Recovery in forensic services: facing the challenge

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SUMMARY

Although there is an increasing focus on recovery within mental health services, there has been limited exploration of the applicability of these principles within forensic services. The authors draw on their experiences within forensic rehabilitation services to discuss the potential obstacles to secure recovery, exploring the systemic and risk management aspects of such a setting as well as considering attachment theory within this context. Some proposals based on clinical experience are given on how such obstacles are faced and tackled.

LEARNING OBJECTIVES

- To understand the limitations of the recovery approach in forensic settings.
- To understand how current risk assessment practice affects patients' autonomy and empowerment.
- To understand how the attachment histories of patients in forensic services affect their ability to recover.

DECLARATION OF INTEREST

None.

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'Recovery is […] a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness' (Anthony 1993)

The recovery approach has been steadily gaining prominence as a guiding principle for mental health services (Department of Health 2001), with rehabilitation services in particular in the process of redefining themselves according to a recovery ethos (Shepherd 2008). This has entailed a fundamental shift in values for mental health services, from a predominant clinical recovery ethos (i.e. symptom reduction) to one primarily aimed at fostering personal recovery. There is no universal definition of 'personal recovery', although Andresen *et al* (2003) give the four key processes in recovery as: finding hope, re-establishing one's identity, finding meaning in life, and taking responsibility and control.

Recovery models such as Andresen *et al*'s five-stage model of moratorium, awareness, preparation, rebuilding and growth (Andresen 2003) have much in common with the Recovery Star's five stages of 'stuckness', accepting help, believing, learning and self-reliance (MacKeith 2010). In contrast to traditional rehabilitation and medical models, the focus is shifted from pathology, illness and symptoms to health, strengths and wellness. Recovery is also closely associated with social inclusion and being able to take on meaningful and satisfying social roles in society. There is some evidence that a recovery-oriented approach is associated with better mental health and social outcomes for patients in general mental health services (Warner 2010). However, there is less evidence on the applicability of personal recovery within specialist mental health settings such as forensic rehabilitation.

The meaning of recovery for forensic patients

In a previous article in *Advances*, Dorkins & Adshead (2011) noted that, although recovery approaches are being adapted for forensic services, such systems offer unique difficulties that may hinder the recovery stance of taking an individual or humanistic ethos. Adopting a recovery approach therefore poses a number of challenges for forensic services, given that the values and ethos within secure settings can differ from those of a recovery approach. The detained status of forensic patients imposes real limits on the capacity for autonomy and choice, which, coupled with length of stay, can lead to the erosion of hope and independence and a non-patient identity. 'Recovery' within forensic settings has to encompass not only mental health problems but also violent offending. Therefore, the 'recovery approach' may arguably be less appropriate, given that the focus of forensic services is on challenging and confronting risk-enhancing patterns of behaviour, rather than accepting and affirming.

Although 'recovery' among forensic patients remains under-elaborated, research has suggested

that the concept may have different emphasis for forensic populations. Using a qualitative approach, Mezey *et al* (2010) found that the core recovery concepts of hope, self-acceptance and autonomy appeared to be less meaningful for individuals in a medium secure unit. Therefore much of the existing literature and research on recovery (largely focused on severe and enduring mental health problems) may be of limited value.

With this in mind, in this article we seek to contribute to the existing knowledge base on applying the recovery model to forensic psychiatric settings, drawing on our collective experiences of working in both low and medium secure rehabilitation settings. The impetus for this article came from our experiences of developing a new low secure recovery service, which highlighted many of the key issues and complexities and how these were worked with therapeutically. The analyses of these issues are presented here in three broad areas: individual, systems and risk.

Issues relating to the forensic population

This section focuses on the psychological challenges (i.e. intra- and interpersonal processes) to working within a recovery model with forensic patients. One of the main themes in the recovery literature is the importance of recovery-promoting relationships, encompassing 'true partnership working' with mental health professionals (Slade 2009a). This statement assumes that building a trusting therapeutic relationship is possible. However, for patients in forensic settings, the process of building trust and rapport is commonly fraught with difficulties, given the attacking and/ or neglectful relationship to care that commonly manifests in relationships with staff (Ruszczynski 2010). These 'attacks' (psychological or physical) can be understood as re-enactments of severe disruptions of childhood attachments due to abuse, loss and neglect. Crucial for the development of the autonomous self, a key recovery task, is the experience of emotional safety within relationships, akin to the function of a 'secure base'. However, for some forensic patients, the process of establishing such relationships can be severely undermined by their early experience of care as cruel, dominating and abusive. Additionally, these maladaptive ways of relating confer a risk that professionals will be drawn into the re-enactment, thus undermining the containment provided (Aiyegbusi 2009).

Working with insecure attachments

Adopting an attachment perspective provides a useful framework for conceptualising the challenges to engaging forensic patients in their recovery. Insecure attachments, characterised by a dismissing stance towards relationships and a difficulty understanding the emotional needs of oneself and others, are particularly prominent in forensic populations (Aiyegbusi 2004). Such attachment difficulties, often linked to abusive and rejecting care in childhood, pose significant challenges to promoting recovery, given that such individuals are less likely to seek professional help and engage with treatment, particularly in times of crisis. There is a growing body of literature linking early childhood attachments to the process of recovery from psychosis, given that an individual's attachment history influences their capacity for self-regulation, adaptive coping and capacity for professional help-seeking (Gumley 2006). The link between styles of attachment and service engagement can be understood to mirror an individual's earlier experience of caregivers, particularly during times of emotional distress.

Poor mentalisation and communication of needs

Insecure attachments also hinder the adequate development of a stable self-structure and reflective function, resulting in a reduced capacity to mentalise and communicate psychological needs in adaptive, non-violent ways (Bateman 2004). Deficits in mentalisation, which Fonagy & Adshead (2012) describe as 'the continuing process of keeping mind in mind', may also have implications regarding the degree to which a forensic service can be patient led, since explicitly stated needs may be different or even conflict with underlying psychological needs. A common example of this in our clinical work is patients explicitly expressing a desire to leave hospital, but communicating indirectly their underlying anxiety about the outside world and need for containment. For example, positive drug tests as the patient moves closer to discharge is a common behavioural expression of such anxiety.

The risks of recovery concepts for forensic patients

Deficits in mentalisation may also have implications for the individual's ability to find 'meaning in life' and make sense of mental health problems, which are essential recovery tasks. For a forensic population, one can argue that recovery also entails making sense of violent and destructive behaviour, and this leads on to considering recovery themes of personal responsibility and control. Within forensic settings, this is often defined quite narrowly as taking responsibility for risk and interpersonal violence. Risk of harm to others often relates to complex psychological difficulties

which may involve maladaptive psychological defences such as projection of blame or denial. Although these defences may pose an obstacle to recovery, there may be serious psychological costs for the individual in accepting 'responsibility', particularly when a serious and devastating act of violence is involved. It is not uncommon for patients to experience depressed mood and an increased sense of shame.

Recovery-based values emphasise increasing opportunities for a life 'beyond mental illness'. However, developing a 'non-patient' identity with an individual who has lived in institutions for most of their adult life poses considerable challenges. Individuals within secure services, especially those in long-term rehabilitation, often present with dependency on the boundaries, structures and containment of the institution. In such cases, the institution (including the staff, who are often cast in the role of 'caregivers') may become the only form of secure base they have ever known, albeit not necessarily a wholly therapeutic one. Recovery-focused interventions aimed at instilling hope and personal control run a risk of being perceived as a threat to emotional security, leading to either withdrawal/disengagement or acting in potentially destructive ways to restore a sense of 'safety'. Therefore, although hope is important, how this is conveyed needs to be carefully considered in secure rehabilitation settings.

Establishing a true secure base

Despite the difficulties of establishing the forensic mental health setting as a therapeutic secure base, this is an important role in a forensic setting. Such a secure base can help reduce violence and increase affect arousal (Adshead 2004) and allow more coherent attachments to develop. Staff can be helped to develop such relationships through the use of regular reflective practice groups in which they discuss honest appraisals of the impact of interacting with a forensic population. Reflective practice groups in our service take the form of fortnightly, externally facilitated non-directive groups for all team members. Through the facilitation of such groups in other secure hospitals we have observed an improvement in staff's ability to reflect on problematic countertransference and to distance themselves from re-enacting the patient's insecure attachments. Furthermore, interventions that improve patients' ability to mentalise, such as longer-term mentalisation-based treatment (MBT) groups (Bateman 2004), can begin to promote the types of functional relationships that their attachment styles have made so difficult in the past.

BOX 1 Obstacles to recovery relating to the forensic population

- Re-enactment hinders recovery-promoting relationships
- Service engagement mirrors early attachment experiences
- Institutions can represent a secure base and moving on may threaten emotional security
- Staff reflective practice and mentalisation-based approaches can help foster secure attachments between staff and service users

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A summary of obstacles to recovery relating to the forensic population can be viewed in Box 1.

Systemic obstacles to recovery

Psychodynamic group analysts such as Menzies Lyth (1960) suggest that healthcare organisations hold substantial anxiety, given the management of risk and the countertransference of anxiety from patients, and that staff use defensive techniques to deal with it. It could be suggested that the anxiety is even greater in forensic mental health services, where the risks relating to sexual offending and homicide are intrinsically high.

An individualised approach to caregiving is an important element of a recovery approach. As Shepherd *et al* (2008) have said, 'no one size fits all'. However, in forensic services, the centrality of psychopathology and a medical model serve to reduce the inherent anxiety by providing a simplification of people's experience and a sense of certainty in mental health professionals' understanding of it. Adopting an individualistic approach, although vital to truly supporting the needs of patients, challenges this certainty and simplification. More threatening is that an individualised approach can lead to inconsistency as different people are treated in different ways, leading to disagreements, a sense of injustice and uncertainty. These will increase the anxiety.

Power differences

Hierarchical decision-making in a forensic system is another attempted solution at managing the anxiety and fear faced by both patients and staff. However, such an approach fuels a sense of powerlessness in junior staff and patients as they are discouraged from making decisions alone, which is contrary to the emphasis in recovery of empowering individuals (Slade 2009b).

Although power differences are inevitable in secure units, the recovery approach challenges the power hierarchy as staff are asked to share power

with patients, who hold the key to professionals' understanding of individuals' experience. This poses various problems in a forensic setting.

First, as in other settings, the realisation that professional training and knowledge is only half the picture to recovery creates uncertainty and disempowerment for professionals, as their reliance on their professional practice is being questioned. This can affect job satisfaction, which is fragile in a workforce who face very damaged, vulnerable individuals and struggle to see positive changes (Happell 2003). This then has implications for the determination of staff to work towards a fairer system for the patients, as they are fighting for their own existence and feeling of worth.

Second, staff may find it difficult to share power with people guilty of violent crimes. Slade (2009a) highlighted the importance of an equal partnership in supporting a recovery focus, but staff may struggle to accept that they are equal to their patients, as this would mean they need to acknowledge there is nothing distinctly different between them and people who have committed serious crimes, thereby forcing them to face the 'evil' in all of us. It is far easier for staff to create a divide between themselves and those that commit such crimes, splitting off the bad parts of themselves and projecting them onto the patients, thus maintaining a punitive power differential.

Real or equal relationships

Slade (2009a) also talks about 'real' relationships, where mental health professionals are more personal in their approach, giving more of themselves to their relationship with services. However, such an approach may be difficult for staff in forensic units, who may wish to separate themselves from the patients' traumatic experiences and the damaging index offences.

Hope is a key concept in a recovery-focused approach and is vitally important in a forensic system. Most people in forensic systems have complex mental health problems with difficult social and family environments which have perpetuated these problems. Working with such individuals can be demoralising for staff, as they see patterns of distress repeating themselves. It is not hard to see how staff can fall into damaging circular processes where their hope is replaced with negative beliefs.

Social inclusion

Social inclusion is a really important element of a recovery approach. However, in forensic services, individuals are removed from their communities and are often ostracised by them. Considering how patients can be helped to remain included in their communities seems a vitally important element of supporting recovery. One of the attempted solutions to manage the risk of future offences and future mental health problems in forensic patients is to control their involvement in the community. Public opinion is not entirely in support of people who have committed offences being in recovery in the community. This is evident from the various campaigns against 'sex offenders' or 'murderers' living in communities. There is a focus on the fear and a need for retribution rather than a focus on supporting recovery. The stigma faced by forensic mental health 'patients' is very ingrained and not something there is much appetite for changing. Therefore the legal and medical systems in forensic services are not conducive to promoting responsibility and building trust because of a fear of negative public perception.

A summary of systemic obstacles to recovery appears in Box 2.

Practical solutions

In our service, attempts have been made to address such systemic issues. As it is easy for power imbalances between staff and patients to hinder 'real' or equal relationships, which can lead to hopelessness and passivity, a Recovery Learning Forum at our unit has aimed to bridge such divides. This forum, consisting of monthly meetings for all staff (of all grades and professions) together with patients, has been established to promote learning for all. Discussions or teaching led by staff, patients or both develop a collaborative environment in which everyone can learn from one another and everyone has something important to offer, regardless of role. To empower patients within the wider system, we conduct recovery-based ward rounds and invite patients to attend the whole of their care programme approach (CPA) meetings, to chair them and to provide written feedback.

Attempts to address social inclusion and the challenges faced by patients post-discharge

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BOX 2 Systemic obstacles to recovery

- Anxiety in forensic systems is high
- Recovery approaches challenge the power hierarchy
- Hope and social inclusion can be difficult to prioritise in forensic services
- Interventions that are inclusive for all attempt to break down power imbalances
- Recovery does not stop at discharge, and ongoing support is crucial

have been worked with in a weekly group for patients approaching discharge or already living in the community. This peer support model allows individuals to discuss the challenges of community living after life in a secure unit. The group revealed common themes of loneliness, boredom and difficulties in negotiating a complex and hostile world, but individuals found that they developed friendships within the group and were helped to approach social and community services with greater confidence and interest.

Risk

Security

One of the dialectics that is ever present in secure settings is that between the security aspects necessary to manage risk and the therapeutic approaches that assist recovery. Such elements are necessary for a secure unit to function optimally, and a healthy tension can assist proper consideration of procedural and relational aspects of security. However, there does appear to be a natural tendency for practice to slide towards a focus on security needs ahead of therapeutic interventions. Without adequate thinking and reflection, the approaches in secure units can easily move towards restrictive practice. This is particularly true when issues such as staff stress and burnout, lack of experience and lack of an organisational structure that supports reflective practice are common.

One of the many reasons why restrictive practices at the expense of recovery may become the dominant model in secure units is the underlying anxiety felt by professionals in their duty of public protection and the consequences if an incident occurs. Events such as an absconsion or risky behaviour can have far-reaching consequences in terms of media coverage, public opinion, internal enquiries and damaged reputations. A 'false-negative' risk assessment, in which an individual who truly poses a risk is assessed as not doing so, is therefore something greatly feared by staff, and it can cause them to employ risk-averse practices in which safety is prioritised. However, this over-caution may lead to a 'false-positive' assessment, in which an individual who does not pose a risk is believed to do so. Perhaps their leave is restricted or they are detained for longer than necessary. These actions may impair their quality of life or even infringe their human rights, but this may be the preferred option for professionals, given the lack of scrutiny and repercussions of a false positive compared with the potentially catastrophic fall-out of a false negative.

Risk assessment

Risk assessment tools such as the Historical Clinical Risk Management-20 (HCR-20) (Douglas 2013) have become widely used in secure hospital settings as a means of determining risk, establishing management plans and ultimately informing decisions to transfer someone to conditions of lower security and to discharge. Although there is much evidence to suggest that structured clinical judgement risk assessments are of great clinical benefit, they are carried out in a wide variety of ways. Few services engage the patient in completing the assessments and it is common for the assessment to be 'fed back' to the patient rather than being a collaborative effort – it is often signed, filed and mainly used by the professionals. Such practices keep the assessment and management of risk in the domain of the professional, which we have found creates difficulties in terms of recovery. First, without a transparent risk assessment, the patient has poor knowledge or awareness of the factors that are keeping them in hospital and what they may need to do to progress. Second, a lack of transparency in the risk assessment process encourages passivity and a lack of responsibility. These are the very factors that need to be overcome to help the patient manage risk in the long term. Third, it may foster resentment in the patient that plans and restrictions are being placed on them without their being the author of their own management.

The common factors within structured risk assessments focus on aspects loosely defined as 'insight', 'attitudes' and 'responsiveness to treatment'. These concepts are difficult to define and are largely based on the view of the professional as to whether the patient has 'insight' and whether their attitudes are pro- or antisocial. Such factors again take the responsibility away from the patient and place greater emphasis on 'expert opinion'.

Further questions aimed at determining whether the patient has 'realistic future plans' again force professionals to judge the person's future goals and ambitions. This is problematic as it puts limits on recovery, as neither patients nor professionals can predict the future. If such limits are placed on individuals it can inhibit them from reaching their full potential. Furthermore, placing the power with the professionals to determine the realism of a patient's ambitions creates a danger of extinguishing the hope that is so crucial to recovery.

Transparency in practice

Ways of addressing the patient's exclusion from the risk assessment process have been trialled

BOX 3 Issues relating to risk in forensic units

- Under stress, forensic services have a natural tendency to risk-averse practice
- Risk assessments often lack transparency and can foster passivity
- Risk language is often vague, subjective and places limits on recovery
- Groups that help understand risk assessment tools are of use
- Changes to risk assessment meetings could enable the process to be more transparent

in our service.† First, patients are routinely fully involved in any development or update of their risk assessments. They are present throughout risk assessment meetings and are encouraged to contribute. Although this may be uncomfortable, it does create transparency regarding the risks that are keeping them in a secure unit and what the professionals are worried about. Our experience is that such meetings are often the first opportunity for clear communication about the patient's risk history.

Second, a 'risk group' in which patients have the opportunity to discuss their risks, to learn about the risk assessment tools that are used and to develop their own risk management plans has been run on two occasions. The group helps patients develop a more sophisticated way of viewing risk and gives them the language to understand and challenge risk assessments on an equal footing with their team. Role-play in which patients present their risks and management plans to a mock mental health review tribunal improves their ability to articulate their knowledge and insight into their personal risk.

Box 3 highlights issues relating to risks in forensic settings.

Conclusions

Implementing recovery-focused practice within secure services is inherently fraught with challenges and obstacles, reflecting the fundamental tension between recovery values and the ethos of forensic services. A fundamental task of forensic services is public protection and so there are real limits to how much primacy can be given to the perspective of the patient relative to that of professionals. Secure recovery therefore involves a careful balance between person-centred care and the need to challenge and confront aspects of the individual that pose a risk to others. This process does not play out in a social vacuum:

social exclusion of mentally disordered offenders is a significant challenge to recovery. Despite these difficulties, forensic mental healthcare has begun to embrace the move towards more recovery-focused care (Gudjonsson 2010; Drennan 2012). Furthermore, it can be argued that the recovery approach does overlap with elements of forensic practice, in terms of its emphasis on promoting greater responsibility and control.

Our view is that secure recovery presents mental health professionals with a challenging yet exciting opportunity to develop more collaborative, innovative and positive ways of working with forensic patients. In this article, we have focused on the challenges and an account of our experiences of developing recovery-focused practice in a low secure service. Unless the complexities regarding secure recovery are understood and interventions adapted accordingly, then forensic services run the risk of disingenuous and tokenistic gestures that ultimately fail the individuals that they are tasked with helping.

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MCQ answers
1 b   **2** e   **3** a   **4** c   **5** b

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MCQs
Select the single best option for each question stem

1 A common theme of recovery is:
a cure
b reclaiming identity
c elimination of symptoms
d total independence
e certainty of goals.

2 Which of these roles depicts a recovery-promoting relationship?
a patient–doctor roles
b friendship with professionals
c total equality
d no further need of support
e partnership working with professionals.

3 A characteristic of an insecure attachment is:
a a dismissing stance towards others
b clinical anxiety
c the absence of life goals
d constant arguments
e a reciprocal relationship.

4 One systemic issue that is an obstacle to recovery is:
a violent offenders
b media views of people with mental illnesses
c uncertainty and disempowerment of professionals
d poor risk assessment
e patients with personality disorder.

5 In risk assessment, it is difficult to define:
a past violence
b insight
c prior supervision failure
d relationship instability
e psychopathy.