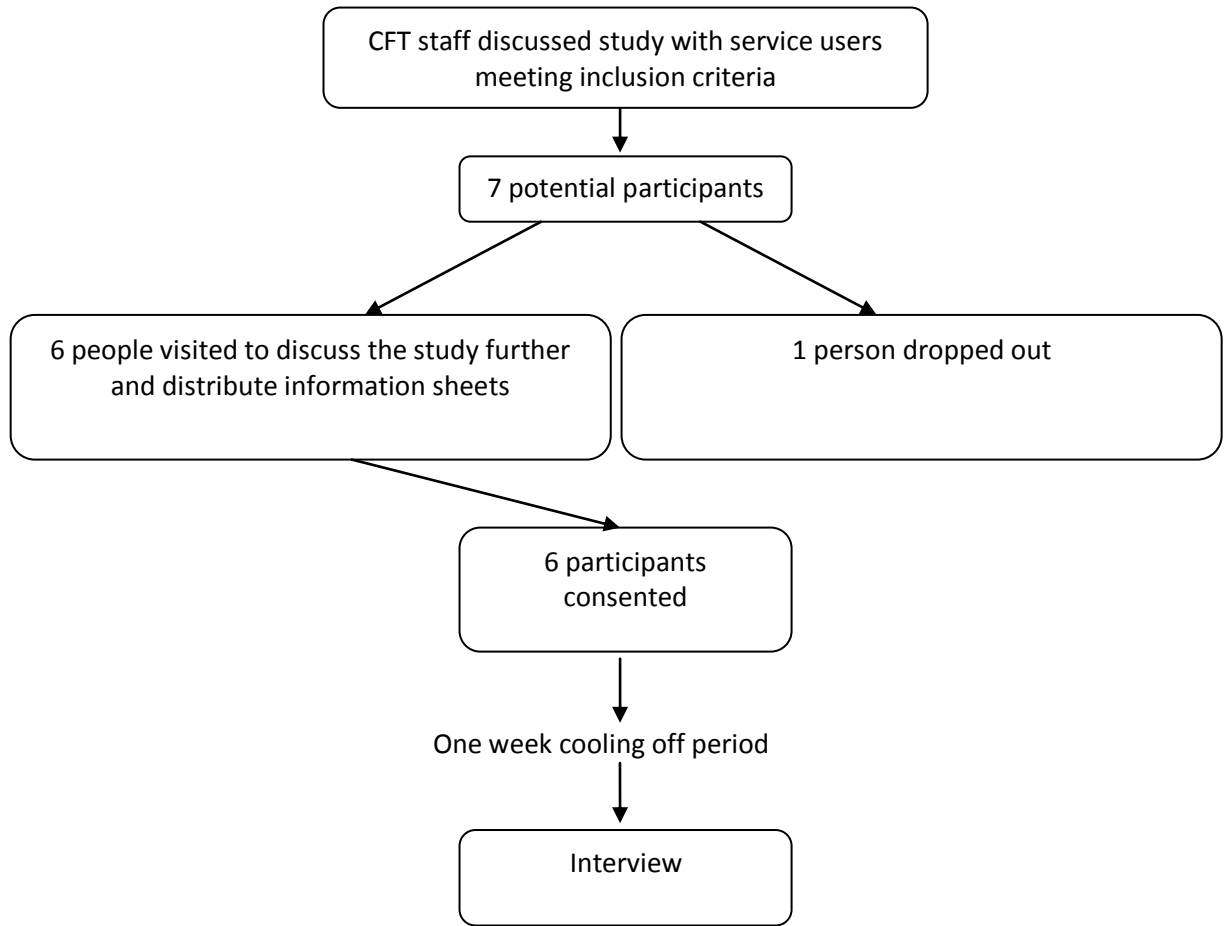
Recruitment Process

In IPA research, the recommended number of interviews for a doctoral study is between four and ten (Smith et al. 2009). For the present study, a final number of six to eight participants was chosen as this was judged large enough to yield sufficient data whilst also allowing for possible recruitment difficulties. A purposive sampling strategy is generally recommended for

qualitative research (Wilmot, 2005). However, for several reasons a purposive sampling strategy was not possible. First, I was constrained by the time available to me to conduct the fieldwork (following an eight month process of securing ethical approval.) I was also constrained by the number of LSUs available to me to recruit from and was further constrained by my rigid exclusion criteria and my route of access to participants. I therefore had to recruit on the basis of what was available to me. Sampling issues are discussed in more depth in my methodological critique (see discussion).

Participants were recruited via the CFTs at the two sites. Meetings were arranged with each team to discuss the research and the inclusion and exclusion criteria to help them identify eligible people from their caseloads.

Members of the two CFTs then approached all people on their caseloads meeting the inclusion criteria to elicit initial interest. I then visited anyone who expressed initial interest along with their workers to discuss the study in more detail. If interest was still shown at the end of this meeting then a consent form was completed and a provisional interview date scheduled. A one week cooling off period (minimum) then lapsed prior to meeting again for the interview to allow participants time to reconsider their participation. See fig. 2 for a diagram of the recruitment process.

Figure 2. Recruitment process**Participants**

Seven people registered initial interest in the research to their workers and six of them agreed to being visited to discuss the study. All six agreed to participate and to have their interviews recorded. All six participants were retained throughout the study (see Fig. 2.) Below is a table of relevant demographics for each participant with their assigned pseudonym.

Table 1 Participant Demographics

Pseudonym	Gender	Age bracket	Time since discharge
Robert	Male	40s	2 months
Aaron	Male	40s	7 months
Ben	Male	20s	10 months
Stefan	Male	30s	11 months
Paul	Male	20s	12 months
Ned	Male	20s	12 months

Procedure

Designing the interview

The interview schedule should facilitate conversation without leading participants because of the focus on eliciting participants' own experiences (Smith et. al. 2009; Willig, 2008). The interview was therefore designed to ask general, open questions to facilitate conversation. The content of the interview schedule was based on a number of factors. These included the existing literature and potentially relevant theories of change, transition and identity outlined in the introduction along with my conversations with practitioners working in the field. Questions followed an approximately chronological flow from reflecting on experiences on then units through to the time of discharge and beyond. 14 main questions complete with prompts and supporting questions were included in the interview schedule (see Appendix C for a copy of the schedule.)

Facilitating the interview

Interviews generally took place on a 1:1 basis. However, two participants explicitly requested for their worker to remain during the interview so they could hear about their experiences. The implications of this were fully discussed with the participants and their workers and they were reminded that their worker would not be able to contribute to the interviews and that their worker would not communicate anything to other sources without permission from the participants, thereby respecting confidentiality.

Interviews lasted between 30 minutes and 1 hour 10 minutes. The mean length was 45 minutes. All participants agreed to follow up interviews in the event that I needed to follow up information; however, this was not generally necessary and on occasions when it was, time restrictions prevented it.

Interviews were digitally recorded. During the interviews, participants' own language was used to follow up on questions in order to build rapport. Questions also deviated from the interview schedule to follow up on experiences raised by participants.

Transcription

Key to the process of IPA research is becoming immersed in the data. One recommended way of doing this is by transcribing the interviews personally, which I did. When transcribing, the following transcription conventions were used:

- I: to denote interviewer speaking, P: to denote participant speaking
- Removal of names of people of places and replacement with Xs

- Brackets for interruptions by either interviewer or participant
- Brackets and italicised writing to record emotions or behavioural responses by interviewer or participant e.g. (*laughs*)
- ... for pauses

During transcription, grammar and use of words was maintained exactly how it was spoken during the interview to ensure closeness to the data was maintained (Landridge & Hagger-Johnson, 2009). Furthermore, punctuation was kept minimal to ensure to flow of words was based on the interview itself rather than my own interpretation.

Field Diary

Throughout recruitment and data collection, I wrote process notes about my reactions and thoughts during the interview process. I also recorded my route of access to the sample to assist me in developing a richer understanding of my sample in context. Alongside the process notes I also took reflective notes about any assumptions I held that might have influenced the way I interpreted data. In IPA this process is called 'bracketing' (Willig, 2008) where the researcher seeks to transcend his/her own assumptions in so far as is possible in order to become closer to the lived experience of the participants. This also helped to ensure credibility of the research (see Whittemore, Chase, & Mandle, 2001 for highlighted role of reflexive diaries in quality checks).

Data Analysis

Training in IPA

I attended a one-day Introduction to IPA training course in October 2010 at Aston University. Here I was able to practice coding data and to review the stages of some completed IPA research. I also attended regular qualitative support groups run by the DClinPsychol programme at the University of Leeds.

Analysis procedure

IPA is concerned with understanding how people make sense of their experiences and uses a number of strategies to do this. Analysis involves working on a case-by-case account initially, working from a descriptive to an interpretative understanding of experience before eventually moving from particular accounts (focusing on individual transcripts) to shared ones (clustering themes across multiple transcripts) Within this process there is some flexibility about the analytic procedure (Smith et al. 2009; Willig, 2009) reflecting the subjective nature of IPA. For the present study, I used an adapted a template published by Smith and colleagues (Smith et al. 2009) for data analysis. The steps taken are detailed below.

Stage 1 Familiarisation with the text

While this began during transcription, this continues by reading and re-reading the text to become more familiar with and engage on a deeper level with the text.

Stage 2: Initial noting

Initial noting involves both descriptive and interpretative coding. In the left hand margin I wrote descriptive codes, which remained very close to the explicit statements of participants. Descriptive codes were used to reduce the content of the participant's interview into smaller units of meaning. Interpretative coding involves more conceptual or abstract comments or questions that arise as the researcher is engaging with the transcripts. Interpretative codes were written down the right hand margins. An example of my initial coding is shown below for Robert.

Table 2 Example of initial coding

Descriptive Codes	Passage	Interpretative Codes
Impact of experience on himself – more empathic towards others Saw injustices take place – unit Plays the game - he knows the system Felt sorry for others	P: Erm.. I'm now more emphatic with erm.. the plight of other individuals who are in similar situations but who for whatever reason can't articulate themselves in the similar manner that I can so for instance I may have seen certain injustices take place while I was actually in hospital but because of my knowledge of the system was able to override that to my benefit or as somebody once said to me 'you're playing the game' but for those individuals who for want of a better word don't know how to play the game you know I felt very sorry for them because they'd be locked up you know for however many years and had made no progress whatsoever	Self as wise and informed? Playing the game – insider? Expert patient? Is this a way of re-establishing a responsible protective role lost on admission?

Stage 3: Emergent themes

This stage involved using the initial noting to reduce the transcript to a set of emerging themes. At this stage, I reduced transcripts to smaller sections and assigned themes to each section of the transcript. In this process the task is to '*produce a concise and pithy statement of*

what was important in the various comments attached to a piece of transcript,' (Smith et al, 2009, p. 92). At this stage I moved away from the exact statements within the text itself towards my own interpretations. This process reflected the double hermeneutic inherent in IPA, which is the researcher's efforts to make sense of participants own interpretations of their experiences (Smith et al. 2009). An example of developing emergent themes from Robert's interview is shown below.

Table 3 Example of development of emergent themes

Passage	Emergent themes
just like little simple things that you may take for granted because you've never been incarcerated in such an institution but you know when people use that term institutionalised you have to appreciate exactly what it means and it's as if at a certain time of day after their meal everyone starts queuing up and its medication time and it's like walking zombies basically and for me the sad part was that when I went back and saw a number of individuals who were actually there, who had been there for years, years and years and I thought to myself is this punishment for them or I mean are they actually getting treated for whatever condition they may have because surely if they've done something wrong they'd have gone to prison and probably tried to have been treated out of the prison but as I said I'm not familiar with how these institutions are run I don't know the politics behind it or anything like that.	Experiences given him a privileged position Impact of experience of worldview Sense of hopelessness Loss of individuality Feels sympathy for others Questioning the purpose of the unit

Stage 4: Connecting themes

This stage involved clustering emergent themes in a meaningful way. I typed out all emergent themes next to samples of the text they were taken from. At this stage not all emerging themes are retained. I used a number of strategies in selecting which themes to retain and which to discount at this stage. Crucially, all emerging themes were considered in relation to the research questions and the context in which the research was grounded. With this guiding my analysis I then identified themes that I felt should be retained based on their repetition throughout the transcript and the importance placed on them by the participant. I also retained themes that I personally felt were salient in enhancing knowledge of this unexplored

area. The process I used reflects the double hermeneutic integral to IPA. Repetition and importance to the participant signified the first stage in the double hermeneutic and my own sense making about importance and relevance reflected the second stage.

During this process a number of super-ordinate themes were developed with subthemes beneath. While super-ordinate themes are largely conceptual, subthemes are generally more descriptive. This provides a means of contextualising and grounding the more conceptual super-ordinate themes firmly in the research data.

Stage 5: Moving to the next case

Once one interview transcript had been analysed and clustered into super-ordinate and component themes, I progressed to the next transcript and repeated the above process.

Stage 6: Final group analysis

After analysing all individual transcripts, I clustered the themes for each participant to form super-ordinate and subthemes for the overall sample, which formed the group analysis. I also developed a table mapping the themes for each participant (see results). While some themes were entirely participant generated (for example a theme around 'playing the game' was so named based on a direct quote from one of the transcripts, see results,) others were researcher generated based on my own interpretations of the experiences being reported. A theme entitled 'the holy grail' for example (see results) was so named because a sense of relief and of reaching a long held goal on discharge gave me an image of finding something that had previously felt unattainable and of reaching a desired point in life. However, no participant explicitly used the 'holy grail' metaphor. This also reflects the subjective nature of IPA and the second phase of the double hermeneutic.

Selecting which themes to present

I decided which themes to retain when presenting the final group analysis based on similar principles as those used when deciding which emerging themes to cluster and which to discard. First I considered how well the theme would help to answer the research questions. Secondly, I considered how well supported the theme was across multiple participant accounts (usually half the accounts of more, Smith et al. 2009). This ensured I had a credible account of experience that was sufficiently grounded in the data. However, on occasions a theme which was not reflected across half of the accounts or more was still included in the final results section. On these occasions I felt that the theme added meaningfully to knowledge of the field thereby warranting its inclusion. For example, a theme emerged around 'working to own

timescales' (see results). While this was only applicable to two participants I felt that this lent a unique insight into the recovery journey, which could be highly influential in understanding how best to support service users on their journey from secure care to the community.

Quality checks

In qualitative research, an independent audit can be employed to check the credibility of findings (Smith et al. 2009). The first part of the independent audit involved implementing recommendations by Yin (1989) and Rodgers and Cowles (1993) who advised that all the data and workings from a qualitative study should be filed in a way that would allow a comprehensive trail to be made between the final report and the very first recorded ideas. Doing this should allow a researcher can check the validity and credibility of their claims. I therefore ensured that all of my data was filed in such a way as to meet this aspect of the independent audit, whilst also respecting principles of confidentiality and data storage to meet ethical standards.

The second part of independent audit involved inviting an independent researcher to review a small section of transcript alongside the themes that I developed. Unlike validity and reliability checks in quantitative research, there is no single correct way of making sense of the data therefore the audit is not used to validate whether themes are 'right' or 'wrong;' rather, it is used to check that the researcher has made sense of the data in a credible way (Smith et al. 2009). I invited a fellow IPA doctoral researcher to independently review a quarter of one of my anonymised interview transcripts. She felt that she was able to make sense of the themes I developed and she could identify no 'missed' themes. She did however identify some of the medical language used by the participant, which actually strengthened one of the sub-themes I had already identified.

Chapter Summary

In this chapter I have outlined the methods used in the recruitment, data collection and data analysis for the present study. I have also reviewed the ethical considerations and approvals for the study and discussed how ethical dilemmas were overcome. In the next chapter I introduce each participant in more detail and present the results from the analysis.

Results

My results and discussion are presented as two distinct chapters in accordance with advice by Smith et al. (2009). In this chapter an account of the data is provided in a way that remains close to participants' accounts. In the discussion I move to a more interpretative account of the findings in the context of existing literature, theoretical frameworks and my own reflections. Below, I present pen portraits for my participants to situate the sample prior to presenting the results.

Pen Portraits

In the previous chapter the six participants were briefly introduced. In this section I provide further information about each participant including their background, their pathway through forensic services and their reasons for participating in the research. These were elicited through conversations with participants during and prior to the interviews. Each pen portrait is followed by my reflections about each interview.

Ben

Ben was born and raised in West Yorkshire. He volunteered little information about his past and described himself as a private person who manages difficulties by '*bottling them up.*' His pathway into low secure care was via the criminal justice system. He was transferred to an LSU directly from court. He did not disclose the reasons for being in court but during the interview vividly recalled moving directly from court to the unit and how overwhelming it felt. After two years the unit where he was originally admitted closed and so he was moved. In total Ben spent four years in low secure care before being discharged on a CTO. On discharge he moved to a flat near to where he grew up. At the time of our interview he had been discharged for approximately ten months.

Ben came to participate in the study after hearing about it from one of his workers. He explained that taking part was a way of challenging himself to talk more to relative strangers, something he felt he struggled with.

During the interview Ben talked at length about his time on the unit. In particular, he recalled feeling on edge and feeling different from the other service users. Ben also questioned the reasons for his admission; questioning how people could class him as having a disorder when he felt his way of being was merely representative of his own personality. When talking about his time since discharge he described positive experiences such as feeling more comfortable in his surroundings and feeling he could reconnect with and continue with life now. He also

talked about challenging himself for example by participating in more social activities and returning to the '*ordinary way things work*' in society but he was also clear about the importance of pacing things appropriately to avoid becoming unwell and jeopardising his community placement.

Interviewing Ben

I recall feeling anxious at the start of the interview with Ben, firstly because this was my first interview and I was concerned about my interviewing skills and secondly because I was aware of Ben feeling anxious around strangers and so felt the need to reassure him. I therefore found myself quickly retracting questions if Ben paused or struggled to answer. As the interview progressed I recall being impressed with how insightful he was about his experiences. I felt a strong sense of relief about how open he was and with how little I needed to prompt him. I also felt that both Ben and I relaxed into the process over time and I allowed longer pauses and felt more confident asking potentially challenging questions.

Robert

Robert had been in and out of LSUs for several years. Predating this he had worked for the local council in the South of England. Robert had a partner and a son and he spoke of a close relationship with his father who lived nearby. When I first met Robert he also told me he used to work in psychiatric hospitals and how this had increased his knowledge of what he termed '*mental illness*,' which may explain the use of medical language that dominated his account. During his last admission he had been in for 6 months before being discharged on a CTO to his existing residence (his own flat). He had been discharged for approximately two months prior to the interview.

In the interview Robert talked about his participation in the research being a sign that he was making progress as he used the four weeks between our initial meeting and the interview as evidence that he was coping in the community. During the interview Robert described feeling like an '*old hand*' at being a patient and of moving between his home in the community and a secure environment. He also talked about himself as different from others on the unit in that he did not come from a forensic background (he did not come into services via a criminal justice route) and as such saw himself in a privileged position to help others. During the interview Robert also referred to his desire to reconnect with the roles he used to hold such as working in a position of responsibility and supporting his local community.

Interviewing Robert

I experienced Robert as somebody who values professionalism and I therefore felt pressured to portray an expert persona when interviewing him. I also felt that he was seeking to create the impression of himself as a wise and knowledgeable person; he frequently reminded me of his history as a professional and skilled individual and spoke about how others viewed him as a *'role model'* and advisory. I wondered whether this was his way of protecting himself from the *'patient'* role he had been assigned as a result of his experiences.

In terms of the interview process, I felt that, similar to interviewing Ben the interview with Robert flowed well and I barely had to prompt him. Robert and I were both surprised when we noticed that we had been speaking for over an hour by the time the interview ended. This was also a testament to how comfortable I felt in the interview with Robert, which reflects how at ease he was with sharing his experiences.

Aaron

Aaron had been an inpatient for several years. He had originally been admitted to a private unit and after two years was transferred to an NHS facility where he stayed for 18 months before being discharged on a CTO. His CTO had expired the weekend before my interview with him, something Aaron told me he was very pleased and relieved about. On discharge he had wanted to move back to his own home but he had lost it during his time on the unit, which he told me made him feel *'upset.'* His second choice was to live with a family member but he explained that there was no room so he moved to supported accommodation near the unit where he had been living for seven months prior to the interview. Aaron's supported accommodation was in the next town from where he grew up and where his family still lived and during the interview he talked about wanting to live closer to them eventually.

Aaron talked about not liking the unit because he had to ask for things and did not like to be *'stuck in all the time.'* He also described difficult relationships with the staff, saying that many of them were *'strict'* and could be *'funny'* with him. By contrast, Aaron described his new home as *'good'* and he talked about getting on well with staff and other service users there and having more freedom. However, he also spoke about his fear about being taken back in to low secure care and how this made him wary of new people in case they readmitted him.

Aaron did not give a specific reason for participating in the study but told me he would like to *'give it a go.'* However, he raised a concern about finding it difficult to find the right words

sometimes so we agreed that I would either help him find the words or if he found some questions difficult then he did not have to try and answer them.

Interviewing Aaron

I felt quite anxious approaching the interview with Aaron because of his expressed anxiety about finding words. I therefore found myself refraining from asking or following up on questions at times. I also felt that Aaron's fear of being readmitted may have led him to censor aspects of his experience at times in case I shared anything with anyone who had the power to readmit it. This anxiety persisted despite my repeated assurances about confidentiality and I felt this resulted in a less detailed account from him than might otherwise have been obtained.

Stefan

Stefan had been admitted twice before to the same LSU. During his most recent admission he was resident there for two years before being discharged on a CTO to his own flat. Stefan did not volunteer information about his family background or any details about his life prior to admission. He described himself as '*quiet and thoughtful*' and as somebody who likes his own company. Stefan had been discharged for 11 months at the time of the interview.

Stefan expressed a keenness to participate in the research although he did not explicitly state his motivation for this. He talked in the interview about the low secure experience as something he did not like but that he had to '*get used to*' over time. He also described on-going worry about being '*dragged back*' to the unit by the police and he reflected on times in the past when this had happened. Stefan had a number of plans for the future that he was keen to pursue but he explained that uncertainty about his own future, namely concern about having a '*relapse*' and potentially returning to the unit meant that he was avoiding implementing plans. Stefan also used words throughout the interview like '*mad*' and '*insane*' and he often described himself in these terms.

Interviewing Stefan

I experienced Stefan as very shy and anxious, which increased my own anxiety. I therefore found myself drifting away from the content of his conversation at times as I found myself becoming preoccupied with what more I could do to help him relax. I also found that Stefan tended to give quite short responses and found myself drawn into repeatedly prompting and at times felt I was taking over the interview. When reviewing the recording I noticed that I took a much more active role in this interview than in most others. However, when talking about his plans for the future I noticed that Stefan became more animated and expressive, particularly

when he spoke at length about a book he was writing and he was explaining the content and background to me.

Paul

Paul had grown up in West Yorkshire. His first experience with mental health services was during an admission to a general mental health ward (non-secure) at one of the recruitment sites. Following a forensic assessment he was transferred from the general ward to the LSU where he spent approximately two years prior to being discharged. Paul said very little about his background before coming into contact with mental health services. However, he did repeatedly refer to his family and spoke about being very close to his mother in particular, citing her as the most important person in his life.

Paul's route to becoming involved in the interview was particularly interesting. During a meeting with his psychiatrist he expressed an interest in participating in my research. This occurred before his worker had explained the research to him and it remains unclear how he first heard about the study. However, he was keen to be involved from the outset, explaining that he enjoyed having the opportunity to express his feelings about his time on the unit and since discharge.

During the interview Paul was particularly keen to talk about his memories of the unit. He talked about having to follow rules, feeling restricted and feeling cut off from family. He also talked more positively about developing lasting friendships there. He volunteered less information about his time since discharge and I noticed that he often revisited his LSU experiences during conversations about his time since discharge. He explained that he felt sometimes as though he was still at the unit. Paul also talked about enjoying being able to spend more time with his family since discharge and being able to work towards the future.

Interviewing Paul

I experienced my interview with Paul as quite demanding as he spoke very quickly and often shifted topics suddenly making it difficult for me to follow. Listening back to the interview I realised that this accelerated my own speech and the entire pace of the interview increased. I also noticed that Paul's attention fluctuated frequently and, on several occasions he interjected to ask if the interview was finished yet, which made me feel pressured to terminate the interview. This felt pressure led me to ask fewer follow up questions than I had in some of the other interviews. My interview with Paul was the shortest, lasting for 30 minutes, which is

a reflection both of the pace of the interview and of my anxiety not to keep Paul talking for longer than he wished.

Ned

Ned was my final participant. He had been in an LSU in West Yorkshire for approximately two years prior to discharge. Before this, he had spent six months in a secure unit further north. Ned was keen to tell me about his previous admissions as well as the time he had spent in various young offenders' institutions and latterly in an adult prison, which he preferred over the unit. Ned was discharged on a CTO to a flat near his father's house. He talked about having a close relationship with his father and brothers and he spent the majority of his time at his father's house.

Ned had been living back in the community for almost 12 months at the time of consenting to participate; however, because of practical difficulties finding a mutually convenient date I did not interview him until he had been discharged for 13 months.

Ned had a great deal to say during the interview. He spoke about how restricted he felt on the unit and how he felt like '*just a number.*' He was also keen to tell me about times when he stood up to the staff there by either fighting or arguing with them. He felt that since discharge he had become healthier, both physically and mentally. He also spoke about enjoying his freedom and looking forward to new challenges like going to college and finding ways to make money and '*succeed*' in life. Interestingly, while he described relief and joy at being discharged he also spoke about a part of him that missed the unit, particularly the relationships he developed there.

Interviewing Ned

I experienced Ned to be a lively, engaging participant who was keen to share his experiences. Similar to Paul he spoke at a fairly fast pace and frequently alternated between topics, which made it difficult for me to follow at times. However, he was always willing to repeat himself or return to topics if I wanted to follow up on them. I also felt quite scrutinized by Ned who made several references to me as a female researcher. However, on one occasion when I felt uncomfortable Ned seemed to realise this and initiated another topic of conversation. I also noticed that Ned was keen to impart advice on what would improve the inpatient or discharge experience for others, which was one of his main motivations for participating.

Presenting the Analysis

When I began my analysis I intended to present the data as one group analysis. However, during analysis I realised that in order to make sense of the adjustment experiences people were describing it was more meaningful to consider them in the context of their experiences in an LSU as the LSU experience emerged as instrumental in understanding adjustment post discharge. The analysis is therefore presented in two stages; experiences on the unit and experiences since discharge. The ways in which people make sense of their experiences is naturally embedded in how experience is described so I have addressed both research questions in the same group analysis.

Group Analysis: Reflecting on the LSU experience

Table four depicts the group themes based on participants' reflections on the low secure experience. The themes were clustered into super-ordinate and sub themes (see methods). However, when looking at the list of super-ordinate themes I felt that it made sense to cluster them into three overarching categories. In IPA these are termed master themes (Smith et al. 2009). This way of consciously organising my data provided a means of highlighting the key concepts that I felt were most salient based on my engagement with the data and the experiences I felt were most pertinent to my sample. Grouping the data in this way is also of benefit in order to 'scale up' individual experiences in making sense of a wider social process. Table four depicts each layer of themes. After presenting the table each theme is discussed in more detail with supporting extracts from participants' accounts.

Table 4 Group themes: Reflections on the LSU experience

Master theme: Power								
Super-ordinate themes	Sub themes	Participants						Number of participants for whom theme is present
		Ben	Robert	Aaron	Stefan	Paul	Ned	
Feeling overpowered by the system	Feeling controlled by professionals	X	X	X	X	X	X	6
	Feeling restricted	X		X	X	X	X	5
	Having to play the game	X	X			X	X	4
Self Control	Feeling controlled by diagnosis		X	X			X	3
	Seeking to regain power					X	X	2
Master theme: The Self								
Loss of identity	Feeling stripped of individuality		X			X	X	3
	Feeling that life is on hold	X	X	X		X		4
A fragmented identity	Feeling misjudged	X			X	X		3
	The self as disordered				X		X	2
A changed identity	Becoming an expert patient	X	X	X		X		4
	A private self turned public	X	X		X	X		3

Master theme: Making sense of the LSU experience								
Super-ordinate themes	Sub themes	Participants						Number of participants for whom theme is present
		Ben	Robert	Aaron	Stefan	Paul	Ned	
Making sense of the reasons for admission	Feeling punished	X	X					2
	Understanding admission as treatment for a disorder		X	X	X	X	X	5
	Finding the experience meaningless	X		X	X		X	4
Experiencing the unit as unhelpful	Feeling that time on the unit was detrimental to health				X	X	X	3
	A non-therapeutic environment	X	X				X	3
	Experiencing staff as unsupportive		X	X	X		X	4
Belonging	A sense of community	X				X	X	3
	Feeling different to others	X	X					2

Power

All six participants referred to feeling powerless and controlled on the units. However, several also spoke about taking control for themselves. Furthermore, while all spoke of feeling out of control it emerged that this was an almost functional position for some as it enabled them to achieve longer term gains such as accelerating discharge.

Feeling overpowered by the system

All participants spoke about feeling under the control of the system, both in terms of the rules and procedures on the unit and also the staff themselves.

Feeling controlled by professionals

All participants spoke about feeling controlled by professionals. Aaron spoke about his sense of the professionals as '*a bit strict and that*' (p.7) and others felt that the staff imposed rules rigidly.

I wanted me own flat ... but he (the psychiatrist) point blank refused. (Ben, p.5)

For Ned, Stefan and Paul the rules were experienced as regimental.

They tell you what you're doing, what you're eating, what time you're off to bed what time you're out for a fag basically. (Ned, p.1)

Well it's just that sort of like you can't sort of like err eat when you want cos it's all sort of like scheduled for you. (Stefan, p.2)

When you're on the wards they make the rules. (Paul, p.4)

Ned also explained how his knowledge of the system led him to withhold certain behaviours because he knew that they would produce a negative response.

How have you managed to learn not to lose your temper? (P.28)

Cos I knew they'd acuphase me⁴... I knew they'd pin me down take me to me room. (Ned, p.28)

Feeling restricted

Five participants spoke about feeling restricted on the units; for example, feeling physically restricted and having limited freedom of movement. Aaron, Ben and Ned spoke about the lengthy process they had to endure before being granted leave.

They keep you in for 6 or 7 months or so before you even get leave. (Ned, p.22)

You had to stop in...⁵ then after a while you get to go somewhere like Asda. (Aaron, p.2)

If you're under certain sections like the home office section which I and a couple of the lads were where outside leave has to go through the home office which can take

⁴ Acuphase (short for Clopixon-Acuphase) is a fast acting neuroleptic drug treatment administered intramuscularly to relieve symptoms of psychosis.

⁵ ... used to denote movement from one part of a sentence to another or one passage to another

anything from four to about 12 weeks to get a reply as to whether you can even go outside in the grounds. (Ben, p.3)

Ned also spoke about feeling restricted in terms of his rights, alluding to a sense of imprisonment.

You've got no rights cos you basically feel like a prisoner you know what I mean. (Ned, p.1)

This sense of imprisonment was also described by Robert.

No matter how much you want to pretty it up it may be a hospital but it's still like, like a jail basically (p.6)

Having to play the game

'Playing the game' was so named based on an extract from Robert's interview where he spoke about how he had learned how to '*play the game*' (p.12) over years of being in and out of LSUs and how he felt sorry for others '*who don't know how to play the game*' (p.12) because this prolonged their inpatient stay. This theme therefore captures the deliberate suspension of self-agency and the adoption of a cooperating role in order to avoid unwanted consequences and achieve desired outcomes.

Four participants spoke about 'playing the game.' Paul spoke about having to follow rules that he did not agree to maximise his chances of discharge.

I didn't like them but you had to follow them that's how I got out of there you do what they say follow the rules and you get out (p.3).

Similarly, Ben spoke about the importance of suspending his own viewpoint and cooperating in order to accelerate his discharge.

I goes look I don't particularly agree with it but if I disagreed with it then it might stretch out the process longer and it might people might say that I was being uncooperative and it might lower by chances of getting out at tribunal (p.5).

Self-Control

In addition to feeling overpowered by the system, four participants spoke about issues concerning control over themselves.

Feeling controlled by diagnosis

Three participants spoke about feeling controlled by their mental health problems. Robert for example spoke of the circular nature of his experience of constant readmissions implying that he had no control over his mental health. Understandably Robert experienced this lack of control negatively, '*It wasn't very nice it was like ah here we go again*' (p.2). Aaron also spoke of his lack of personal agency in relation to his diagnosis.

Why do you think you went there (the unit) in the first place? (p.3)
I was hearing voices they told me to do bad things. (Aaron, p.3)

Asserting own power

Despite speaking of feeling out of control a further theme emerged around seeking to assert authority and redress the power imbalance experienced on the units. Ned and Paul both spoke about asserting their own authority by flouting the rules.

The lady said I had to be back for 3 o'clock and so I couldn't that was the majority of the time gone cos the fun actually starts at 3 o'clock so I was quite annoyed so I went back and stayed they weren't happy but I said I wanted to go out and enjoy myself. (Paul, p.2)

I escaped a couple of times. (Ned, p.3)

Ned also asserted his authority through physical retaliation.

How did you deal with that? (Being told what to do, p.1)

Fighting with them basically... they had respect for me at the end of the day did staff. (Ned, p.2)

The Self

All participants spoke about ways in which their LSU experiences had impacted on their identities, both in positive ways but also in ways that they interpreted as detrimental. Some also spoke of a fragmented identity because of having to behave out of character or because their own self-concept contrasted with the ways in which professionals constructed them.

Loss of Identity

Five participants spoke of aspects of the identities that were lost on the units. These losses included a loss of individuality, loss of life stage and loss of valued interests.

Feeling stripped of individuality

Ned, Robert and Paul spoke of feeling stripped of their individuality. Ned explained how he felt 'like a number,' (p.1) implying how he felt he was given a collective identity. Similarly, Robert alluded to this loss of individuality when describing how everyone behaved the same on the unit.

It's as if at a certain time of day after their meal everyone starts queuing up and it's medication time and it's like walking zombies basically. (p.5)

Paul also spoke about being stripped of his individuality by being banned from wearing items that allowed him to express his own style.

It's like you can't wear heavy jewellery you can't wear rings. (p.1)

Feeling that life is on hold

Four participants spoke about their life feeling on hold during their admission. Aaron, Paul and Robert spoke of how they were cut off from valued people in their lives and from their valued activities. Aaron explained that *'you were limited in what you could do there'* (p.3). Ben spoke about how on the unit he was unable to live the life that most people of his age and developmental stage could live.

The other lad that I usually come up and see that is still in here and he's getting out soon so the three of us will be able to start going out having a couple of drinks and just being young lads cos that's the sort of thing that you lose when you're in here, you know. (p.3)

A fragmented identity

Four participants spoke about ways in their identity was divided on the units.

Feeling misjudged

Stefan, Paul and Ben spoke about feeling misunderstood and misjudged by professionals. For Stefan, he felt that the staff type cast him into a role before getting to know him.

I suppose they didn't actually talk to me or anything so they weren't in a position to sort of like decide if I were sane or insane. (p.3)

Paul spoke of how professionals assigned negative labels to him before trying to make sense of his behaviour.

Cos I'm right boisterous and I've got ADHD see so I'm right boisterous and he thought oh he went ah you're gonna end up somewhere in the gutter ... he thought I were a no hoper. (Paul, p.10)

The self as disordered

Both Ned and Stefan spoke about a fragmented identity in terms of a disordered identity. Stefan described himself as *'insane'* while Ned assigned himself labels, *I've got something called schizoaffective I've got schizoaffective disorder'* (p.4).

A changed identity

Five participants spoke about how feeling changed on the units. While some changes were perceived positively, others were understood as less helpful or unwanted.

Becoming an expert patient

Four participants spoke about becoming expert patients. Robert described himself as an 'old hand' at being a patient and how without the expert status he would have found the procedures disorientating.

If you are not familiar with the protocol behind the units then it can be very disorientating... it wasn't such a worry for me though cos I'd been through it all before. (p.1; 4)

Similarly, Ned, Ben and Stefan all spoke about becoming experts in terms of habituating to the procedures. Stefan in particular repeatedly spoke about how he 'just got used to the situation that I was in' (p.1; 2).

A private self turned public

Both Ben and Stefan described themselves as private people; for example, Stefan described how 'I like my own company' (p.5) and Ben explained 'I'm not much of a people person' (p.2). However, both felt their privacy was lost on the units as they were expected to share aspects of themselves with others.

*They changed your medication how did that come about? (p.1)
Just complaining about it really in ward rounds. (Stefan, p.1)
You've got all the patients running up to you asking how you are where you're from and you've been in the door five minutes ...I was looking forward to having some time on me own again where I wouldn't have people barging in and out me room all the time. (Ben, p.3; 6)*

While Robert did not profess to be a private person, he too described a loss of privacy, particularly in relation to sharing aspects of himself with others as part of the rehabilitation process. In the passage below Robert describes a group he participated in.

*What was it like for you doing that kind of thing? (p.1)
Difficult at first because you have to open up your heart to a number of individuals a number of strangers basically. (p.1)*

Making sense of the LSU experience

Making sense of the reasons for admission

All participants sought to make sense of the reasons behind their admission and the purpose of LSUs.

Feeling punished

Ben and Robert both made sense of their admission as a punishment for wrongdoing. In Ben's case, although he did not divulge the reasons for his involvement with the criminal justice system, he explained that he was transferred to an LSU '*because I did what I did*' (p.4). Robert was more questioning of the reasons for admission with punishment forming one of several hypotheses.

I thought to myself is this punishment for them or I mean are they actually getting treated for whatever condition they have? (p.6)

Understanding admission as treatment for a disorder

All participants except Ben made sense of their admission as an opportunity to be treated for a mental health problem or disorder. Stefan example spoke of how he was admitted because of mental health problems.

I suppose I was really paranoid at the time so I sort of like recognise that I wasn't really that mentally fit. (p.2)

Aaron spoke of being admitted because he was '*hearing voices,*' (p.3). Similarly, others spoke of how their mental health had deteriorated, which had prompted their admission.

My mental health was deteriorating so they put me in there it's like forensics it's like when you get unwell. (Paul, p.4)
In retrospect I can see why I was actually admitted to hospital because it was a relapse. (Robert, p.2)

Finding the experience meaningless

For four participants the purpose of their admission was questioned as they experienced their time on the units as meaningless. Ned spoke of how time there was '*slow, the days seemed like weeks*' (p.7). He also talked about the things he did to try and pass the time.

Sometimes I'd get up during the day and I'd talk to the lads and you know what I mean go out for a cigarette have me tea and that lot some days I'd be up I'd say 90% of the time I'd just stay in me bedroom all night listening to music. (p.3)

Aaron spoke of being '*limited in what you could do there*' (p.4). By contrast, Robert spoke of how he was accustomed to the experience feeling meaningless but on his last admission he was pleasantly surprised by having the opportunity to take part in something he felt was valuable.

I managed to undertake a training course, an educational course in psychosis, which is one of the first innovative things they've done there for quite a while and as well as being able to occupy yourself, your time in a meaningful manner on a weekly basis I was meeting with a number of individuals under the auspices of various professional staff. (p.1)

This in turn seemed to improve Robert's overall evaluation of the experience as '*a very enjoyable experience under the circumstances*' (p.1).

Experiencing the unit as unhelpful

Apart from Robert's positive evaluation, all participants referred to aspects of the environment or procedures within the units that they found unhelpful or detrimental to recovery.

Feeling that time on the unit was detrimental to health

Stefan, Paul and Ned made reference to ways in which their time in low secure care negatively affected their health and wellbeing. Paul spoke about how he was '*right depressed when I were in X*' (the unit, p.7).

Stefan spoke about how the medication he was given to improve his health made him feel unwell.

They gave me drugs that had sort of like quite unpleasant side effects so I think it was the ⁶ that sort of like stopped me from sleeping it was uncomfortable so sort of like I didn't actually sleep for sort of like a long time. (p.1)

Ned felt the restricted movement and lack of opportunity was detrimental to his health in terms of energy levels and physical fitness.

You come out with a belly like this (pats stomach) ... you get lazy being confined to a ward and that you know what I mean. (Ned, p.22)

A non-therapeutic environment

Three participants spoke of aspects concerning the environment itself that they found unhelpful or detrimental to recovery. Ben in particular spoke about feeling uncomfortable and uneasy on the unit.

You never really knew what was gonna happen, y'know people can have a relapse or kick off at any moment so a lot of the time on certain wards you're always kind of on edge cos like I was on a ward with people before that could change depending on y'know anything, if you said hello to a certain person sometimes they might say hello back, at other times they might start screaming at you for whatever reason and that's the sort of things I'd have to deal with sometimes. (p.8)

Robert described the environment as '*a nightmare*' and how '*you hope and pray that one day I suppose I should use the word that the nightmare will end*' (p.11). Both Robert and Ben also spoke of how removed they felt from the outside world.

It's in the middle of nowhere it's very difficult for my family to actually come and visit me. (Robert, p.5)

⁶ Seroquel is a market name for Quetiapine, an atypical antipsychotic drug used in the treatment of psychosis

You kind of lose touch with the outside world cos when you're in places like this it's such a closed off area... your only way of finding out about the outside world is either from the TV or the people you talk to an' that's one way of getting the information but it's not like experiencing stuff and when people tell you about stuff that's going on in the outside world if you're not actually seeing it or experienced if it's just words you don't really quite get it. (Ben, p.3)

Experiencing staff as unsupportive

Four participants talked of certain experiences on the units where they found staff to be unhelpful or insensitive to their needs. Robert and Stefan described how they felt that staff members were sometimes neglectful of their needs and how this resulted in them feeling alone in managing their difficulties. For Robert *'it was a case of out of the frying pan and in to the fire,'* (p.4). Stefan felt that *'psychology were the only ones people that tried to assess you to see how mentally fit you are,'* (p.2). As opposed to feeling neglected, Aaron and Ned both spoke of how they felt staff members were deliberately unhelpful.

Staff were a bit funny with us... some were ok but some I didn't like. (Aaron, p.2)

Yeah some of the staff wind you up at X (the unit) there's a certain member of staff at X (the unit) and he said to me he goes you only got yourself sectioned cos you couldn't handle jail. (Ned, p.21)

Belonging

This final super-ordinate theme relates to participant's sense of belonging or community on the units. While some felt cut off or isolated, others found that they forged positive relationships and felt immersed in the low secure community over time.

A sense of community

Paul, Ben and Ned identified a sense of community that developed from establishing positive relationships with other people. Paul highlighted friendship as the one factor that improved his experience of the unit.

The rules were crap but I had quite a good time there good... I made friends and stuff. (p.2)

And have you stayed friends over time? (I, p.2)

Yeah for a long time. (p.2)

Similarly, Ben spoke of how he had developed lasting friendships with a small number of people who he felt more comfortable spending his time with.

The two lads that I used to get on really well with up here we actually came from X (another unit) anyway and was on the same wards there and was in the same little rehab areas where there was I think 4 beds and like the 3 of us was all in that little area together a lot of the time together anyway. So like we'd sit in each other's rooms, listen to music ... and we'd play cards and stuff and even now like one of the lads that was on here where I were on the two lads he's actually out now and we still meet up every now and again. (p.2)

Ned also talked about developing positive relationships on the unit and how he missed the social aspects and the apparent sense of belonging he experienced there.

I don't wanna see the place again but in a way I miss it as well; being with the lads and that. (p.8)

Feeling different to others

While many participants spoke about developing positive relationships with other service users, both Robert and Ben also repeatedly distanced themselves from other service users in the interview, speaking about how different they felt. Ben talked about how these differences made life on the unit difficult at times.

Even when I was like extremely depressed I was still y'know wash clean look after myself because it was routine. Anything worse. And then for someone like me to be put in a place where not everyone had the same standard of hygiene let's say you know it used to really used to get at me cos there's people on here that might y'know go for months without having a wash, wear the same clothes every day all over the place y'know and they'd sleep in their pyjamas drool all over the sides and walk past and you could it and err and I used to hate it y'know stuff like that really got to me. (p.1)

Robert also separated himself from other service users in terms of his background and talked of how he felt uneasy around some service users.

It was always difficult when you're actually amongst a group of people some people talk, other people their reputation precedes them as well and you think you don't want to mess around with that guy cos he may have done this he may have done that or whatever. (p.4)

Robert also interpreted having to reside alongside other service users as evidence that he had 'hit rock bottom.'

Plus the fact that some people had been to places like Rampton where I'd think what? And that's where at one point I thought to myself Robert you've hit rock bottom. (p.4)

Summary of section

In this section I presented a group analysis of reflections the experience of low secure care. Three master themes emerged; 'power', 'the self' and 'making sense of the LSU experience', each with several super-ordinate themes and supporting sub-themes. In the following section, I present the group themes for the post discharge experience.

Master theme: Relationships contd.								
Super-ordinate themes	Sub themes	Participants						Number of participants for whom theme is present
		Ben	Robert	Aaron	Stefan	Paul	Ned	
Relationships with family/friends	Loss of Relationships		X	X				2
	Reconnecting with key systems		X	X		X		3
Master theme: Making sense of transitions								
Settling in	Discharge as the holy grail	X			X	X		3
	Reconnecting with a life on hold	X	X	X	X	X	X	6
	Living with a sense of impermanence	X	X		X			3
	Belonging			X		X	X	3
	Working to own timescales	X	X					2
The next chapter	Aspiring to succeed		X	X	X	X	X	5
	New interests	X	X	X				3
	A fresh start		X			X		2

Power

The master theme of power from the previous group analysis re-emerged post discharge. Two super-ordinate themes emerged under 'power,' 'remaining under the power of the system' and 'self-control.'

Remaining under the power of the system

All participants spoke to varying degrees about continuing to feel controlled and overpowered by the forensic system.

Feeling controlled by professionals

All participants except Paul spoke about continuing to feel controlled by professionals. For Aaron, control was experienced in relation to needing permission. For example, he spoke about needing permission from staff at his supported accommodation to do the things that he wanted, '*I wanted a canary so they would let me have one*' (p.10). Ben and Ned also spoke about aspects of their life where professionals continued to have power over them. Ben felt that professionals continued to place expectations on him and that he had to comply even if they were disparate with his own goals and expectations.

They just didn't want me to get to the point where I was withdrawing from society... when I might see Dr X (psychiatrist) they always ask if I still see my friends, go out that sort of thing (p.8; 14)

When asked about his own viewpoint Ben acknowledged '*the social side of it I could take or leave*' (p.14). This highlights the discord between staff and participant perspectives. Ned also experienced professionals as holding a great deal of power over him, which he expressed in relation to the on-going expectation of compliance with regular depot injections.

X (his worker) sees me like as a power thing you know what I mean he's like Dennis the menace it's like that song from Busted do you know that "this is what I go to school for" this is what I go to work for and X is stood there with the needle' (sings "this is what I go to work for" and laughs. p.12)

Ned talked about his worker's power in a humorous way; however, this passage still emphasises the power differential between him and his worker and the on-going expectation that he complies with rules and procedures.

Feeling monitored

Ben, Robert, Stefan and Ned spoke specifically about feeling monitored by staff. Stefan spoke about having his privacy invaded by staff and having to prove himself to them.

X (his worker) sort of like she sort of like checks me medication when she comes on visits and she's come without sort of like telling me so she's actually checked sort of like my medication. (p.6)

Robert also spoke about having to demonstrate his compliance without warning as he 'can be subject to a blood test at any time' (p.7). Stefan spoke of how challenging it was convincing the professionals of his compliance with procedure.

Just sort of like err being convincing and convincing them I was actually taking me medication cos like a couple of times in the outpatients when I see the psychiatrist she says you're not taking your medication and I am so it's just a matter of convincing them I'm actually taking them and not just throwing them away. (p.5)

For Stefan, he also felt that the standards by which he was monitored were both unhelpful and inaccurate.

Some of the symptoms that sort of like of me being mentally unwell are pretty inaccurate cos like err I weigh about 10 stone which is fine sort of like with me sort of like height but err I've been told by psychiatrists that I'm underweight and I have an eating disorder and sort of like I mean it's just not true. (p.13)

Robert was due to be discharged from the community team to an assertive outreach team and he spoke of his excitement at having the level of monitoring reduced once this transfer took place.

I won't have this spectre I suppose by that time of the forensic services breathing over my shoulder with it being the assertive outreach team who are more community based. (p.14)

Feeling the need for external input

Despite speaking in broadly negative terms about professionals holding the power, three participants also spoke about the importance of external input. Robert for example talked about continuing to feel out of control and how professionals realised this and increased their input.

I think Dr X (psychiatrist) himself had realised that I mean I'll use the word I was more special, I needed a bit more taking care of and so from the once a week I used to see X and X (his workers) he's made it twice a week just to make sure I'm ok. (p.6)

Robert also spoke of his family as an extension of his professional support and how reliant he was on them to monitor his mental state.

I used to hide my thoughts but now I suppose the important thing is like talking through at an early stage so that if anything erm other individuals key to my life know my various triggers and signs so they say Robert have you got such and such or are you ok, ask soul searching questions which should hopefully alert me to the fact that something's wrong. (p.10)

Aaron and Paul also spoke about relying on other people to support them both practically and emotionally. For Paul he identified how *'my Mum will help me with my shopping'* (p.12) highlighting this on-going dependence, which was also identified by Aaron.

If you are upset or poorly you just ask staff and they will try to help you. (p.10)

On Mondays I go to the gym with X (another service user) staff take us... go out with staff to bird shows or car boot sales on Sundays. (Aaron, p.11)

Self Control

While all participants spoke on some level about feeling controlled, they also spoke of regaining control since discharge. Self-control appeared in various forms including taking charge, feeling freer and noticing a shift in the power imbalance between themselves and professionals.

Taking charge

All participants spoke about aspects of their experience that signified to them that they were taking charge of their lives. For most, taking charge related to making their own decisions and being able to *'do the things I want'* (Aaron, p.10) without needing permission.

I could do what I wanted to do...there's many things I can do things like shopping, I can see my family see my niece my cousins all sorts.(Paul, p.6; 7)

If I wanted to go out I could go out I could go where I wanted do what I wanted without having to ask. (Ben, p.7)

Feeling Free

Similar to taking charge over their lives all participants also described feeling a sense of freedom since discharge.

The first thing I did when I came here when I got referred probably was then I bought a McDonalds and I err I felt free just to sit there and eat that food without anybody telling me what to do. (Paul, p.5)

Paul embraced this sense of liberation in relation to his future plans to attend a festival.

Next year I can stay 'til about 3 or 4 o'clock in the morning... I'll have to take about 200 pound out I'm gonna get myself drunk quite drunk... I'm gonna get myself drunk til I throw up. (p.3)

Both Robert and Ned also described a sense of freedom. Robert described the freedom to come and go as he pleased in contrast to the prison like secure environment described in the previous analysis.

The freedom as well you know you're not behind I want to say invisible bars, you don't have to account to anybody say where you're going or how long you're going to be. (p.5)

For Ned, he made sense of freedom as having the opportunity to take his time rather than adhering to the rigid timescales and procedures experienced on the unit.

Not having 15 minutes to smoke a fag you can just (puffs quickly) you know what I mean I could relax and take my time. (p.9)

Finally, increased freedom was associated with enhanced wellbeing. Stefan acknowledged 'I had more freedom obviously and err I sort of started enjoying myself more' (p.5) and Ben also identified how he could 'enjoy me time do the things I wanted to do' (p.6). Ned also acknowledged the value he placed on freedom.

It's your liberty innit at the end of the day it's just your liberty it's how you are you enjoy your freedom I do enjoy my freedom do you know what I mean? (p.10)

Feeling a shift in the power dynamics

Four participants talked about their relationships with professionals as having changed since discharge. These changes seemed to reflect a change in the perceived power dynamics between themselves and their workers; for example, Ned, Robert and Aaron spoke about their workers as friends as opposed to carers.

To be honest I'm come to regard them as friends (laughs) and I know they're only doing their job and everything but you know they've been X has been a big help and so's X (workers) and it's erm it's like the company that I can have and I like it sometimes during in the week it's something to look forward to. (Robert, p.7)

He has a laugh with you and that lot he'll take you over to pick a college course for you he'll take you out for a meal and that anything. (Ned, p.13)

You can have fun with them, have a joke with them and that, can have a laugh. (Aaron, p.7)

Ben also seemed to have regained power by expressing his own viewpoint and negotiating with his care team.

My dealings with the team has been really good we've had no problems with them and they've not been invasive at all, they've not really dictated to me exactly what I need to do cos I'm always a straight up kind of guy I've been straight with them and they've been straight with me. (p.6)

The Self

When reflecting on the LSU experience all participants talked about ways in which they felt changed by their experiences, both in terms of an improved but also a fragmented identity; for example, having to behave out of character and feeling misjudged/misunderstood. Similar themes around a changed and fragmented identity re-emerged post discharge.

A changed identity

Robert, Stefan, Paul and Ned all spoke about being changed by their experiences either in terms of their own sense of self or in the way that others saw them. While some changes were understood as positive, others were experienced as unpleasant or unwanted.

An improved sense of self

Robert, Paul and Ned all talked about ways in which they felt improved because of their experiences. Paul and Ned felt improved in terms of their physical and mental health. Paul described his mental health as a '*hell of a lot better*' since discharge (p.8). Similarly, Ned spoke about how his recovery had been a steady process but how he felt he had improved over time.

I feel a lot better from what I did (p.14)

Can you say anything else about that? (p.14)

When I was first discharged I was still poorly you know what I mean I weren't 100% but now I feel a lot better... basically I feel normal I feel normal again. (p.14)

Loss of status

Despite identifying areas of the self that had been improved, both Ned and Robert also spoke of experiences that signified a loss of status or life role. Robert spoke about aspects of his role in the family as being detrimentally affected by his experiences, particularly his role in caring for his son, his father and his partner.

At the moment I'm still waiting for my car to be released ...my father lives about two minutes away in the car and I normally visit him on a daily basis, which is something I can't really do now you know it's a lot harder to do. (p.8)

I wait for my girlfriend to come home from work. Before I use to drop her but she's taken to walking now (p.9)

Robert also spoke of his efforts to try and reconnect with these lost roles as a key part of reintegrating into the community.

What does reintegration mean to you? (p.12)

My son he plays football for the local football team and every time there's a match I'll go and support him and it's going up there and mingling with all the parents and the coaches from the football team. (p.12)

A self changed in the eyes of others

Robert, Ben, Ned and Stefan all referred to how others saw them differently as a result of their experiences. In the following passage, Stefan speaks about how even his friends see him differently.

I've got a friend called X and sort of like when I sort of like went to see him and he said sort of like as long as you don't do anything funny sort of like cos as if I was going to sort of like go psychotic stab him to death so I suppose it's sort of like made the people I've known for sort of like a long time sort of like really worried about sort of like what I'm sort of like like now. (p.10)

Ned similarly spoke about people latching on to his diagnosis and using this to make sense of him as a person.

Because other people know I've been ill once it starts with schiz they automatically assume schizophrenia so they assume I'm schizophrenic you know what I mean it does display a little bit of prejudice for people. (p.16)

Ned made sense of other people's behaviour as a common reaction and implied that he had little control over this.

They don't say it basically oh it's just talk behind his back a bit and blah blah so but you just get that everywhere you go. (p.16)

For Ned, these reactions had resulted in him going out less so that instead he would '*just stay in and listen to music*' (p.17). This seemed disparate with how Ned wished to live as he described himself as someone who '*likes to be part of the crowd*' (p.20) implying a potential loss for him as a result of how others saw him. Other participants described how they felt their experiences had resulted in people pitying and patronising them at times.

If I'm in one of my lower moods and stuff it might be like people are just they're cos they're there and taking pity and whatever. (Ben, p.14)

I saw people there who I hasn't seen for a number of years and these individual people who I'd known as a child growing up and through middle aged and even when I used to work in London and I yet hadn't seen them in years and years and years and yet when they saw me it was as if they had not seen me since only yesterday, I thought to myself is it patronising or what? Because they knew I'd had problem mental health problems like years ago and they knew that I'd been in and out of hospital since that time and yet all the time they were probably coming up to X (his home town) they didn't give me a call or visit me or anything. (Robert, p.11)

Interestingly, no participants spoke of feeling emotionally affected or of internalising these attitudes. For example, Ned described having '*broad shoulders*' and how they could '*go to hell*' (p.16) while Ben described himself as '*indifferent*' to stigmatising attitudes (p.13).

A fragmented identity

The fragmented identity is a theme which describes ways in which participants felt a divided identity; for example when expected to behave incongruously as in the subtheme below. While this theme emerged when reflecting on the LSU experience, it remained prevalent for several participants after discharge.

Having to behave out of character

Ben and Stefan both spoke of having to behave incongruously. Stefan, who professed to be a '*quiet and thoughtful*' person (p.9), spoke of how he has had to become more open about his experiences and to involve himself in social activities as part of his care plan.

Cos I'm a bit of a loner I don't have to sort of like justify meself to other people but since I've been in X (LSU) I've had to actually sort of like articulate what sort of like is happening with sort of like life and what sort of like state of mind I'm in. (p.9)

Stefan also spoke about the expectation placed on him to attend organised activities and how this diverged from his sense of self as a 'loner.'

Well another concern was me not sort of like interacting with people sort of like isolating myself so I've been sort of like going to sort of like leisure groups cos if you sort of like miss appointments they'd start to think there was something wrong.(p.6)

Ben, who similarly described himself as someone who is 'not much of a people person' (p.1) also spoke of having to behave out of character by interacting more with others.

They just didn't want me to get to the point where I was withdrawing from society actually what's the word I'm looking for (laughs) isolating meself cos I'm quite prone to that they just didn't want me to get to that point so even though I didn't have to be doing pathways and stuff they wanted me to do them actually do something and even when I don't go to pathways I always go for a walk every day. (p.8)

Relationships

All participants referred to relationships both with their close family and friends but also with the professionals supporting them in the community. While many of these relationships were experienced positively, for some, more turbulent relationships were described.

Relationships with professionals

All participants spoke at length during the interviews about their relationships with their care teams.

Feeling supported

All participants valued the support they received from their support team, particularly their community workers. Robert spoke about how '*the levels of support I have received have been exceptional*' (p.10) while Stefan felt that things were '*really well organised... it was sort of like planned sort of like just the meetings the care plan meetings and that everything was arranged*' (p.4). Ned also spoke of how respectfully he felt he had been treated by his most recent care and how this had changed his opinion of professionals.

I've had to change me doctors cos I threatened to kill me first doctor so I've been given another one. He's alright, he treats me fair (p.4).

Relationships with family and friends

Three participants also spoke about the impact of their experiences on their personal relationships.

Loss of relationships

Two participants described losses in relationships as a result of their inpatient admission. Aaron in particular identified losing touch with valued friends.

I've got this friend who I've had for years but I've lost contact with him since I come here cos I lost contact with him. (p.14)

Stefan spoke of how the most important relationships in his life were those people who were 'paid to take care of you' (p.8) rather than people from friends or family.

Reconnecting with key systems

Robert, Aaron and Paul spoke about the time since discharge as presenting a valued opportunity to reengage with key systems, both family and friends. Aaron and Paul spoke about valuing the opportunity to spend more time with their families and to be in closer proximity to them since discharge.

My family that's my number one priority I'm just glad to have my family and I can go and see them any time I want. (Paul, p.8)

For Aaron, reconnecting with family was central to his sense of wellbeing.

What are your biggest hopes? (p.13)
To have a good life really...seeing my family and erm doing things with them and going out with them and stuff like that. (p.13)

Making sense of transitions

This master theme captures the different transitional experiences participants described and the ways in which they sought to understand the process of community adjustment.

Settling in

All participants spoke about matters relating to 'settling in' to their lives in the community. While many acknowledged positive feelings and a sense of relief at being discharged others identified difficulties settling in. Some also spoke about transitions as a personal journey and one they were planning to take their time over.

Discharge as the Holy Grail

Three participants spoke of relief at being discharged. This relief seemed to be a product of reaching a desired point in life, which felt to me to resemble 'finding the Holy Grail' as discharge from low secure care seemed to be the ultimate goal attainment. Paul for example spoke repeatedly about his happiness at being discharged, even one year on.

How would you describe yourself as a person? (p.10)

Just chilled out and happy to be out of X (unit). (p.10)

Paul gave the same response '*happy to be out*' to questions throughout the interview including questions about his priorities and future aspirations, highlighting discharge as a major goal attained for him. Similarly, Stefan spoke about how his main goal of discharge was simply '*to be discharged,*' (p.3) and he repeatedly told me he was '*just happy to be out*' at points throughout the interview.

Reconnecting with a life on hold

In addition to relief, all participants also spoke about being able to reconnect with a life that they felt was on hold on the units (see previous group analysis). For many, reconnecting with a life on hold involved reengaging with previously valued pursuits.

I wanted to do bowls ... they used to take me to a place in X (city) that did OT. (Aaron, p.9)

I want to buy a fishing rod and start going out more yeah go piking... I enjoy piking I used to do it before I went in hospital. (Ned, p.23)

I'm a member of the local tenants federation and it's going getting involved back again with the meetings...the first one I went to it was quite promising but I'd like to get back and get more involved with that. (Robert, p.12)

Stefan and Paul spoke more literally about reconnecting with their lives since discharge.

I started enjoying myself more cos I didn't keep having to come back to the X (unit).

(Stefan, p.5)

I got me life back. (Paul, p.4)

Living with a sense of impermanence

Despite feeling able to reconnect with a life that had been on hold, three participants: Ben, Robert and Stefan spoke about the sense of uncertainty and impermanence that accompanied their life since discharge. Ben and Stefan for example both spoke about avoiding planning for the future for fear that readmission would prevent them from implementing plans.

I hope I've sort of like got to the position where I can sort of like make plans cos at the moment I'm not sort of like making plans to sort of like do anything. Trivial sort of things sort of like getting a pet sort of like... but it's err I can't really do that just in case I don't sort of like you know I get taken in to well hospital again. (Stefan, p.12)

I don't really look too much into the future it's a case of like I don't really plan ahead I'm more of a like take things as they go at the minute until like certain situations are

out the way and over and done with cos I'm still sectioned out in the community so I don't really plan past that at the minute. (Ben, p.15)

Stefan repeatedly highlighted readmission as one of his major worries.

Just sort of like me being dragged back into the X (LSU) again ...it sort of like the police always arrested me if they'd actually have told me they wanted me back in X I would have probably just come but they always send round the police to sort of like kick in your door. (p.4)

Belonging

A key theme under 'settling in' was the sense of belonging that Aaron, Ned and Paul described. For Aaron it took time for him to feel a sense of belonging in his new environment and he described feeling almost homeless at the point of discharge.

I wanted to go back home but I'd lost me house and my sister couldn't cos she hadn't got room for us. (p.5)

However, Aaron described how over the time he had begun to feel more at home.

I just stayed in my room most of the time when I come here ... still do a bit now but I come out, I come down the stairs for a couple of times.(p.6)

This sense of belonging seemed to have developed as a consequence of him building positive relationships with others.

I've made friends with a person called X and X me and X just tickle each other and chase each other around the room and that. (p.7)

The sense of belonging felt by Aaron over time contrasted with Ben's experience. Ben talked about himself as an 'outsider' in the community (p.14), and he questioned the extent to which his contact with forensic services was responsible for creating his 'outsider' status.

I don't always analyse it too much as to whether I think I'm an outsider as to like my particular interests or just because of the way I am or who I am ... like maybe that sometimes I think it might be because of who I am and the way I am because I've been in this place and stuff like that and the things I've done in my life kind of separates me from them. (p.14)

For Ned and Paul, despite feeling positive about their discharge they struggled to disaffiliate with the units. Ned in particular seemed to miss the sense of belonging, describing how he 'misses it' in particular 'the lads' he knew there (p.8). Paul also spoke about how the LSU experience had remained with him; however, rather than missing it he felt almost haunted by his time there.

It's like my Mum goes you're not in hospital now Paul and I say oh I forgot cos I spent that long in hospital it's like it sticks to your mind like glue or something.(p.6)

Working to own timescales

Both Robert and Ben spoke throughout their interviews about transitions as very personal and how they were focused on meeting individual targets at their own pace. Robert for example self-imposed short milestones to aim for such as the interview date and later, his upcoming 50th birthday by identifying that '*all my actions are geared towards that time*' (p.15). Ben talked about taking his time and remaining aware of his own limits when working towards goals and integrating into the community.

I struggle a lot in social situations and actually having a lot of pressure on me I don't want to rush into those situations where I might have a bit of a breakdown I honestly believe that if I just walked into work tomorrow I wouldn't be able to cope I'd just jelly out. (p.10)

Despite this, he still tended to make sense of the world as somewhere where there was a 'proper' way of being that he needed to aim towards.

I obviously do you know like obviously I do think actually it's important to actually get back into the proper way things work you know actually getting back into real routines like work or education, actually getting reintegrated into it that way. (p.14)

This sense of becoming ordinary reflects language used by Ned who described himself as feeling '*normal*' since being discharged and how he experienced this positively as evidenced by his statement '*I enjoy it*' in relation to feeling '*normal.*' (p.14)

A new life chapter

While settling in was a recurring theme for all participants, many also spoke of entering or aspiring towards a new phase in life since leaving the units. This theme name developed from a powerful statement by Robert whose closing remarks in the interview were as follows:

I'd like to see it (discharge) as final that I never have to return there again like it's a door closing behind me never to be reopened. (p.16)

Aspiring to succeed

Five participants talked about aspirations for the future, in particular aspirations for success or status. Ned for example spoke about his desire for success.

*When you think about your future what are your biggest hopes for it? (p.20)
Just to succeed you know what I mean? Make something of myself yeah go places you know. (p.20)*

Paul also talked about his desire to succeed and how he had begun working towards this.

Go to college again, a proper course... get err get err a qualification (coughs) get a qualification maybe... knowing I've achieved something. (p.11)

New Interests

Three participants spoke on a less ambitious scale about valuing the opportunity to pursue new interests. Aaron spoke about his enjoyment of keeping birds, *'I could take her to bird shows you know win trophies and so on'* (p.10) and what a valuable opportunity this was for his life. Robert also spoke about how he used his most recent discharge as an opportunity to embark on his *'octagonal aquarium'* (p.7) that he had intended to pursue for many years.

I'd always said to myself I had the table for the aquarium built about 10 years ago and it's not through laziness but in the past I've never been in a position to actually realise the project and this time I said to myself ok then you're gonna build this tank. (p.7)

A fresh start

Paul and Ben spoke about their discharge as a 'fresh start' in their lives. Robert for example made sense of discharge as an opportunity to start afresh by sorting things out.

I'm still in the stage where I've got loads of scrap paper around, letters, mail you know spam mail and all that stuff and I keep saying to myself I need to sit down and get through some of this and say what you don't want just shred and get rid of it... I'm gonna have a major overhaul hopefully of my wardrobe and ... just keep what I want to keep down to the bare essentials. (p.9)

Paul spoke about a fresh start in more conceptual terms when speaking of how his new home in the community was a second chance for him.

They always give people second chances... X (his new accommodation) like they give you a second chance. (p.5)

Summary of chapter

Reflecting on the LSU experience

When reflecting on the LSU experience, master themes emerged around 'power', 'the self' and 'making sense of the LSU experience'. Each of these are summarised below.

Power

- Participants felt controlled and restricted on the units; however, there were elements of seeking to take control.
- In some circumstances powerlessness was a functional stance adopted to achieve desired outcomes such as accelerating discharge from the units as shown in the theme 'playing the game.'

The Self

- A strong sense of a lost identity emerged. Some felt their lives were on hold and that their individuality had been stripped away during their admission.
- A fragmented identity was experienced by participants having to behave out of character in order to adhere to unit policy and staff expectations.
- An improved sense of self also emerged for some in terms of becoming wiser and more experienced patients over time, which reduced the sense of disorientation previously experienced on the units.

Making sense of the LSU experience

- All participants understood the purpose of the LSU as either treatment or punishment or a combination of both.
- Despite having some theories about the purpose of admission, most questioned how helpful the experience was with many alluding to the experience as meaningless.
- In addition to feeling meaningless, many also felt that the LSU environment was unhelpful or detrimental to recovery.

The post discharge experience

Many similar themes emerged concerning experience and sense making since discharge. Four master themes emerged: 'Power,' 'the self,' 'relationships' and 'making sense of transitions.'

Power

- All but one participant continued to feel controlled and monitored post discharge.
- Despite this, many also spoke of asserting their own authority and noticing a shift in the power dynamics between themselves and professionals.

The Self

- Themes around a lost and fragmented identity also resurfaced post discharge with some feeling they had lost their status/role in life.
- Some felt that other people saw them differently and that even old friends had become suspicious of them or pitying towards them as a result of their experiences.
- More positive changes were also reported with many feeling they had moved closer to recovery since discharge while others made sense of their experiences as something that made them wiser and more knowledgeable about the world.

Relationships

- All participants cited a high level of support and satisfaction with their care, which differed from reflections on the LSU experience evaluations of support were less complimentary.
- Participants also valued reconnecting with close relationships, although this was tainted for some by losing relationships as a result of their experiences.

Making sense of transitions

- Discharge was associated with a strong sense of relief and for many represented the achievement of an ultimate life goal.
- Transitions were experienced as personal and as something that should be taken at an individual pace although this was incongruous with the pressure some felt to seek 'normality' and fit in with dominant social norms.
- Some participants felt a gradually developing sense of belonging in the community. However, others missed the sense of community experienced on the units and for one participant in particular belonging was far from the experience he felt; rather, he saw himself as an outsider in his community.
- Finally, a continued feeling of impermanence and uncertainty remained present for some, which impacted on their ability to settle and to plan for the future. Despite this, ambitions for the future and for starting a new life chapter were common to all participants.

In the next chapter the results are discussed in the context of current literature and existing theory. Clinical applications are also discussed in addition to limitations and further directions.

Discussion

Introduction to the chapter

This study sought to answer the following questions: What are the experiences of community adjustment for service users recently discharged from a low secure forensic unit and how do service users make sense of these experiences? In the previous chapter I presented and described the main findings. In this chapter I first critique the study. I then discuss the findings in the context of existing literature, theory, and in the context of my own reflections on the process in order to adhere to the more interpretative component of IPA. Finally, clinical applications and further directions are discussed.

Critique

Critique of the sample

In qualitative research, where the intention is to study a particular group of people, a purposive sampling strategy is used to ensure that the individuals within a sample share particular characteristics. It is not necessary, however, for all participants to share all characteristics. Indeed, Wilmot (2005) argues

'a phenomenon need only appear once in the sample. With a purposive non-random sample the number of people interviewed is less important than the criteria used to select them. The characteristics of individuals are used as the basis of selection, most often chosen to reflect the diversity and breadth of the sample population' (p.3).

Wilmot (2005) also argues that for purposive sampling, *'where resource and time constraints are in place then a more constrained sampling strategy can be devised' (p.3)*. While I was unable to recruit purposively, my sample was constrained in a number of highly significant ways. These constraints included the routes by which I could access participants, the number of LSUs available to me to recruit from, the stringency of my inclusion criteria and the time available to me to conduct my fieldwork. This meant that I had to recruit within these constraints, limiting the possible pool of participants. Despite this, in keeping with Wilmot's emphasis on the importance of considering the criteria used to select the sample, I ensured that through my method of access I sought to understand and theorise about the composition of my sample, thereby engaging with the IPA process from the outset. For example, my route of access was one where I interrogated professionals working with service users through the adjustment phase from low secure care to the community and, these professionals acted as gatekeepers to my sample. By engaging with and theorising about these routes of access, this, along with the background I elicited of my sample (see pen portraits) allowed me to situate and use this knowledge of my sample throughout data analysis.

By recruiting a diverse sample, this also enabled me to elicit experiences concerning the range of adjustment experiences and enabled me to conduct cross-case comparison and draw together similarities, but also differences for my participant group. This was vital given the focus of my research on offering an initial insight into the adjustment experience.

Critique of the interviewing method

Semi-structured interviews were used for data collection because of the exploratory nature of the research. Using semi-structured interviews I was able to ask some general questions that had been shaped through my knowledge of existing literature, potentially relevant theories of identity, change and transition and also through my own professional practice and on-going discussions with professionals in the field. However, using semi-structured interviews also enabled me to retain flexibility, allowing the interview to be shaped by aspects of participants' own experiences. In turn I was then able to refine some of the questions used in subsequent interviews on the basis of the emerging findings in order to check how far aspects of experience were shared by other participants and as a means of developing an in-depth understanding of the adjustment experience.

The alternative to semi-structured interviews was focus groups or unstructured interviews. However, as outlined in the pen portraits the high levels of anxiety experienced by several participants would likely have increased in a focus group setting or in a setting where they were expected to entirely own the process (as in unstructured interviews). By contrast, having a few questions to initiate the conversation seemed useful in reducing anxiety whilst also giving weight to participants' own experiences. This reflects previous findings from the literature about the relative preference of semi-structured interviews over other data collection methods (Carrick et al. 2001).

Aside from the interview method itself, the times in which I conducted the interviews also warrant consideration. Constraints on the time I had to conduct my fieldwork (identified above) also meant that I was only able to interview my sample at one time point. While through the use of both prospective and retrospective interview questioning I was able to elicit narratives of transition and change, offering temporally sensitive accounts of transition, there were some occasions when participants seemed to struggle to recall precisely how they were feeling at different times during their adjustment journeys. By interviewing participants at more than one time point this could have allowed me to capture more the emotion being experienced at the time rather than relying on recall.

Reflections on my role in the interviews

Overall I feel I managed to maintain flexibility in my interviewing style by both asking questions from my interview schedule but also deviating from this in order to follow up on participants' narratives. I also feel that overall I managed to ask open rather than closed or leading questions in order to facilitate the conversation and encourage participants to give their own accounts of experience. However, for two of the interviews when participants volunteered less information and gave very short answers I noticed that I asked a lot more questions, making the interview feel more structured. At times as a novice researcher I also noticed that I interrupted too quickly during pauses, which may have stifled accounts, particularly when it is likely that some of the more difficult aspects of experience will have been those that participants needed to take their time over explaining. As the interviews progressed I feel I became more confident, which was demonstrated in me allowing longer pauses and becoming even less reliant on my interview schedule. I feel that if I were to repeat the study it is likely that the quality of the interviews would be improved by my developing skills as an interviewer.

My role as a Trainee Clinical Psychologist may have also impacted on the experiences elicited in the interviews. All participants were aware of my role and so despite presenting myself as a researcher and positioning myself between practitioner/ researcher and consumer of services (Katz, 1994) they may still have held some concerns about sharing aspects of their experience with me. For example, in Stefan's case, he alluded to the beneficial role of psychologists in his recovery. While this may represent Stefan's real experience, it is also possible that his awareness of my role prompted him to offer this particular aspect of his experience as a means of building rapport.

Critique of the data analysis

Concerning data analysis, IPA was chosen because of its use in exploring experience and sense making, which matched the research questions under study. This approach was also used because of the focus on eliciting personal experience as opposed to relying on preordained concepts, which would have been the case if quantitative methods had been employed. There are however costs to using this method of analysis. IPA is by its very nature a subjective approach as the double hermeneutic principle means that much of the analysis is concerned with the researcher's own interpretations of experience (Smith et al. 2009) which has raised questions about the credibility of IPA.

To maximise credibility of the findings I employed several quality checks. First, the independent audit identified in my methods chapter was used to ensure that an independent

reviewer could understand the process by which I came to the final themes. A fellow doctoral student also using IPA reviewed a percentage of one of my transcripts and confirmed that she was able to logically follow the development of my themes and could identify no missed themes. Another part of the independent audit was to ensure I had a comprehensive data trail that would hypothetically permit someone to trace the development of the final themes right back to the earliest stages of the study (Yin, 1989; Rodgers & Cowles, 1993). Finally, I also used a quality check outlined by Yardley (2000) who acknowledged the importance of transparency and coherence in qualitative research to enable the reader to make sense of how the final results emerged. To adhere to the principle of transparency I have written in the first person throughout the study and have included regular summaries and reflective paragraphs enabling the reader to understand how the findings may have been influenced by biases or assumptions. Furthermore, through the use of pen portraits and a comprehensive literature review I have sought to contextualise the data fully. Both of these strategies should help the reader to make sense of how the final themes have emerged and should also be able to understand why I have interpreted the data in the way I have.

Reflections on my role in data analysis

As identified above, one of the potential limitations of IPA is that it is too subjective. I was aware of this from the outset and as a result may at times have moved too far in the other direction, becoming too objective and descriptive rather than interpretative. This trap is common amongst novice IPA researchers (Smith et al. 2009). To evaluate this I used a further quality check of looking back from my final group themes to my initial coding of the data. On doing this I could identify that over time I had moved to deeper levels of interpretation as my final group themes were more abstract than the highly descriptive initial coding. This satisfied me that I had brought enough of my own interpretation into the process. However, if I was to undertake future IPA projects then my developing experience and confidence as a researcher may lead me to take my interpretations further.

I chose to present my analysis in two separate sections, 'reflecting on the LSU experience' and 'the post discharge experience.' This presentation style was selected because I felt it was the optimal way of demonstrating how the LSU experience may have shaped community adjustment. While I feel that this was the optimal method of presenting the data, there are shortcomings with this organisation. As already identified, participants lived with a great deal of uncertainty about remaining in the community and for many; the transition from LSU to community residence was not linear but circular. Presenting the data in the way I have may not have allowed this circularity of experience to be fully appreciated. Furthermore, in some

passages it was difficult to separate experience into distinct categories as the experience was more fluid so the distinction in these instances was more arbitrary. In future research, this limitation could be addressed by revising the research questions asked in the present study to ask 'how does the LSU experience shape community adjustment?' An overall group analysis pertaining specifically to this question could then be presented.

Discussion of the findings in the context of existing literature and theory

In this section I discuss the findings of the present study in the context of existing literature and in the contexts of theories of social identity (namely social role theory, labelling theory and social identity theory), change and transition (including self-efficacy, the theory of planned behaviour and the transition cycle). Each of these theories were outlined in the introduction as potentially pertinent to understanding the adjustment experience, therefore they will not be reiterated here. As identified at the start of the results chapter, as I progressed through the analysis it became clear that the LSU experience was fundamental in shaping participants' post discharge experiences and that it is vital therefore to consider adjustment in the context of experience on the units. I have incorporated this into the discussion by embedding relevant findings from participants' reflections of low secure care into discussions around the findings post discharge in a way that permits an understanding of how prior experience shapes subsequent experience.

Power

Research previously conducted in long-stay institutions has consistently highlighted the perceived power imbalance between inpatients and staff (Goffman, 1961.) In recent years, research from general psychiatric facilities (Hughes, Hayward, & Finlay, 2009; Hardcastle, Kennard, Grandison, & Fagin, 2007; Johansson & Lundman, 2002) and secure facilities (Wilkinson, 2008; Baker, 2003) have continued to highlight how disempowerment is central to the inpatient role and therefore to the inpatient identity (given the outlined link between social roles and identity according to social role theory, Sarbin & Allen, 1968; Sarbin & Scheibe, 1983). For example, Johansson and Lundman (2002) explored the experience of involuntary inpatient care, finding themes around a loss of autonomy on the wards (Johansson & Lundman, 2002). The sense of lacking control has therefore been deemed central to the 'inpatient role' that service users are granted on admission to inpatient care. This has significant implications for people moving out of inpatient facilities in terms of identifying possibilities for disengagement from the inpatient role in order to reconnect with previously valued social roles so as to reconnect with a preferred social identity and adjust to community living.

There is ambivalence in the existing literature concerning the extent to which people are able to disengage from the disempowered inpatient role and regain autonomy on discharge from inpatient facilities. Some research has, for example, shown that even service users living in the community feel overpowered in their relationships with professionals (Nelson, Lord, & Ochocka, 2001) suggesting a loss of autonomy in community as well as inpatient settings. In addition, a recent study examining discharge from a medium secure unit found that participants continued to feel restricted post discharge (Humphreys, Riordan, & Smith, 2002). However, this can be contrasted with a number of studies from the general psychiatric literature, which have found a relationship between discharge and regaining autonomy (e.g. Forchuk et al. 1998; Johnson & Montgomery, 1999; Pinfold, 2000). For example, Pinfold (2000) interviewed 25 previously hospitalised service users about their experience of returning to community living. One of the emerging themes around living independently in the community was around freedom, both freedom to move around and freedom of choice. This was in contrast with the inpatient facility which was associated with feeling restricted. Similarly, Forchuk et al. (1998) interviewed service users over a six month period to document the transition from general inpatient care, finding that discharge was associated with a gradual transition from dependence to independence. It seems therefore there is ambivalence as to the extent to which service users are able to regain autonomy, thereby disengaging from the inpatient role on discharge from inpatient care.

Similarly, contradictory findings emerged from the present study, both between and within participant accounts. As reported by Humphreys et al. (2002) all but one participant described a sense of on-going control post discharge. Several participants spoke of feeling monitored and having to demonstrate their compliance with medication and treatment plans. Others spoke of continuing to need permission to do things as opposed to owning their own decisions, representing an on-going loss of autonomy. The word 'remaining' was used as this highlights how the sense of feeling controlled and overpowered for many was a continuation of how they viewed their time on the units. The sense of needing permission, in particular, seemed to persist from the LSU experience where many felt they had little ownership of their choices and were reliant on professionals. These findings imply that the powerless inpatient role does not naturally dissipate on discharge but is instead an on-going experience.

However, despite feeling controlled, all participants in the present study also spoke of regaining self-control since discharge representing a divergence from the LSU experience. Regaining self-control was experienced by participants as making their own choices without

needing permission. This clearly symbolised a shift from the units where they spoke of avoiding acting in certain ways and of having to 'play the game' for fear of retribution.

Alongside taking charge of their lives, further evidence of participants regaining autonomy stemmed from the apparent shift in power dynamics between them and their workers. Participants recalled experiencing professionals on the units as strict with some feeling almost fearful of staff; however, post discharge professionals were experienced as people whose company was valued and who were understood as friends rather than carers. However, it is notable that most of the professional team in the community differed from those on the units. Consequently, the shift in power dynamics may also reflect a genuine difference in staff teams where staff in the community are perhaps more able to present a friendly rather than controlling relationship than those working on the units, so this finding may be at least in part a product of the changed environment.

These findings suggest that, while the transitional experience in some ways permits service users to disengage from the disempowered inpatient role, there is evidence that particular aspects of the this role persist despite the physical act of discharge. This highlights the difficulties experienced when separating from the granted inpatient role. One possible reason for the persistent lack of autonomy reported could reflect the CTO status assigned to five of the six participants. Under a CTO, people receive mandatory treatment in the community and can be recalled to an inpatient facility at any time should it be felt that they are not complying with their treatment programme or in the event that their mental health has deteriorated (Snow & Austin, 2009; Burns & Dawson, 2009). Consequently, the on-going expectation of compliance may be responsible for the carry over in the inpatient role status from an LSU to the community. At the time of writing this to my knowledge there have been no UK studies exploring the lived experience of a CTO. Consequently, the findings of this study offer the first recorded insights into the loss of autonomy and control associated with being subject to a CTO.

A second area of debate to which the findings of this study contribute, concerns the importance participants ascribed to their sense of autonomy in enhancing feelings of wellbeing and thereby facilitating the transition from inpatient to community living. According to Ridgway (2001) and Andresen, Oades, & Caputi (2003), a direct relationship exists between feeling in control, by for example taking responsibility for one's own recovery and the success of the recovery journey, which has been supported by the general mental health literature on community adjustment. For example, several research papers focusing on the experience of

community adjustment in general mental health care have found a relationship between regaining autonomy (particularly an increased sense of liberty) on discharge from an inpatient facility and an increased sense of wellbeing (Pinfold, 2000; Johnson & Montgomery, 1999).

The results of the present study echo existing findings about the relationship between greater autonomy and wellbeing as demonstrated by Ned and Stefan's comments when comparing their experience of community living to their time on the units. Aside from commenting on their enhanced sense of freedom since discharge, both also associated this with enhanced enjoyment of life. This lends support to the relationship between autonomy and wellbeing, underscoring the importance of practitioners working to enhance service users' autonomy as part of the adjustment process.

However, further ambivalence exists here because participants also spoke to varying degrees about needing and welcoming on-going control despite having been discharged, findings which reflect the attitudes of some participants in the study by Humphreys et al. (2002). This may represent a loss of self-efficacy as a product of having autonomy removed on the units resulting in participants no longer feeling competent at certain tasks. Further research would however be needed to confirm the role of self-efficacy here. These findings add to the existing literature by suggesting that the relationship between autonomy and wellbeing is a complex one and that, while enhanced autonomy is instrumental in aiding recovery, it needs to be paced in a way that meets individual need so that it aids rather than undermines the adjustment process.

Identity and self-concept

As outlined in the introduction, one's identity, defined as *'a tool by which individuals or groups categorise themselves'* (Owens, 2006, p. 206) impacts on their overall self-concept, *'how we envisage or perceive ourselves'* (Owens, 2006, P.208) implying the importance of identity is understanding and making valuations of who we are. Identity and the self-concept are subsumed under a more global concept of self and selfhood, which is more of an abstract process, defined as *'an organised and interactive system of thoughts, feelings, identities, and motives that is 1.) born of self reflexivity and language, 2.) people attribute to themselves and 3.) characterise specific human beings'* (Owens, 2006, p.206). As outlined in the introduction, for the purpose of my thesis I am focusing on identity and the self-concept (or sense of self) although I wish for the reader to have an understanding of the broader issues of self and selfhood implicated by discussions of identity and self-concept (see introduction for further discussion of these concepts.)

In the ensuing discussion, two key questions are addressed concerning how the LSU experience impacted on participants' identities and their sense of self and how this in turn influenced the adjustment process.

Reaching an improved sense of self

The first question concerns how well low secure care supported service users to reach an improved sense of self prior to discharge into the community in order to facilitate community adjustment? As outlined in the introduction, one of the main aims of low secure care (and general mental health care) is rehabilitation (Pereira et al. 2006) implying that individuals will make improvements before discharge. Despite this, a large body of literature from general inpatient facilities suggests that service users report the opposite, feeling the inpatient experience negatively impacts on their sense of self and impedes recovery. For example Hughes et al. (2009) interviewed 12 service users involuntarily admitted to an inpatient facility and found that many experienced inpatient care, in particular the medication regimes as more harmful than helpful. Furthermore, research by Gilmartin (1997) exploring the reflections of two previously hospitalised service users about their experiences found that they felt they improved post discharge rather than during their inpatient admission.

A body of research has also shown that hospitalised service users are cut off from valued life roles such as parent, partner or employee (Johnson & Montgomery, 1999; Goffman 1961) which, according to social role theory can be damaging to one's self-concept. Furthermore, participants in the study by Johnson and Montgomery (1999) who were interviewed both pre and post discharge felt they would never be able to reconnect fully with these lost roles, implying a more permanently damaged sense of self as a result of the inpatient experience. The existing literature thereby suggests that rather than helping people to improve prior to discharge in order to maximise the chances of a successful community placement by contrast the reverse seems to occur where they feel harmed by the inpatient experience and only feel able to work towards an improved sense of self and towards recovery post discharge.

A similar reversal of the recovery process was reported by participants in the present study. Several spoke of how they became physically and mentally unwell on the units, either because of medication giving them unpleasant side effects or because the environment felt detrimental to recovery. In turn many felt they only improved both mentally and physically post discharge. Furthermore, similar to the findings from Johnson and Montgomery (1999) several participants also alluded to the loss of valued roles and thereby a loss of identity on the units. For Robert,

the main loss of role was in relation to his family duties as father, partner and son, which he understandably experienced negatively. Under social role theory this suggests that for some, low secure care was experienced as a loss of identity and in turn as detrimental to the self-concept. However, the present findings also somewhat contradict the previous literature as, rather than feeling that valued social roles had been permanently lost, Robert particularly was still focused on reconnecting with them by for example attending his son's football games and associating with other parents, possibly in order to regain with a more valued identity. This discords with the principle of self-efficacy, which would assume that, because of Robert's frequent readmissions his self-efficacy would be reduced in relation to his family roles, which could in turn reduce his pursuit of these roles (Bandura, 1977). However, Robert persisted in trying to reengage in them. This can be explained using both theories of change and identity. The theory of planned behaviour (Ajzen, 1991; 1985) would assume that, because of the strong value Robert placed on his family, this could be sufficient to lead to intention and subsequent action, even if he did feel reduced perceived behavioural control in being able to succeed at the behaviour. Theories of identity, namely social role theory also provide an explanation for these findings as Robert seemed to be trying to disengage from an unwanted inpatient social role that was experienced as damaging to his self-concept to move instead towards a more valued role. Indeed, Robert spoke at length about the value he placed on his family and so this may explain his persistence at reengaging with this role despite previous difficulties in this area.

It is however important to consider the context in which these excessively negative inpatient experiences and beliefs about the unhelpfulness of the units were being discussed. For example, given that many participants in the present study spoke of wanting to improve care for others by participating in the interview, it is likely that the most negative aspects of the inpatient experience were being reported in the interview context rather than those experiences that they felt were protective of their identities or that facilitated recovery. Furthermore, given that many of them spoke consistently of a fear of being returned to the unit (see below for further discussion of this), it is also possible that reflecting on the most negative and detrimental aspects of the experience could have served a motivational function in reinforcing their determination to remain in the community. However, despite this, the findings still quite powerfully show the lasting effect of the inpatient experience of participants' identities and their sense of self and how this in turn influenced the recovery process for them.

While in some ways as highlighted above participants were able to reconnect with lost identities on discharge, in other ways lost this persisted. This was demonstrated in the fragmented identities reported by participants both on the units and in the community. Participants spoke of how on the units they were expected to adhere to procedures and work towards goals that were often incongruent with their own. Robert for example spoke of feeling like *'walking zombies'* on the unit and Ned felt treated *'like a number'* rather than an individual. Unlike other aspects of identity which participants described as improved post discharge, the fragmented identity persisted into the community. For example, two participants who identified themselves as essentially private people spoke of being pressured to participate in social circles to meet the conditions of their discharge. This suggests that the LSU experience resulted in a number of changes to identity that persisted post discharge.

A self changed in the eyes of others

Secondly, my findings also address questions concerning how the LSU experience affects how service users are perceived by others and how this impacts on community adjustment? It is well documented that mental health is widely stigmatised (e.g. Verhaeghe et al. 2007; Goffman, 1963; Falk, 1996). Goffman's labelling theory of social identity (Goffman, 1961; Owens, 2006) posits that stigma arises because people with mental health problems are assigned minority group status by relatively more powerful groups on the basis of their deviance from dominant social norms (termed *'virtual social identity,'* Goffman, 1968) and are attributed stereotypical traits on the basis of this identity. These stereotypical traits include unpredictability and dangerousness (see Lammie et al. 2010 for a recent study identifying how even mental health practitioners continue to ascribe dangerousness and unpredictability to service users in forensic mental health services). Moreover, existing research has also documented the consequence of being labelled and stigmatised as a minority group on community integration in the general mental health field. For example research has shown that service users either avoid going out at all or choose to associate only with other members of the service user group (Gerber et al. 2003; Nikkonen, 1996) in turn avoiding involvement with non-service user groups to avoid being subjected to further discrimination.

Results from the present study echo existing findings as several participants spoke of how others viewed them negatively as a result of their experiences. Stefan for example spoke of how even his friend who had known him predating his contact with services had labelled him as dangerous and unpredictable demonstrating how he had been assigned the virtual social identity of a service user and assigned traits that commonly position members within the *'mentally ill'* group. These traits, however, did not form part of Stefan's self-concept

highlighting how they were assigned rather than actively chosen by him. Furthermore, as in the literature above, participants spoke almost entirely of involvement in service user led activities such as the gym or leisure groups with minimal reference to non-service user led activities. This also suggests that some participants actively sought to affiliate with the service user group rather than wider societal groups, which can be understood by social identity theory (Tajfel & Turner, 1986), which postulates that people seek to involve themselves in groups. Both the assignment of minority group status and the affiliation with service user groups seems to have restricted the scope for adjustment by limiting participants' involvement in wider social networks. In turn, these findings support the idea that for participants in the present study at least, it was not possible to fully disengage from the LSU experience because their identity, at least from the perspective of others remained permanently altered by their experiences.

Relationships

An important question addressed by the current findings is what is the importance of relationships for the adjustment process? This is discussed below in the context of existing literature.

Relationships with Professionals

A number of studies examining the lived experience of service users with mental health difficulties in the community have reported positive experiences of professional relationships (Borg & Kristiansen, 2004; Borg & Davidson, 2008). In turn, the experience of feeling supported by caring professionals has been linked with recovery (Anthony, 2008 and see Zolnierok, 2011 for a review) and other research has found a link between positive professional relationships and successful community adjustment (Forchuk et al. 1998). Concerning forensic mental health specifically, a recent study exploring experiences of low secure care also found that service users felt supported on the units and how this in turn was experienced as positive for recovery (Wilkinson, 2008).

Echoing previous findings, the value of supportive professional relationships was also demonstrated in the present study. Robert for example spoke of feeling supported on the unit and how he understood this as instrumental in accelerating his discharge. However, contrary to the findings of Wilkinson (2008) all participants except Robert felt unsupported on the units with some even feeling deliberately mistreated (refer to Ned's comments about feeling wound up by professionals). This is of concern given the apparent relationship between support and recovery especially given the stated aims of LSUs in promoting recovery prior to discharge (Pereira et al. 2006). In contrast to the LSU experience, all participants alluded to feeling

supported and cared for post discharge as evidenced by Stefan describing the discharge process as *'really well organised'* and Ben classing how his *'dealings with the team have been really good.'*

Personal Relationships

In addition to professional relationships, a body of literature has highlighted the association between personal relationships and successful adjustment. For example, Bradshaw et al. (2007) found that positive interpersonal relationships were strongly valued by service users with family members often acting as pseudo care workers thereby aiding recovery (Bradshaw, Armour, & Roseborough, 2007). Additionally, Davidson, Stayner, Nickou, Styron, Rowe, & Chinman (2001) suggested that friendship is central to successful social inclusion and in turn beneficial to recovery. Despite the emphasised importance of retaining relationships, there is evidence in existing literature that inpatient admissions are associated with a loss of valued relationships (Hughes et al. 2009). Furthermore, ambivalence exists about the extent to which relationships can be developed or reinstated post discharge. For example, while Leff and Trieman (2000) found that in the year following discharge service users social networks increased significantly, research by Johnson and Montgomery (1999) found that several participants continued to cite a lack of confidence in establishing relationships suggesting a lasting impact of the inpatient experience on being able to reconnect with or form relationships.

In line with the findings from the general mental health literature my findings imply that time spent in an LSU resulted in participants feeling disconnected from friends and social networks. Several reasons were given for this; the physical geography of the unit was deemed too far from social networks and the psychological sense of being detained in an LSU was experienced as separate from the life worlds of significant others. This is of concern given the stated importance of retaining relationships in promoting recovery. On discharge, several participants spoke of their desire to reconnect with family and friends and about the value they placed on being able to spend unlimited time with them. Indeed, unlike the ambivalence identified from existing literature, participants in the present study felt able to reconnect with their key relationships suggesting some ability to disengage from and move forwards from the LSU experience. One participant took this further and expressed his belief that his family were instrumental in keeping him well as they were able to monitor him and identify when he was struggling, reflecting the findings of Bradshaw et al. (2007) about family as pseudo care workers. This further strengthens the role of personal relationships in facilitating the recovery process and thereby aiding adjustment.

Making sense of transitions

The present findings were instrumental in understanding what the scope is for 'settling in' to life in the community and moving forwards following discharge from an LSU. Two main points in relation concerning what opportunities participants had to settle in to the community and move forwards in their lives are discussed below.

Belonging

First, data emerged concerning opportunities for belonging in the community following discharge. Studies from the existing literature have highlighted how service users are concerned about belonging in the community on discharge from inpatient care. For example, Mezey et al. (2010) interviewed service users in a medium secure unit about their experiences finding that many identified a strong sense of belonging on the unit and felt concerned about losing this on discharge. However, there are contradictions here because another recent study exploring the social identities of inpatients in a general mental health facility found that some deliberately separated themselves from the service user group suggesting that striving to belong on the wards is not a universal experience (Jackson et al. 2009); rather, they sought to actively separate themselves as a means of protecting their self-concept. Concerning the post discharge experience, a number of studies from the general mental literature have also suggested that discharged service users are psychologically detached from the community rather than experiencing a sense of belonging (Prince & Prince, 2002; Nikkonen, 1996; Gerber et al. 2003; Kearns et al. 1989). However, as highlighted in the introduction, researchers such as Pinfold (2000) have found that this is not always experienced negatively; rather, for some service users they are not striving to fully immerse themselves in the community but instead choose an identity position between inclusion and exclusion. This highlights the complexity of the issue of community and belonging associated with adjustment following discharge from inpatient care.

The findings of the present study echo the complexity outlined in existing research around belonging as there was a great deal of contradiction both within and between participants' accounts concerning both the scope for and desire to belong in the community. Ned for example spoke of missing fellow inpatients. Under social identity theory, this can be understood as Ned's active affiliation with the inpatient group protecting his self-concept, which was something he missed on discharge as he was no longer so closely tied to the inpatient group. Ned's experience reflects concerns of participants in the study by Mezey (2010). However, Aaron, who spoke of feeling almost homeless on discharge alluded to an

increased sense of belonging in the community over time. This suggests that for some, belonging and settling in to the community is a gradual transitional process but one that is possible to achieve. By contrast, for others, Ben in particular, feeling different from others and feeling like an outsider was an experience that persisted throughout the inpatient experience into to the community. On the units, he actively distanced himself from the service user group by acknowledging how different he was from them, similar to several participants in the study by Jackson et al. (2009) However, on discharge he continued to see himself differently to others, calling himself an '*outsider*' in the community. This position, rather than an actively chosen one seems to be a consequence of Ben being labelled an outsider by the community on the basis of his experiences and in turn, his outsider status seemed to result in him feeling actively separated from others. These findings suggest that while for some, there was scope for belonging in the community for others, their assigned minority group status restricted opportunities to feel like part of the community. However, interestingly, despite feeling like an '*outsider*', Ben and several other participants also alluded to feeling unconcerned by their outsider status with Ben describing feeling '*indifferent*' to it. This reflects the findings of researchers such as Pinfold (2000) about how belonging and fitting in is not a universally sought adjustment goal, highlighting the importance of considering adjustment at a personal level.

Moving on

Secondly, findings from the present study are also pertinent to understanding opportunities for moving forwards following discharge from an LSU. Similar to the literature on belonging, there is significant contradiction amongst existing literature on this topic. For example, Montgomery and Johnson (1998) interviewed service users pre and post discharge from a general mental health inpatient facility and found that for many, discharge was associated with hope for new beginnings and with the opportunity to reconnect with aspects of their lives that they had lost as an inpatient. However, despite this, most had little confidence in their ability to remain in the community. This ambiguity was reflected in a similar study by Johnson and Montgomery (1999) where service users described subsequent readmission as a relative certainty, suggesting that the scope for disengaging from the inpatient experience and moving forwards is tempered by uncertainty about the success of the transition. Interestingly, similar pessimistic outlooks concerning the success of community transitions have also been reported by mental health practitioners (Lammie et al. 2010, see also Thornicroft, 2006, and Schulze, 2007)

In the present study, similar ambiguity existed between seeing discharge as an opportunity to move forwards and feeling tied to the LSU or feeling uncertain about their ability to remain out of the unit. Similar to Johnson and Montgomery (1999) participants spoke of the opportunity to reconnect with a life they felt was on hold on the units (which many described as feeling meaningless and devoid of opportunity) representing a shift away from the inpatient experience. In an extension of previous research, a novel finding of the present study was that rather than just reconnecting with previously valued roles several participants also saw discharge as an opportunity to embark on long held ambitions. In Robert's case for example, he spoke of fulfilling his long held desire to build an aquarium. Notably however for others, the act of discharge alone was classed as sufficient goal attainment, as reflected in the theme of discharge as representing finding 'the holy grail.' However, as described in the previous literature, despite feeling relieved on discharge and making plans for the future, most participants also spoke of living with uncertainty in their community placement and fearing readmission. Robert took this further by describing the circularity of his experiences of constant readmissions through this statement of '*here we go again*' on his most recent admission. Furthermore, the present findings extend previous research about the consequence of living with uncertainty as participants alluded to how uncertainty prevented them from embarking on desired futures as shown by Stefan who avoided buying a pet for fear of being '*dragged back*' to the unit. Here is a further example of where reduced self-efficacy impacted on approach of novel situations as reduced self-efficacy in relation to remaining in the community withheld participants from pursuing ambitions and in turn from moving forwards.

It is possible that the strong sense of uncertainty and avoidance of planning for the future was a product of the CTO status of five of the six participants because, as outlined above, under a CTO service users are aware that they can be recalled to the unit at any time. Consequently, it is possible that the level of uncertainty and avoidance of planning for the future was a way of participants coping with their ongoing section. As mentioned previously, this is to my knowledge the first study of its kind exploring community adjustment for people under CTO status in the UK; therefore the present findings lend the first insights into some of the challenges that may be presented in terms of moving on from low secure care under CTO status.

Adjustment as a personal experience

Finally, the present findings also emphasise ambiguities between the personal nature of the adjustment experience and the desire and felt pressure to achieve 'normalcy'. Existing research has suggested that on discharge from inpatient care, service users aspire towards normalcy and to lead an ordinary life (Lorencz, 1991), a desire that was also reflected in a recent large scale study exploring the lived experience of mental health service users in the community (Zolnierek, 2011). On one hand, this desire for normalcy was reflected in the accounts of several participants, Ben in particular who spoke of aspiring to fit in to the '*proper way things work*.' However, several participants also referred to adjustment as a personal journey with self-imposed timescales and individual goals for the future rather than striving purely to emulate 'normalcy'. Interestingly these personal goals and timeframes were often incongruous with those that professionals held for them; for example, several spoke of having to increase social networks as part of their care plans but feeling this did not match their own definitions of adjustment or their goals for the future (see Fakhoury et al. 2005 for another study in which the goals of the individual discarded with that of professionals in a community setting). This suggests that participants were torn between taking control of their own adjustment experience whilst equally feeling pressured both by professionals and by wider societal norms to meet specific adjustment goals and to integrate into the '*proper way things work*' in the community.

The pressure to achieve 'normalcy' and the disparity between this and the desire to adjust at their own pace has some important implications in terms of the success of the adjustment process. Indeed, for many participants, the importance of pursuing adjustment goals at their own pace was understood as a way of protecting their wellbeing, as explained by Ben when he spoke of fearing he would '*jelly out*' if he had to return to work before he felt ready. This can be understood using the stress vulnerability model (Zubin & Spring, 1977), which postulates that psychological difficulties, particularly psychosis result from the interplay of two factors, one's vulnerability (which is understood to be influenced by genetic, social and psychological factors) and one's stress levels, according to both exogenous and endogenous stressors (Zubin & Spring, 1977). The model posits that people with different vulnerabilities all have different thresholds whereby they become unable to assimilate and tolerate stressors and, once this threshold is exceeded it can result in a psychotic episode (Zubin & Spring, 1977). In the event therefore that service users' feel pressured to achieve 'normalcy', this may in turn result in them approaching certain tasks before they feel ready. This may present too many stressors,

thereby exceeding their threshold of tolerance resulting in deteriorating mental health. This in turn would likely compromise their adjustment into the community and their recovery journey, potentially resulting in being returned to inpatient care. This highlights the importance of trying to reconcile the desire for normalcy and the importance of careful pacing of the adjustment process in order to protect wellbeing.

Summary

Three main findings from the present study are summarised below.

- 1) Community adjustment was a complex experience characterised by change and continuity. While there was evidence of participants moving forwards from the LSU experience by regaining autonomy, reconnecting with valued roles and identities and planning for a future away from the units, there was also evidence of continuity and difficulty disengaging from the LSU experience and the identities afforded to them as a result of the assignment of the inpatient role. This was shown through an on-going loss of autonomy and dependence on others as well as a persistent sense of uncertainty about remaining in the community. This suggests that the experience of discharge from an LSU is not a linear development characterised by a full separation from the inpatient role; rather, there appears to be both a level of circularity of experience and a blurring of the boundaries between low secure and community experience.
- 2) Adjustment was a largely personal experience in that participants held personal goals concerning the pacing of the adjustment process and their overall adjustment goals. The personal nature of adjustment was however complicated by pressure from both professionals as well as an internal pressure to aspire for normalcy and to fit in to with dominant societal norms of how to belong and behave in the community suggesting some internal disparity between remaining true to their own individual needs and striving to fit in.
- 3) Finally, findings also emerged about what factors can facilitate recovery, thereby aiding the adjustment process. Reengaging with and developing positive and supportive relationships, reconnecting with valued social roles and regaining autonomy (at a personal pace) were all experienced by participants as positive for wellbeing, implying that these are all important considerations in facilitating community adjustment. However, most felt that these opportunities were only available to them on discharge and that on the units they felt a loss of or damaged sense of self. This suggests that, contrary to the role of LSUs in seeking to promote recovery prior to discharge, in reality participants felt that only on discharge were they able to feel an increased sense of wellbeing and work towards a recovered self. This implies an inverse recovery process to that intended in the structure of low secure forensic services, implying that adjustment is not merely associated with trying to fit back in the life in the

community but instead presents a far greater challenge in that it provides the context in which individuals can start working towards recovery.

Summary of findings in relation to theories of identity, change and transition

Three theories of social identity; Goffman's labelling theory, social identity theory and social role theory are pertinent to understanding how well participants were able to disengage from the LSU experience and the extent to which they experienced a sense of belonging in the community. Labelling theory (Goffman, 1963) can explain why some participants were viewed differently as a result of their inpatient experiences because their assigned social identity of a 'mentally ill' group member resulted in people imputing stereotypical traits to them and judging them in accordance with this 'virtual social identity' (Goffman, 1963). Being labelled in such a way also reduced participants' opportunities to settle in and experience a sense of belonging in the community; for example, some continued to see themselves as outsiders and only one spoke of interacting outside of a service user group. This represents a lasting impact of their assigned social identity on their capacity for inclusion in the community.

However, despite the stigma and outsider status imputed to some as a result of their assigned service user identities, some participants actively affiliated with the service user group both on the units and in the community and in turn experienced this as instrumental for belonging. This cannot be understood using labelling theory, which claims that social identities are '*applied from the outside*' (Owens, 2006, p.224) rather than actively sought (Owens, 2006). However, this experience can be understood using social identity theory (Tajfel & Turner, 1986) which postulates that people seek to affiliate with groups and experience this as protective of their self-concept (Ouwerkerk & Ellemers, 2002). It seems therefore that a blending of both labelling and social identity theory is needed in order to capture both the passive group assignments and active group affiliations in addition to the diversity of the experience of belonging found in the present study.

One further aspect of belonging that cannot be explained by current theories of social identity is the extent to which several participants who felt like outsiders (not actively affiliated with any group) seemed unaffected by their outsider status. While this may represent a defence used as self-protection from their outsider status, it may instead represent a more genuine comfort with their status, suggesting that they were at ease with being outsiders rather than seeking to be part of a group. This contrasts with the claims of social identity theory that group affiliation is necessary to protect one's self concept and that favourable in-group comparisons are necessary for the preservation of self-esteem. Consequently, it would appear that neither

theory of social identity is sufficient to explain the diverse and highly individual nature of belonging that was apparent in the present study.

The most salient identity framework underscoring many of the present findings is social role theory (Sarbin & Allen, 1968; Sarbin & Sheibe, 1983). Through an extended LSU admission participants acculturated to the LSU environment and to the social role they were granted as inpatients, which was characterised by a loss of autonomy, being treated as one of a group as opposed to having their individual identity respected and in feeling cut off from valued social roles. All of these factors can be understood using social role theory as contributing to a loss of identity. On discharge, while to an extent they were able to reconnect with these valued roles, thereby regaining their previous identities and moving away from their inpatient identity, in other ways they were unable to separate from the inpatient role. This was demonstrated by the continuing loss of autonomy in some domains and in continuing to have to behave incongruously by, for example participating in group activities when they preferred their own company.

Social role theory is however unable to explain the inconsistency between in some ways being able to disengage from the inpatient role and in other ways retaining this identity post discharge. Theories of change are therefore pertinent here in helping to understand the inconsistencies in disengaging from the inpatient role. Reduced self-efficacy for example may explain why participants continued to welcome control by others because they doubted their ability to manage certain tasks by themselves after being forcibly dependent on others for such an extended period on the units. The principle of self-efficacy may also explain why some found it difficult to make and implement plans for the future, possibly because they had reduced self-efficacy in relation to being able to remain in the community. However, on occasions participants spoke of being able to move forward and reconnect with valued social roles (such as going to college or attending son's football matches in Robert's case) despite having potentially reduced self-efficacy in these areas, which cannot be explained by the principle of self-efficacy. Instead, this can best be understood using the theory of planned behaviour (Ajzen, 1985; 1991). Here, the strength of the attitude towards certain behaviours may have overridden the lack of 'perceived behavioural control' over the situation. This fits with the theory of planned behaviour, which claims that sometimes, one dimension such as the attitude towards the behaviour if strong enough can be sufficient to prompt intention and action even if perceived behavioural control (akin to self-efficacy) is reduced. It seems therefore that theories of change blended with social identity theories can help explain the

inconsistencies in being able to disengage from the inpatient identity in order to reconnect with a more valued and preferred identity post discharge.

My findings also extend the applicability of social role theory by suggesting that, in addition to being integral to one's identity, the loss of valued social roles can also be detrimental to recovery. Several participants described how their physical and mental wellbeing was compromised on the units. Incidentally, once they were separated from the inpatient experience and had increased opportunity to reconnect with valued roles they were then more able to move towards recovery, as evidenced by how several described feeling physically and mentally healthier in the community. This lends further support to the idea that social roles are particularly important in considering the adjustment process from secure care to the community implying that there is more at stake for service users than a lost identity; rather, the granted inpatient role and loss of valued social roles is detrimental to wellbeing and compromises recovery.

Finally, in the introduction I presented the transition cycle (Adams et al. 1976, see Fig.1), which claims that at transitional points in life, people follow a normative pattern of moving from a 'honeymoon' period of excitement and unrealistic expectation to a gradually declining sense of wellbeing culminating in crisis before finally achieving a stage of acceptance and renewed confidence. My findings are disparate with this model in several ways. Firstly, the 'honeymoon' period of relief seemed for my participants to be a more lasting and real sense of relief rather than a transient experience immediately post discharge (see the theme 'finding the holy grail' in the results.) Moreover, rather than following a normative pattern of adjustment, the transitional experience was a personal one where participants imposed their own timescales (although as emphasised above there was some internal conflict between self-imposed timescales and adhering to those laid out by professionals). Furthermore, the transition to community living was associated with both continuity and change and with an element of circularity of experience, suggesting that there is not a linear transitional pathway as implied by the transition cycle.

Clinical applications

The individual nature of transitions emphasised in my findings has implications in terms of person-centred care planning on discharge from LSUs rather than constructing care plans around normative or practitioner defined concepts of successful adjustment. The need for person-centred planning was evident in accounts highlighting how participants had varying

adjustment goals and time by which they wanted to achieve them. Concern was also raised about undertaking tasks too quickly potentially compromising wellbeing. In order to boost self-efficacy in relation to adjustment challenges, care plans should therefore be tailored to the individual so that tasks can be undertaken at a pace that they feel able to tolerate. This also applies to regaining autonomy as, while autonomy emerged as important for wellbeing, some participants sought and welcomed on-going dependence rather than desiring complete autonomy. It seems therefore that transferring autonomy to service users at a pace agreeable to them would be optimal in order to preserve rather than compromise wellbeing. A potential secondary gain of person-centred planning would be to reduce the pressure service users feel to behave incongruously with their self-concept by adhering to goals outlined by practitioners. In turn, this may help service users to move closer to a more intact self-concept rather than experiencing a fragmented sense of self.

The potential stress of undertaking tasks too quickly in addition to the many other stressors reported by participants in the present study also has implications in terms of how stress is managed. Indeed, given the link between stress and vulnerability to deterioration in mental health as outlined in the stress vulnerability model (Zubin & Spring, 1977, see above), it is vital that prior to discharge, psychosocial interventions are delivered, either on an individual or in a group situation to try and promote coping skills for managing stress to avoid exceeding the threshold by which wellbeing may be compromised. Such interventions can be led by a variety of staff, including Clinical Psychologists, nurses, or by adopting a multidisciplinary approach. A potential secondary gain of interventions focused on stress management and coping skills would be to minimise the use of potentially unhelpful coping strategies such as self-medicating, which may in turn compromise wellbeing and impact on the success of the adjustment process.

My findings also imply that maximising the scope for service users to retain their identities on admission to LSUs is vital. While there are restrictions on this in a secure environment there is some scope for maintaining identity on the units through the retention of valued social roles. One way of facilitating this would be by ensuring that service users are still able to engage in valued activities and pursuits on the units. Many participants in the present study for example spoke of their time as inpatients was meaningless and how they were only able to reengage with valued interests and occupations on discharge. Offering a variety of leisure activities and opportunity for vocational pursuits where possible can help to ensure that service users are able to retain some of these valued roles on the units, thereby retaining their identities. Retaining valued roles also has implications in terms of recovery (Andresen et al. 2003, see

below). The importance of offering activities that fit for the individual has also been highlighted in a recent text by Hardcastle et al. (2007) who identified that while inpatient facilities offer a number of activities, service users are often expected to attend these even if they do not meet individual need and interest. This also applies to involvement with family; where possible all efforts should be taken to maximise service users' ongoing involvement with families during their time on the units. This may involve practical considerations such as trying where possible to admit service users to units as close as possible to family and facilitating family visits where appropriate.

Service users should also be involved in decision making processes and should retain choice in their care as inpatients so as to preserve their self-efficacy in being able to manage tasks independently. This may help to buffer against the loss of autonomy experienced, which some participants in the present study found difficult to entirely regain post discharge.

Supporting service users to retain valued social roles during their time in low secure care could have the secondary gain of helping to promote recovery on the units rather than the LSU experience feeling detrimental to recovery. Indeed, it has been argued that recovery does not occur in a vacuum; rather, recovery is facilitated by involvement in roles that hold meaning and offer satisfaction to an individual (Shepherd, Boardman, & Slade, 2008). Consequently, regaining valued roles or being supported to become involved in new roles that are of value to the individual whilst on the units may help to support service users further along their recovery journey. Working towards recovery prior to discharge may in turn help to reduce the gravity of the transition to the community by ensuring that service users are at the optimal levels of physical and mental health prior to discharge.

In terms of further promoting recovery, a number of authors have highlighted how building a personally meaningful life and finding a way to make sense of difficult life experiences (such as mental health difficulties or experiences as an inpatient) is one of the core components of recovery (Andresen et al. 2003; Shepherd et al. 2008; Repper & Perkins, 2006). There is a key role for Clinical Psychology here in supporting service users through therapy to make sense of experiences in a way that is meaningful to them. A number of psychological approaches could be of benefit here including cognitive behavioural therapy and narrative therapy (Morgan, 2000), which works on deconstructing the stories people hold for their lives in order to support them in moving towards preferred stories, in turn enabling them to make sense of their experiences in a positive and meaningful way. This would further support service users to move closer to recovery prior to discharge.

Finally, the findings of the present study suggest that in addition to individual intervention, increased attention should also be paid to community based interventions aimed at further reducing the stigma assigned to people with mental health problems, particularly those who have been in contact with the criminal justice system. 'Community psychology' which '*concerns the relationships of the individual to communities and society,*' (Dalton, Elias, & Wandersman, 2001, p.5) is pertinent here. Interventions aimed at a societal level promoting inclusion and dispelling myths around forensic mental health may help to reduce the labels assigned to service users and the outsider status they experience. This may in turn increase their activity spaces to include wider circles than service user led activities, which were the dominant social networks and activities of most participants in the present study. However, there is a caveat here in that not all participants in present study wished to be fully included in social groups. Consequently, while it is important to work towards reducing outsider status for forensic mental health service users it does not naturally follow that service users should immerse themselves fully in groups; rather, their individual preferences for inclusion versus exclusion should be respected.

Further directions

I outlined in my critique that I was only able to interview participants at one time point and that if time had permitted, it would have been interesting to prospectively interview participants prior to discharge, shortly after discharge and again at a later date to map initial expectations as well as experiences of change and continuity over time. This would make a useful extension of the present study.

In addition, as this study has progressed it became clear that the experience of admission to an LSU is clearly instrumental in shaping service users' experiences of community adjustment and the ways in which they make meaning out of those experiences. Identity also seemed integral to the adjustment experience, something which, although outlined early in my introduction I did not realise the full salience of until analysing the findings of my research, which is understandable given the iterative process of my research. Any further extension of this study would benefit from revising the research questions to examine more specifically how experiences of a low secure forensic unit impacts on identity maintenance and how this in turn affects community adjustment.

Final reflections

Despite having worked in forensic mental health services, I still felt shocked and saddened by aspects of participants' stories. In particular, I felt sad hearing how some participants experienced the units as actively detrimental to their recovery and how some staff were experienced as deliberately unhelpful. I was also startled by the pervasiveness of the LSU experience in continuing to affect participants long after discharge. Hearing about the long-lasting impact of the LSU experience on participants' identities and on their life plans left me with a new found understanding of the gravity and life changing impact the experience has on people.

Aside from feeling saddened, I also felt uplifted by aspects of experience, in particular the positive relationships with both staff and family and friends experienced by many participants. I was also struck by how, despite the many adjustment challenges they were facing and the circularity of experience reported by some, none of them described a sense of hopelessness about the future and all retained some ambitions to aspire towards. I experienced this resilience as extremely humbling and hope that in my presentation of the results I was able to sufficiently privilege this aspect of participants' experiences.

Finally, I was also struck by the complexity of the transitional experience and the diversity that was present both within and across participant accounts. This presented a significant challenge in trying to make sense of the findings in the context of existing theory and literature. However, I feel that merely demonstrating the individual nature and complexity of the transitional experience is in and of itself a highly valuable finding that lends the first unique insights into the adjustment experience.

Conclusion

In this study I sought to answer questions concerning what were the experiences of community adjustment following discharge from a low secure forensic unit and how did participants make sense of their experiences? Key findings emerged concerning the complexity and diversity of the adjustment experience. There was ambiguity both within and across participant accounts about the extent to which they could separate from the inpatient identity (afforded to them on the units through the assignment of inpatient roles) on discharge in order to reconnect with a lost and valued identity and implement plans for the future. While they were all able to do this to an extent, the inpatient role remained present in several domains, including the extent to which they could regain autonomy versus remaining dependent on others and the extent to which they were able to reconnect with and work

towards attaining valued social roles. Some also continued to experience a fragmented sense of self, highlighting the continuation of the inpatient experience. In turn, difficulty separating from the inpatient experience resulted in the transitional period as one in which there was circularity of experience as opposed to a linear trajectory from LSU to community. This circularity of experience was further demonstrated by participants feeling uncertain about remaining in the community, which also had implications for being able to make and implement plans for the future to reach a more desired identity and a more valued and intact self-concept.

There was also evidence that the scope to which participants were able to belong and settle in to the community was impacted on by their social identities as reflected through the behaviour and attitudes of others. Being labelled as outsiders and having stereotypical traits of a 'mentally ill' minority group imputed to them resulted in some feeling separate from the community, presenting a barrier to complete inclusion. However, others who actively identified with the service user group experienced this group affiliation as central to a sense of belonging and were not seeking inclusion within the wider community, which demonstrates the highly individual and diverse nature of the adjustment experience.

Finally, the findings imply that in addition to presenting a challenge in terms of adjusting to living back in the community, the transitional experience following discharge from an LSU also presented an opportunity to work towards recovery. Several participants understood the LSU experience as detrimental to their health and wellbeing and instead made sense of discharge as the time in which they began to feel physically and mentally healthier. This suggests that the transitional process is more than a matter of adjustment; rather, for many, it is experienced as the start of the recovery journey.

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Appendices

Appendix A Ethics Approvals

Leeds (Central) Research Ethics Committee

Yorkshire and Humber REC Office
 First Floor, Millside
 Mill Pond Lane
 Meanwood
 Leeds
 LS6 4RA

Telephone: 0113 3050108
 Facsimile:

29 June 2010

Mrs Sophie Louise Horrobin Burgess
 Programme in Clinical Psychology
 Charles Thackrah Building
 101 Clarendon Road
 Woodhouse
 Leeds
 LS2 9LJ

Dear Mrs Burgess

Study Title: Exploring the experiences of service users re-entering the community following discharge from a low secure forensic unit
REC reference number: 10/H1313/51
Protocol number: 1

The Research Ethics Committee reviewed the above application at the meeting held on 18 June 2010. Thank you for attending to discuss the study.

Documents reviewed

The documents reviewed at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Investigator CV		
Protocol	1	28 April 2010
Email - university indemnity		07 May 2010
Doctor of clinical psychology transfer viva report		28 April 2010
REC application		27 April 2010
Letter from Sponsor		
Participant Information Sheet	1	28 April 2010
Participant Consent Form	1	28 April 2010
CV - Dr Gareth Hagger-Johnson		
Letter to healthcare providers	1	28 April 2010
Mini-mental state exam		
Interview schedule	1	28 April 2012
Evidence of insurance or indemnity		08 October 2009

Provisional opinion

The Committee would be content to give a favourable ethical opinion of the research, subject to receiving a complete response to the request for further information set out below.

The Committee delegated authority to confirm its final opinion on the application to the Vice Chair.

Further information or clarification required

1. Consent to inform the healthcare providers should be added to the consent form.
2. The £10 payment should be in the form of vouchers and should be removed from the section of benefits on the information sheet.
3. The reference to the West Yorkshire playhouse should be removed from the protocol and the correct location of the interviews explained.
4. The Committee agreed that page two of the information sheet was confusing as after the sentence about the possibility for the need to break confidentiality it states that further information is given in part two but part two only gives further information about confidentiality not disclosure. The Committee agreed the paragraph on page two should be revised to be clearer about the information in part 2.
5. The consent form should have boxes big enough to initial, a line for the researchers name and signature and should include the standard paragraph for audit 'I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from [company name], from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records'.
6. The information sheet should make it clearer this is for a student project as it is thought that many people may not know what a doctoral thesis is.

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.

The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 27 October 2010.

Membership of the Committee

The members of the Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H1313/51

Please quote this number on all correspondence

Yours sincerely

Dr Margaret L Faull
Chair

Email: Rachel.bell@leedspft.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments.

Copy to: Rachel de Souza

*R&D Office
St Mary's House
St Mary's Road
Leeds, LS7 3JX*



National Research Ethics Service

Leeds (Central) Research Ethics Committee

Yorkshire and Humber REC Office
 First Floor, Millside
 Mill Pond Lane
 Meanwood
 Leeds
 LS6 4RA

Tel: 0113 3050127

04 November 2010

Mrs Sophie Louise Horrobin Burgess
 Programme in Clinical Psychology
 University of Leeds
 Programme in Clinical Psychology
 Charles Thackrah Building
 101 Clarendon Road
 Woodhouse
 Leeds
 LS2 9LJ

Dear Mrs Burgess

Study title: Exploring the experiences of service users re-entering the community following discharge from a low secure forensic unit
REC reference: 10/H1313/51
Amendment number:
Amendment date:

The above amendment was reviewed at the meeting of the Sub-Committee held on 26 October 2010 by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Participant Consent Form	4	03 September 2010
Participant Information Sheet	4	03 September 2010
Notice of Substantial Amendment (non-CTIMPs)		
Covering Letter		21 September 2010

This Research Ethics Committee is an advisory committee to Yorkshire and The Humber Strategic Health Authority
 The National Research Ethics Service (NRES) represents the NRES Directorate within
 the National Patient Safety Agency and Research Ethics Committees in England

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

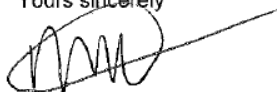
All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H1313/51:	Please quote this number on all correspondence
---------------------	---

Yours sincerely



Mrs Nicola Mallender-Ward
Committee Co-ordinator

E-mail: Nicola.mallender-ward@leedspft.nhs.uk

Enclosures: List of names and professions of members who took part in the review

Copy to: Mrs Rachel E de Souza

Appendix B R&D Approval



West Yorkshire
Mental Health and Learning Disabilities Research Partnership

Our Ref: 2010/211/LS

Research & Development Department
North Wing, St Mary's House,
St Mary's Road
Leeds LS7 3JX

E-mail: john.hiley@leedspft.nhs.uk
Direct Line: 0113 295 2387
FAX: 0113 2954466

Mrs Sophie Burgess
Programme in Clinical Psychology
University of Leeds
Charles Thackrah Building
101 Clarendon Road
Woodhouse
Leeds
LS2 9LJ

COPY

18 November 2010

Dear Sophie,

RE: Exploring the experiences of service users re-entering the community following discharge from a low secure forensic unit

Following the recent review of the above project I am pleased to inform you that the above project complies with Research Governance standards, and has been approved by the relevant Partnership Trust management. We now have all the relevant documentation relating to the above project. As such your project may now begin within **Leeds Partnerships NHS Foundation Trust and South West Yorkshire Partnership NHS Foundation Trust**.

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

Document	Version	Date
Protocol	3	05 July 2010
Participant Consent Form	4	03 September 2010
Participant Information sheet	4	03 September 2010
Letter to healthcare providers	1	28 April 2010

This approval is granted subject to the following conditions:

- You must comply with the terms of your ethical approval. Failure to do this will lead to permission to carry out this project being withdrawn. If you make any substantive

The Partnership members are:

- South West Yorkshire Partnerships NHS Foundation Trust
- Leeds Partnerships NHS Foundation Trust
- University of Leeds
- Leeds Metropolitan University
- University of Bradford
- University of Huddersfield

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changes to your protocol you must inform the relevant ethics committee and us immediately.

- You must comply with the Partnership's procedures on project monitoring and audit.
- You must comply with the guidelines laid out in the Research Governance Framework for Health and Social Care¹(RGF). Failure to do this could lead to permission to carry out this research being withdrawn.
- You must comply with any other relevant guidelines including the Data Protection Act, The Health and Safety Act and local Trust Policies and Guidelines.
- If you encounter any problems during your research you must inform your Sponsor and us immediately to seek appropriate advice or assistance.
- Research projects will be added to any formal Department of Health research register.

Details of participant recruitment to projects should be carefully maintained, and supplied to the R&D Department on request.

Please note that suspected misconduct or fraud should be reported, in the first instance, to local Counter Fraud Specialists for this Trust. Partnership R&D staff are also mandated to do this in line with requirements of the RGF.

Adverse incidents relating to the research procedures and/or SUSARs (suspected unexpected serious adverse reactions) should be reported, in line with the protocol requirements, using **Trust incident reporting procedures in the first instance and to the chief investigator**².

They should **also** be reported to:

- The Partnership R&D Department
- the Research Ethics Committee that gave approval for the study
- other related regulatory bodies as appropriate.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice (<http://www.dh.gov.uk/assetRoot/04/06/92/54/04069254.pdf>) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

Changes to the agreed documents MUST be approved by both the Trust/s and Research Ethics Committee granting initial approval, before any changes in documents can be implemented. Details of changes and copies of revised documents, with appropriate version control, must be provided to the R&D Office. Advice on how to undertake this process can be obtained from R&D.

Projects sponsored by organisations other than the Partnership Trusts are reminded of those organisations obligations as defined in the Research Governance Framework, and the requirements to inform all organisations of any non-compliance with that framework or other relevant regulations discovered during the course of the research project.

¹ Details from:

http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4108962&chk=WdeITv

² SUSARS – this must be within 24 hours of the discovery of the SUSAR incident

The Partnership members are:

- | | |
|--|---------------------------------|
| • South West Yorkshire Partnerships NHS Foundation Trust | • Leeds Metropolitan University |
| • Leeds Partnerships NHS Foundation Trust | • University of Bradford |
| • University of Leeds | • University of Huddersfield |

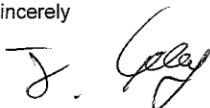
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Once you have finished your research you will be required to complete a Project Outcome form. This will be sent to you nearer the end date of your project (Please inform us if the expected end date of your project changes for any reason).

We will require a copy of your final report/peer reviewed papers or any other publications relating to this research. Finally we may also request that you provide us with written information relating to your work for dissemination to a variety of audiences including service users and carers, members of staff and members of the general public. You must provide this information on request.

If you have any queries during your research please contact us at any time. May I take this opportunity to wish you well with the project.

Yours sincerely



John Hiley
Research Management and Governance Manager

Cc Dr G Hagger-Johnson

Appendix C Information Sheet**Participant Information Sheet****Version 4. Date: 03 September 2010****The experience of community adjustment after discharge from a low secure unit**

You are invited to take part in a research study. Before deciding whether you want to participate it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information.

Part 1 tells you the purpose of this study and what will happen to you if you take part. Part 2 gives you more information about the study.

Take your time reading this information before deciding whether or not you would like to take part. Also, please ask if there is anything that you are not sure about or if you would like more information.

Part 1**What is the purpose of the study?**

People who are detained in low secure units often stay there for a long time before being discharged into the community. Moving back to the community is often a big event for people. I wish to find out what it is like for people when they are going through the change from living in a low secure unit to living back in the community. The main aim of the study is to find out what kinds of experiences people have when they are going through these changes.

Why have I been invited to take part?

You have been chosen to be asked to participate by myself, Sophie Burgess and your CPN because you have been discharged from a low secure unit in to the community in the past year. Approximately 10 other people will also be invited to participate.

Do I have to take part?

It is entirely **your choice** whether you choose to take part or not. The choice you make will have **no effect** at all on the care you receive.

If you consent to participate and you later change your mind, this is ok. You can do this without having to give any reason and this will have **no** effect at all on the care you receive.

What will happen to me if I take part?

You will be asked to attend a one to one interview where you will be asked some questions about your experiences of moving back to the community. These are not difficult questions. You will be able to answer them in whichever way you choose. The interview will be conducted by myself, Sophie Burgess and will last about 40 minutes. It may be shorter or longer than this depending on how much you would like to say. The interview will be tape recorded.

At the end of the interview, you might be asked to come back for another interview if you have said some things that we would like to find out more about. It is up to you whether you choose to come back for this second interview.

At the end of each interview you will be given a £10 gift voucher for either Tesco or Asda (you can choose which one you prefer) as a thank you for participating.

What are the possible risks of taking part?

It is possible that talking about your experiences might bring up some upsetting memories for you. However, you do not have to talk about anything you do not want to. Also, your CPN will be available to discuss this if you do feel upset about things you talk about.

What are the possible benefits of taking part?

Some people find that talking about their experiences is quite helpful for them. You might find this when talking in the interview. However, we cannot promise that this will happen for you. Also, we hope that the information we get from this research will go towards improving services in the future for people going through similar experiences.

What happens when the research study stops?

If you would like a summary of the results found from the research we can arrange to send this to you. Also, if you choose to, after we have analysed the results we can send you parts of your interview along with our interpretations of what you have said to check that we have understood you correctly. It is your choice whether you do this or not.

Will my taking part in the study be confidential?

Yes, all of the information recorded from the interview will be kept completely confidential and anonymous. However, if in the interview you said something that meant you or somebody else was at risk then I would need to pass that information on, meaning that I would have to break confidentiality. There are more details about this in part 2 of the information sheet as well as more information about how we keep your information confidential.

If the information in part 1 has interested you and you think you might want to participate then please read part 2.

Part 2

What will happen if I don't want to carry on with the study?

You are free to take away your consent at any time without having to explain your reasons. Your decision will not affect the care you receive. If you ask to take away consent before the study has been written up then your data will be completely removed. However, once the study has been written up it will no longer be possible to have your data removed.

Complaints

If you wish to make a complaint about anything relating to the study then please contact Sophie Burgess at the University of Leeds (contact details on a separate sheet for you to keep). If you wish to make a formal complaint you can do this through NHS Complaints Procedure. You can get their details from your CPN.

Harm

In the unlikely event that something goes wrong and you are harmed during the research because of something we have done wrong you might have grounds for legal action against Leeds Teaching Hospital NHS Trust. You may have to pay your own legal costs. You can still use the normal NHS complaints procedure.

Will my taking part in the study be kept confidential?

If you agree to participate, your recorded interview(s) and the consent forms containing your name and contact details will be kept confidential. They will always be stored in a locked filing cabinet at the University of Leeds when they are not being used. The results will also be anonymised. This means that we will take away any information that could be used to identify you. Your data will **not** be passed on to anywhere else.

The only other people apart from the research team who will be aware of your participation is your CPN/care team. If you choose to take part, your CPN will receive a short letter telling them that you are taking part in the study.

The only other time that information about you would be passed on to others would be if you talked about something in your interview that meant that you were at risk of harm or that somebody else was at risk. If this happened, information would have to be passed on to the relevant people (usually your care providers). This is called **breaking confidentiality** and is needed to make sure that you and other people are safe from harm.

What will happen to the results of the study?

We will send you a summary of the results when the study is finished if you want this. You can say whether or not you want this on the consent form. The results of the study will be written up for my student research project. Some of the quotes from the interviews might be put in the final research project. However, these will be completely anonymous meaning that it would not be possible to identify you from the quotes. The results may also be written up to be published in a journal. Any report that is written will **not** contain information that could identify you.

Who has reviewed this study?

This study has been reviewed by experienced staff at the University of Leeds. This study has also been confirmed as reaching ethical standards by Leeds Central ethics panel.

If you decide to take part in this study you will be given this information sheet to keep. You will also be given a consent form to sign.

Thank you for taking the time to read this information.

Appendix D Consent Form

Anonymous ID number for the study:

Consent form

Version: 4

03 September 2010

Title of project: Community adjustment following discharge from a low secure unit

Please initial box

1.) I have read and understood the information sheet dated 03 September 2010 (version 4) for this study and I have had an opportunity to ask questions about the study

2.) I understand that choosing to participate is voluntary and that I can withdraw my consent at any time without giving a reason and without any aspects of my care being affected

3.) I consent to take part in this study

4.) I consent to having my interviews tape recorded

5.) I consent to my healthcare provider being informed of my participation

6.) I understand that relevant sections of data collected during the study may be looked at by individuals from the University of Leeds, from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

7.) I understand that quotes from my interview might be put in the final research project but that all quotes will be anonymised

8.) I consent to receiving a written summary of the final research project

Name of participant	Signature	Date
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Contact telephone number and address for participant. Chosen vouchers.

Name of researcher	Signature	Date
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Appendix E Interview Schedule

Interview Schedule

Version 1 Date: 28 April 2010

1. Can you tell me a bit about your time at X?
 - Day to day life, people in life, expectations, feelings, ways of coping. How long were you there for and pattern of admission
 - People in life at that time.
2. Thinking more specifically about time coming up to your discharge from X. What do you remember about the time leading up to your discharge?
 - Hopes and expectations
 - Feelings and ways of coping.
3. Tell me about your life when you were first discharged
 - Differences between expectations and reality
 - Ways of coping
 - Important people in life
4. What were the priorities for you at this time in your life?
 - How you coped with this
5. How, if at all have things changed since you were first discharged?
 - Response to changes and ways of coping with changes
6. Describe your day to day life for me at the moment
 - How you feel about this
 - Match between reality of daily life and hopes and goals.
7. What are the best and worst things about your life at the moment compared to living at X?
8. What do you do to deal with difficulties in your life?
9. Who are the most important people in your life now?

Identity and relationships

10. How would you describe yourself as a person?
 - How, if at all have your experiences changed how you see yourself?
11. How do you see yourself compared to other people around you?
 - How if at all have your experiences changed how others see you?
12. Lots of people talk about the word 'reintegration'. 'What does this word mean to you?
13. How do you see your future in a years' time? 5 years' time?
 - What you think life will be like then?
14. When you think about your future, what are your biggest hopes and fears?