Personal Recovery Within Forensic Settings

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4.1 Introduction

In this chapter I provide an overview argument in relation to the concept of personal recovery as it is enacted and may be understood within forensic institutional settings—for example, prisons, secure hospitals and probation settings. This is drawn from the perspective of a psychiatrist working in England—with experience particularly in the North West of England. An initial limitation becomes immediately apparent in that this is a sole author chapter—a position that may be seen as anathema to the concept of personal recovery which, by its very nature, represents a process of co-construction. This chapter is therefore partial in its perspective—and there is an inherent power assumption that comes with that situation that is particularly painful and sensitively enacted within forensic settings and practice. This limitation is remarked upon not to dismiss the content of this chapter—but to draw the reader's attention to this partial perspective. This point is returned to at various stages of the argument set out below.

With this in mind the chapter begins with a brief overview of the concept of personal recovery—focusing on the core ideas of personal identity and identity work which will be considered in light of the particular nature of forensic environments and mental health practice within these institutional settings. This leads to a discussion on the nature of forensic recovery before then addressing some particular points of consideration and finally some suggestions for future work and direction of travel. Contextualising remarks are provided throughout for readers unfamiliar with forensic mental health practice in England and Wales.

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4.2 Personal Recovery

The conceptualisation of *personal recovery* represents a profoundly political act—building on a legacy of disability activism and the emergent field of mad studies [1]. Two key moves are captured in the claim of personal recovery: Firstly, the introduction of the concept of "the personal" nature of recovery ties this into a legacy of feminist research and argument [2]. Secondly, the word recovery itself is radical—rejecting a historical legacy of mental illness and disorder being seen as untreatable—and, perhaps worse, unmanageable [3]. Moving on from its radical beginning the idea of personal recovery, as a goal for mental health service provision, is perhaps best summarised by one of the most widely cited definitions:

> Recovery is described as 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, p. 527 [4])

This definition has been criticised (for example, in relation to its novelty as a claim [5]) but has been largely accepted and seen as a transformative introduction to the field. Seeking to operationalise the concept into a workable structure a significant piece of research was undertaken by Slade and colleagues [6]—leading to the development of a transtheoretical framework of change in relation to personal recovery [7]. This is often referred to as the CHIMES framework:

- Connectedness
- Hope
- **Identity**
- Meaning
- Empowerment
- Spirituality

For the purpose of the argument in this chapter I would suggest that "identity" can be seen as the core component of this framework—from which each of the other components flows as a facet or emphasis. In this sense then recovery can be understood as a form of "*identity work*"—a process of making sense of personal experience in the face of adversity [8].

4.3 Forensic Settings and Practice

Within England and Wales, through the Royal College of Psychiatry (the organisation responsible for the post-graduate training and certification of psychiatrists—www.rcpsych.ac.uk), forensic psychiatry is defined as: "…*work at the interface between the law and psychiatry, managing patients with mental disorders who have*

been or have the potential to be, violent." [https://www.rcpsych.ac.uk/become-a-psychiatrist/choose-psychiatry/what-is-psychiatry/types-of-psychiatrist/forensic].

Most forensic psychiatrists will therefore practice in secure hospitals—previously known as special hospitals—these units provide multidisciplinary mental healthcare within a locked setting. Prison psychiatry represents an emerging field of practice and development focusing on the mental health of prisoners. In England and Wales movement between forensic institutions and disposal from court to hospital are handled under a particular section of the Mental Health Act (1983, revised 2007)—known as Part III. A further significant potential role for psychiatrists lies, as above, at the interface with the law—including roles where psychiatrists may be summoned as expert witnesses in relation to ongoing legal proceedings: While beyond the scope of this paper discussion of this role is significant in relation to the concept of recovery calling as it does into focus definitions of power and the role of the mental health professional in relation to a person's experience.

Prisons represent sites of significant mental suffering—with epidemiological studies estimating high levels of mental disorder globally [9]. Rates of deliberate self-harm and suicidal behaviour are also significant [10] and such behaviours are easy to misunderstand or dismiss [11].

Prisons, in a sense, represent a form of community setting in forensic psychiatry—they are chosen here as an illustrative example of a secure environment. A deconstruction of a prison environment would likely highlight the following features: The perimeter wall, gates and doors impeding passage, cells, keys providing access.

The perimeter wall serves a particular function—not simply as a means of containment—but also as the defining boundary for an example of a total institution [12]. Total institutions serve as cultural containers—with the emergence of institutional practice, that is a series of shared practices reaching towards a common goal. In the case of prisons in England and Wales these goals are defined by Her Majesty's Prison and Probation Service (https://www.gov.uk/government/organisations/her-majestys-prison-and-probation-service) as:

- Restriction [preventing escape or free movement]
- Retribution [enacting punishment on behalf of the State]
- Rehabilitation [providing education to allow reintegration into society]
- Restoration [facilitating acts of restorative justice, for example, community service, where appropriate]

Although a controversial point, in England and Wales it is the *loss of time* through incarceration that acts as retribution—not the act of incarceration itself. Beyond containment the perimeter wall serves a wider function—drawing the attention of the general population to the prison, while obscuring the suffering and experience of prisoners within [13].

Inside the prison progress is impeded by the presence of locked doors—keys therefore become a symbol of power and authority within the institution.

4.4 Forensic Recovery

With this context let us now return to the concept of recovery—and particularly recovery in forensic settings. The immediate problems of the concept can be seen through returning to the CHIMES framework:

- Connectedness: By virtue of acts of violence, or potential for violence, people are excluded from their home communities, often with considerable geographical distance. How can connectedness be considered with this restriction and when should this connection be restored?
- Hope: Prisons and other secure settings are often experienced as profoundly hopeless environments.
- Identity: A person introduced into a forensic setting experiences a profound act of personal stigmatisation being marked as a "*forensic patient*" or "*offender*".
- Meaning: Within prisons and secure settings meaning becomes contested—as discussed in more detail below.
- Empowerment: Secure institutions disempower patients or other residents, for example, through the introduction of locks and gates to impede progress—simultaneously empowering professionals in relation to others.

A systematic review and meta-synthesis, focusing on qualitative research into the process of personal recovery in forensic mental health settings identified three core themes [14]: The need for a sense of safety and security, dynamics of hope during the course of a sentence or hospital admission, and the need for integration with social networks.

Building on the central concept of identity work, outlined above, is perhaps helpful in further illustrating the challenging situation that offenders and forensic psychiatric patients experience. In a sense, offenders going through a court hearing and eventual conviction experienced an enforced identity shift—with the conclusion of a guilty verdict. Without wishing to apologise for criminal acts this represents a form of stigma likely to accompany the individual even after the completion of a prison sentence [15]. Introducing a concept of mental disorder, or substance use, layers on this stigmatised experience—resulting in an experience of double or even triple stigma [16].

Rightly or wrongly therefore the forensic patient's identity if forced—and any act of recovery will have to contend with this. Recovery narratives and experiences in this context may be understood as acts of resistance [17]. Narratives can be understood as a means of expressing personal identity—both to ourselves and to others. Redemption narratives have been shown to have a particular resonance when the act of rehabilitation and "*making good*" in relation to criminal activity are considered [18]. Narrative understanding ties in with the concept of meaning making, and identity work, as outlined in the CHIMES framework and can serve as a helpful means of understanding the experience of offenders who experience mental disorder. Such narratives are, sadly, too often punctuated by acts of trauma and

experiences of alienation: There is a pressure therefore to avoid further alienation through the act of incarceration within forensic settings—this is returned to in the concluding section of this essay.

4.5 Particular Issues

Moving beyond this general conceptualisation of recovery in forensic settings we turn now to some of the particular issues that characterise the distress and disorder experienced by individuals within this space, and the challenges facing practitioners.

4.5.1 Ethics

For the past nearly 40 years [19] much of the ethical curriculum in medical education has been dominated by the work of Beauchamp and Childress [20]: Although their approach has been criticised—for example, in relation to the risk of its becoming common ethical understanding as opposed to being drawn from common understanding [21]—the work remains a bulwark for many. Forensic mental health practice raises some key issues in relation to these principles however (for further discussion see Adshead, 2000 [22])—and some of these are highlighted here with a focus on any overlap with the concept of personal recovery.

- Beneficence and Non-maleficence: Acting with the good of the patient in mind seems an uncontroversial aim in medical practice, and this is often held in balance with the need to minimise harm in the pursuit of benefit. In forensic practice there is an essential truth however that any therapeutic interaction essentially introduces a third party—in the form of the wronged state—which complicates the process substantially. How then is the balance of treatment maintained? When an individual, in the context of a mental health crisis, displays aggressive behaviour what is the role of the clinician in managing this? To whom does their responsibility lie? Is there a risk that treatment becomes a means of containing an individual simply within a toxic environment—where mediation of that environment can seem like an impossible endeavour?
- Respect for autonomy: All individuals exist as autonomous agents and respect for that essential dignity and right is essential in all areas of medical practice. Within the CHIMES framework this is captured in the concept of empowerment. How far does this right extend however? An individual suffering from a mental disorder with a relapsing remitting nature may disagree with the benefit of continuous medication and may question the evidence for longitudinal treatment [23]. How can their right to choice in this respect be balanced against a need for public protection however if—in the context once more of a mental health crisis—they have previously acted in a violent manner towards others?

- Justice: In England and Wales the principle of "*equivalence*" is proposed as a means of understanding distribution of resources with respect to prison healthcare [24]. A challenge rises here in terms of interpretation however—does this mean equivalence of resource and treatment availability or equivalence of outcome? If the latter then, given the significant position of disadvantage from which prison populations are drawn, a far larger investment will be required.

4.5.2 Complexity, Co-morbidity and Personality Disruption

Complexity is the norm within forensic healthcare—with individuals often showing signs of distress and need across several different domains of need [25]: For example, an individual may show signs of severe mental illness, such as acute psychosis, exacerbated by personality disorder with dissocial and impulsive traits, and substance misuse. Each of these factors may pose a complication with respect to the understanding an individual's recovery experience and support needs—for example, in relation to personality disorder systematic review has shown that many of the underpinning concepts of personal recovery become problematic [26, 27].

4.5.3 Offending Behaviour

Essential to the nature of experience in forensic mental healthcare is the fact that most patients will have carried out some form of criminal act. This in and of itself can pose a problem for the individual and for any mental health practitioners working to support them—raising challenging interpersonal and intrapersonal psychodynamics [28].

4.6 Future Work and Directions

In this chapter I have attempted to set out the particular issues that arise in relation to the concept of personal recovery in forensic settings. I have argued that placing the concept of identity, and identity work, as central to this process is a helpful means of working to understand individual experience. In this lies the truth that additional work is required to capture the particular experience of individuals within forensic settings—raising them up from beyond the position of subjects to agents in their own rights.

Considering the individual's identity—beyond the experience of mental disorder—also demands particular attention to lived experience, taking account of specific experiences and cultural influences. For example, the experiences of women who offend are radically different from their male counterparts in terms of social response [29] and in terms of their experience within therapy or contact with mental healthcare providers [30, 31].

Recovery narratives are essentially social in their nature—relying as much on audience as performer in terms of credibility [32]—as such forensic recovery focused work must take account of the multiple agencies that are essentially involved in the individual's narrative: For example, courts, parole, probation and wider community and potentially media interest. Building on the idea of connection as essential in recovery it is also important to consider ways in which the individual may wish to forge or re-forge links with their family and social networks. This sense of disconnection, always present for the incarcerated individual, has become more apparent with the atomisation of experience attendant following the emergence of a global viral pandemic [33].

In closing, I set out a proposal for a three-stage process for working in a recovery focussed fashion with individuals in forensic settings:

1. Safety in security: In keeping with Maslow [34] a sense of safety is essential to any therapeutic endeavour and can be provided within forensic environments.
2. Containment and expression: Appropriate witnessing of trauma and containment of this experience is essential in allowing the individual to process trauma in their past.
3. Synthesis and re-direction: Moving beyond their current trapped state allows individuals to develop a new sense of purpose—a positive sense of self, or positive narcissistic construct, in comparison with older internal representations.
4. Individuation and flourishing: Ultimately, as the concept of personal recovery suggests—the act is a personal one and personal narrative accounts and understanding represent a potential means of expressing this growing individuation and sense of eudaimonia [35].

References

1. Howell A, Voronka J. Introduction: the politics of resilience and recovery in mental health care. Stud Soc Justice. 2012;6:1–7.
2. Hanisch C. The personal is political. 2006.
3. Mechanic D. Illness and social disability: some problems in analysis. Sociol Perspect. 1959;2:37–41.
4. Anthony W. Recovery from mental illness: the guiding vision of the mental health service system in the 1990s. Psychosocial Rehabilitation Journal. 1993;16:11–23.
5. Davidson L, O'Connell MJ, Tondora J, Lawless M, Evans AC. Recovery in serious mental illness: a new wine or just a new bottle? Prof Psychology Res Pract. 2005;36:480–7.
6. Slade M, Willia J, Bi V, Leamy M, Boutillier CL. Recovery grows up. J Ment Health. 2012;21:99–103.
7. Leamy M, Bird V, Boutillier CL, Williams J, Slade M. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. Brit J Psychiat. 2011;199:445–52.
8. Longden E. Making sense of voices: a personal story of recovery. Psychos. 2010;2:255–9.
9. Fazel S, Baillargeon J. The health of prisoners. Lancet. 2011;377:956–65.
10. Young MH, Justice JV, Erdberg P. Risk of harm: inmates who harm themselves while in prison psychiatric treatment. J Forensic Sci. 2006;51:156–62.

11. Dear GE, Thomson DM, Hills AM. Self-harm in prison. Crim Justice Behav. 2000;27:160–75.
12. Goffman E. Asylums: essays on the social situation of mental patients and other inmates. Doubleday; 1961.
13. Foucault M. Discipline and punish. Gallimard; 1975.
14. Shepherd A, Doyle M, Sanders C, Shaw J. Personal recovery within forensic settings—systematic review and meta-synthesis of qualitative methods studies. Crim Behav Ment Health. 2016;26:59–75.
15. Moore KE, Stuewig JB, Tangney JP. The effect of stigma on criminal offenders' functioning: a longitudinal mediational model. Deviant Behav. 2015;37:196–218.
16. Hartwell S. Triple stigma: persons with mental illness and substance abuse problems in the criminal justice system. Crim Justice Policy Rev. 2004;15:84–99.
17. Nielsen E. Counternarratives of breast cancer and chronic illness: performing disruption, patienthood and narrative repair. Perform Res. 2014;19:97–106.
18. Maruna S. Making good: how ex-convicts reform and rebuild their lives. American Psychological Association; 2001.
19. Rauprich O, Vollmann J. 30 years principles of biomedical ethics: introduction to a symposium on the 6th edition of Tom L Beauchamp and James F Childress' seminal work. J Med Ethics. 2011;37:454.
20. Beauchamp TL, Childress LF. Principles of biomedical ethics. Oxford University Press; 2009.
21. Lee MJH. The problem of 'thick in status, thin in content' in Beauchamp and Childress' principlism. J Med Ethics. 2010;36:525.
22. Adshead G. Care or custody? Ethical dilemmas in forensic psychiatry. J Med Ethics. 2000;26:302.
23. Wunderink L, Nieboer RM, Wiersma D, Sytema S, Nienhuis FJ. Recovery in remitted first-episode psychosis at 7 years of follow-up of an early dose reduction/discontinuation or maintenance treatment strategy: long-term follow-up of a 2-year randomized clinical trial. JAMA Psychiat. 2013;70:913–20.
24. Birmingham L, Wilson S, Adshead G. Prison medicine: ethics and equivalence. Brit J Psychiat. 2006;188:4–6.
25. Forrester A, Till A, Simpson A, Shaw J. Mental illness and the provision of mental health services in prisons. Brit Med Bull. 2018;127:101–9.
26. Shepherd A, Sanders C, Shaw J. Seeking to understand lived experiences of personal recovery in personality disorder in community and forensic settings—a qualitative methods investigation. BMC Psychiatry. 2017;17:282.
27. Shepherd A, Sanders C, Doyle M, Shaw J. Personal recovery in personality disorder: systematic review and meta-synthesis of qualitative methods studies. Int J Soc Psychiatr. 2016;62:41–50.
28. Adshead G. Psychiatric staff as attachment figures. Brit J Psychiat. 1998;172:64–9.
29. Cho S, Crenshaw KW, McCall L. Toward a field of intersectionality studies: theory, applications, and praxis. Signs J Women Cult Soc. 2013;38:785–810.
30. Shaw C, Proctor G. I. Women at the margins: a critique of the diagnosis of borderline personality disorder. Fem Psychol. 2005;15:483–90.
31. Welldon EV. Dancing with death. Br J Psychother. 2009;25:149–82.
32. Hillman A. 'Why must I wait?' The performance of legitimacy in a hospital emergency department. Sociol Health Ill. 2014;36:485–99.
33. Hewson T, Shepherd A, Hard J, Shaw J. Effects of the COVID-19 pandemic on the mental health of prisoners. Lancet Psychiatry. 2020;7:568–70.
34. Maslow AH. A theory of human motivation. Psychol Rev. 1943;50:370–96.
35. Bauer JJ, McAdams DP, Pals JL. Narrative identity and eudaimonic well-being. J Happiness Stud. 2008;9:81–104.