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Clinicians' perspectives of forensic rehabilitation

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Having sought 22 clinicians' views of how rehabilitation was practised in a forensic mental health service, this study explores whether or not these views are consistent with claims that forensic rehabilitation can be hampered by the lack of a coherent rehabilitation framework. Two major, mutually influencing themes emerged from the participants' narratives, the first of which delineates the culture and functioning of individuals and systems in a forensic service and the underlying philosophies and beliefs guiding professional behaviour. The second theme outlines the participants' views of the ways in which client needs are assessed and how clients are subsequently provided with the skills and opportunities required for their rehabilitation. The results indicate that while the participants perceived that there were positive aspects to the forensic mental health care that was provided, they also stated that systematicity in the formulation and provision of forensic mental health clients' needs was lacking. These findings reinforce previous claims that there needs to be a theoretically sound means of embedding and systematising effective rehabilitation practice in forensic services.

Keywords: rehabilitation; risk management; forensic services.

1. Introduction

It is only in the last few decades that forensic mental health care has developed as a specialty, and along with it a growing awareness of the specific needs of this population. Prior to the development of specialist forensic services the primary focus for intervention was mental illness, with the assessment and management of reoffending risk only more recently becoming considered an essential component of forensic mental health care (Mullen, 2000). The shift to this simultaneous emphasis on psychiatric treatment and risk assessment and management has occurred due to both the development of forensic mental health care as an independent entity in general

and the growing body of empirical evidence regarding the validity of risk assessment developed for use in the correctional field. However, unlike their correctional and general mental health colleagues, forensic mental health clinicians now find themselves in a position where they must assess and manage risk alongside treating mental illness, with the dual goals being the care of the individual and the protection of society (Blackburn, 2004). The interventions used in forensic mental health care reflect these dual goals, with the majority reported in the literature broadly categorised as being based on a psychopathology model to manage mental illness or a correctional model to attend to the individual's offending risks,

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needs and responsivity (Barnao, Ward, & Casey, 2015; Robertson, Barnao, & Ward, 2011). In order to address the two imperatives, forensic rehabilitation programmes typically blend interventions from both paradigms.

Robertson et al. (2011) note that such a blending is problematic in that the two models are based on different assumptions, values, etiological theories and philosophical underpinnings, leading to conceptual confusion. A blended approach does not provide a theoretically informed basis for selecting intervention targets and, furthermore, does not indicate the emphasis to be given to risk assessment for recidivism versus the treatment of mental illness. In fact, the strong emphasis that blended approaches place on avoidance goals (i.e. eliminating the attitudes and behaviours associated with offending and symptoms of mental illness) may be counterproductive in the sense that such paradigms often fail to be engaging or motivating for clients.

The blended or hybrid approach to forensic mental health care appears to have arisen in the absence of a comprehensive framework being developed to guide forensic practice. There has been a strong drive for recovery-based principles to guide practice in forensic mental health care, with acknowledgement of the need to manage risk as part of the recovery process leading to the coining of the term 'secure recovery' (Drennan & Elred, 2013). However, the recovery paradigm neither accounts fully for offending in the context of mental illness nor serves to guide rehabilitation explicitly. What then could guide forensic rehabilitation practice in a way that bridges the gap between the two different paradigms while incorporating recovery and other humanistic principles? Ward and Maruna (2007) note the importance of theory-driven models of rehabilitation and outline the key aspects of rehabilitation theory. They assert that without a rehabilitation theory driving practice, practitioners will be unaware of the broad aims of rehabilitation and their relationship to offending.

Although the lack of a cohesive framework and the dual role challenge may be of theoretical concern, it is unclear whether or not these issues actually impede the provision of forensic mental health care or pose a concern for clinicians. It could be that moving between two paradigms is in practice neither difficult nor disruptive to client-centred care. It is possible that forensic mental health care is provided in a systematic way, with community protection issues being relatively easily incorporated – along with mental health treatment and other needs – into rehabilitation pathways. Conversely, with discordance between the dual systems and imperatives, there may be confusion about rehabilitation aims and thus a systematic rehabilitation pathway may be difficult to provide. Such difficulties could thwart professional practice and constrain the ability of services, teams and clinicians to work collaboratively in order to provide client-centred care and promote client autonomy and self-direction.

If the use of dual frameworks is indeed problematic to clinicians in a way that stymies collaboration, client autonomy and client-centredness, for example, this could reasonably be expected to show up in the literature on client and staff experiences in forensic mental health care. Service-user-focused research seeks to describe lived experience in forensic mental health care, gauging patients' views on their daily experiences of therapeutic relationships, their interactions with staff, the ward atmosphere/social climate and their quality of life. Studies have noted a range of views on these topics, including the expression of some satisfaction with staff care and quality of life. However, striking exceptions are noted, including claims of the lack of a person-centred approach (Schel, Bouman, & Bulten, 2015), the assertion that care and rehabilitation is 'patchy' (Hörberg, Sjögren, & Dahlberg, 2012) and the belief that paying insufficient attention to the therapeutic alliance and non-criminogenic needs such as personal distress and low self-esteem can result in perceptions of 'non-caring caring' (Hörberg et al., 2012).

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Few studies have directly canvassed views on issues related to the *raison d'être* of forensic mental health that is rehabilitation. The research of Barnao et al. (2015) is an exception. The authors sought users' experiences of rehabilitation in its entirety, as well as giving their participants the opportunity to comment on any aspect of forensic mental health care. They note that while support was expressed for a person-centred approach being taken to rehabilitation, positive staff relationships were mentioned and some awareness of the rehabilitation pathway was conveyed, most participants had a more negative perception of their care and rehabilitation.

Research has also explored clinicians' perceptions of a number of issues characteristic of forensic mental health care. To date, the focus of this discourse has been more on how forensic work affects clinicians rather than specifically on client rehabilitation and treatment issues or on the suggested reoffending risk versus psychopathology dichotomy. One consistent finding is the experience of significant levels of occupational stress, psychological distress and burnout (i.e. frustration, emotional exhaustion and physical fatigue), particularly among those working in secure environments (e.g. Elliott & Daley, 2013; Fagin et al., 1996; Nathan, Brown, Redhead, Holt, & Hill, 2007). Most of the research on stress amongst forensic mental health professionals has been undertaken with nursing staff, with a few studies including medical and allied health professionals (e.g. Elliott & Daley, 2013). However, the number of studies involving medical and allied health professionals is considered too small to make the results generalisable beyond nursing (Brown, Igoumenou, Mortlock, Gupta, & Das, 2017).

Research has also explored staff and service users' experiences of issues more directly related to rehabilitation. Livingston and Nijdam-Jones (2013) examined the foundation of the rehabilitation process and treatment planning by seeking the views of service users and providers. The study highlights needs

perceived by both staff members and peer groups for client-centredness (client participation, communication and knowledge of the client), the inclusion of a wider rather than restricted team of professionals, quantifiable progression along the rehabilitation pathway and trust and openness between staff and clients. Others have noted the demands and resulting role confusion of having to undertake surveillance and monitoring in forensic nursing (Doyle & Jones, 2013). Overall, the literature tentatively supports claims that the current position of forensic rehabilitation at the intersection of the two paradigms is problematic (e.g. Adshead & Sakar, 2005; Barnao et al., 2015; Doyle & Jones, 2013).

In light of the above, the present study aims to further the current understanding of staff perceptions of how forensic rehabilitation is conceptualised and provided. Specifically, the research goals are firstly to delineate clinicians' views of rehabilitation in a forensic mental health context and secondly to establish the extent to which their views reflect problems arising from the lack of a rehabilitation theory or framework.

2. Method

2.1. Setting

The study was carried out in the Forensic and Psychiatric Rehabilitation Service located on the North Island of New Zealand. The participants were drawn from four in-patient units: a male-only, medium-secure forensic unit; a mixed-gender, medium-secure unit; and two mixed-gender, combined forensic/psychiatric rehabilitation units.

2.2. Participants

Brief presentations on the research were given during ward business meetings, nursing handovers and professional development and other staff meetings, and staff members were asked to contact the researcher if they wished to participate.

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The 22 staff members who volunteered to take part in the study (17 females, 5 males) had all worked with forensic clients for at least six months; their ages ranged from 27 to 78 years ($M = 44.40$, $SD = 13.65$.) and their ethnicities are New Zealand Caucasian (45%), New Zealand Maori (23%), Pacific Island (9%) and other not born in New Zealand (23%). The disciplines represented include occupational therapy and support staff (13.6%), nursing and support staff (50.0%), psychiatry (9.0%), psychology (13.6%) and social work (13.6%).

2.3. Procedure

The Rehabilitation Evaluation Guide (REG) is a semi-structured interview guide that was developed for the purpose of this research to elicit participants’ perceptions about current forensic rehabilitation. In addition to general open-ended questions such as ‘How clear are you about what the client needs to do to move through the service and back to the community?’ and ‘What do clients do every day?’, the REG also includes questions developed from the theoretical concepts that underlie rehabilitation theory (see Robertson et al., 2011; Ward & Maruna, 2007) such as ‘Do you have an understanding of how an individual became a forensic client?’

Each participant took part in an approximately one-hour interview focused on their perceptions of the delivery of forensic rehabilitation. The participants signed consent forms at the beginning of the interview and it was made clear that the interview would be audio-recorded, that participation was voluntary, that published material would not be identifiable and that they were free to withdraw at any time. The interviews were scheduled during work hours, at a time and location that suited the participants. No compensation was provided. The interviews were audio-recorded and the data were transcribed verbatim.

2.4. Data analysis

The data were examined using thematic analysis (Braun & Clark, 2006), a qualitative procedure that was considered suitable for this project because of its flexibility in identifying and organising patterns in data. The interview transcripts were first analysed in detail by the lead author. This allowed for the identification of groups of meanings (initial codes) within the data until key patterns began to emerge. Further review and refinement enabled categorisation into sub-themes, allowing for greater understanding of the data (Stebbins, 2001). With further analysis, concepts became more abstract and those relating to the same sub-themes were grouped into higher-level themes (Braun & Clark, 2006). During this initial stage – in order to ensure the validity of the codes and themes – the data were also coded and refined in collaboration with the research supervisor. The resulting themes and sub-themes were then cross-referenced across all transcripts. An independent rater was then provided with a description of the themes and a random sample of the transcripts (23%) and asked to indicate the presence or absence of these themes in the sample.

3. Results

The participants’ experience of forensic mental health work is categorised into two superordinate themes, each with constituent sub-themes (see Figure 1). The first theme, **Professional Context and Culture**, refers to the landscape or context of forensic rehabilitation. This theme reflects the participants’ perspectives comprising:

- *Team Functioning* – how the collective provision of forensic mental health care was experienced;
- *Professional Self and Other* – insights into their own and their colleagues’ roles and behaviour;
- *Philosophies, Values and Frameworks* – the underpinnings of their principles

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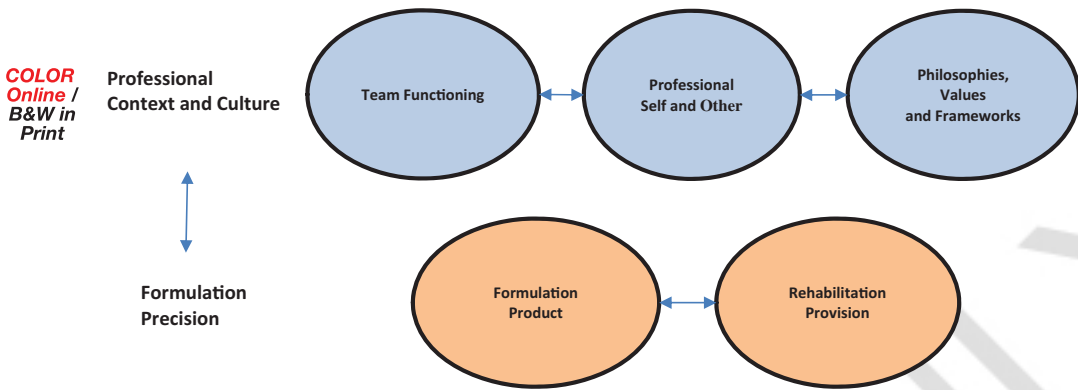


Figure 1. Themes derived from the participants' perceptions of forensic rehabilitation.

and practice as forensic mental health clinicians.

The second theme, *Formulation Precision*, refers to the ways in which rehabilitation needs were devised and rehabilitation was provided. This theme reflects the participants' perspectives comprising:

- *Formulation Product* – narratives on the ways in which clients' rehabilitation needs were formulated;
- *Rehabilitation Provision* – the actual interventions that were provided to clients.

3.1. Professional context and culture

This overarching theme, which pertains to the context in which the forensic rehabilitation was provided, embodies perceptions of team and individual practice and the principles and frameworks that guided this practice. The three constituent sub-themes – *Team Functioning*, *Professional Self and Other* and *Philosophies, Values and Frameworks* – are outlined below.

3.1.1. Team functioning

A well-functioning team was considered to enable staff to collectively formulate client needs and work through complex clinical issues in a relatively democratic way. Almost all participants expressed positive views about

their team – particularly regarding the importance of the work that the other disciplines carried out – as well as admiration for the complex, demanding and sometimes high-risk clinical work that was being undertaken. However, they were less positive when discussing decision-making processes and power hierarchies within the team; although some participants described positive experiences of collaborative teamwork, most articulated a more ambivalent view of team functioning. This can be seen in their descriptions of how clinical decision-making was carried out:

This unit is pretty good in terms of being [made up] of a lot people's opinions, so usually decisions are made in weekly multidisciplinary team meetings where that's obviously driven by psychiatrists' impressions and assessments of the client at that point – but usually there is input from the rest of the team, this unit more than other places.

A dominant theme in the participants' reflections is the extent to which the team worked together effectively to plan and provide rehabilitation for mentally disordered offenders. One factor influencing the participants' perceptions was the degree to which they considered they could not only participate in multidisciplinary team meetings but also feel that their viewpoints were being heard and considered when rehabilitation planning and

provision were taking place. Some participants felt that their viewpoints were not being considered, when expressed either in clinical situations or in more formal meetings. Some participants also noted that they did not have the opportunity to attend meetings and/or express their viewpoints, despite their key roles working directly with clients. Several participants explained that their shift patterns precluded attendance of multidisciplinary team meetings, while others expressed that it was not considered to be within their remit to do so. As a result, they often experienced confusion about the rehabilitation decisions that were being made by the team:

One of the difficulties about the current work situation is that not everybody in the team feels empowered to speak at meetings, which is to do with the way meetings are run.

Many participants described power imbalances within the team's social hierarchy, noting the ascendancy of psychiatry in clinical decision-making. They also perceived that the views of the psychiatrists overshadowed others' opinions. Whilst some participants believed that the lack of participation in decision-making was determined by the dominance of psychiatric opinion and the strong medical culture of the institution, others suggested that the unilateral decision-making was due to a general lack of confidence among some clinical staff, rooted in the perception that alternative clinical opinions were not welcomed by the psychiatrists. This is illustrated by the following quotation, in which the participant suggests that some team members prefer to leave decision-making to the doctors:

I do think that this service automatically falls back on the medical model: 'we don't want to make decisions so you make decisions as a doctor'. That is very unhelpful – you could be in a room with 100 years of mental health experience and people don't say anything, that gets very difficult and that is what perpetuates the medical model because you are forced to

make those decisions because nobody else wants to.

A lack of effective leadership was also suggested as a factor, with staff not having a shared understanding or agreement of what they needed to do, resulting in inconsistent practice with the client and a 'splitting' of the team. These participants appeared to view leadership as a means of ensuring that treatment planning was democratic and that staff felt empowered and confident to participate:

I feel that a lot of staff who come here don't actually know what they are doing and so you need to have leadership so that everybody is on the same page [...] because you could have a plan for a patient who you are working with but you have other staff who are completely against that plan – so you have a lot of staff splitting.

3.1.2. Professional self and other

All participants had a strong narrative about their own professional practice and that of others, including both positive and negative aspects of carrying out their roles as forensic mental health professionals. This aspect was clearly important, as each participant provided an account of their own and their colleagues' professional roles and behaviour, and the extent to which they considered themselves and others able to effectively execute these roles.

Most participants offered a positive view of their role in forensic mental health care, expressing the satisfaction that it gave them on both a personal and a professional level. A variety of factors were noted as contributing to this satisfaction, including: the legal aspect of forensic assessment and treatment; the challenges of forensic work; the acute but responsive nature of the client group; the attributes of the client group; the comparatively better resourcing of forensic mental health services compared to general mental health services; the variety of the work; working with people;

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571 and the knowledge that there is good commu-
 572 nity follow-up for forensic clients.
 573 For example:

574 I enjoy it, I don't have to do the same
 575 thing every day and I quite like change.
 576 I love working with people on a personal
 577 level so I really enjoy it. I think I enjoy it
 578 because people stick around a lot longer,
 579 so you can actually see improvement in
 580 their lives.
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582 Some of the participants in support or
 583 occupational therapy roles emphasised the
 584 importance of supporting clients to work
 585 towards their goals, such as obtaining a driv-
 586 er's licence, with the broader purpose of help-
 587 ing them to carry out self-directed, intentional
 588 actions designed to achieve valued goals. They
 589 considered their non-medical roles to be more
 590 straightforward than the roles of their medical
 591 colleagues, because they did not have to
 592 engage in active negotiation about the medico-
 593 legal aspects of client care – such as supervising
 594 medication adherence – or be involved in
 595 the decision-making around leaves and restric-
 596 tions. This allowed them to interact with cli-
 597 ents in a more normative, more agentic and
 598 less threatening way than some of the other
 599 mental health clinicians:
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601 For nurses there are lots they have to do
 602 [...] there is medication they have to
 603 argue with clients over, all of that; and
 604 I don't have to get into any of those
 605 arguments with people, so the relationship
 606 is a bit different – I think it can be seen as
 607 more of a mutual ground.

608 Those participants whose role required
 609 them to deal with the less palatable presenta-
 610 tions (such as serious self-harming behaviour)
 611 and aspects of care that are more complex
 612 reported how both training and experience
 613 helped them to negotiate such major chal-
 614 lenges, which included the assessment and
 615 management of risk of harm. A strong feature
 616 of the participants' accounts is an expressed
 617 confidence in dealing with interpersonal
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619 challenges with clients, an ability that they
 620 attributed to experience:
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622 For me the most important thing is to treat
 623 people with respect, but I am real about
 624 that. If we have a patient that's come in or
 625 any patient for whatever reason is abusing
 626 the crap out of me I will be very honest,
 627 'I don't get paid for that', and it's being
 628 honest and reflective about that, quite
 629 often they will stop and apologise – but
 630 when you start digging deep and finding
 631 out what is actually going on for this
 632 person and you start to unravel some
 633 anxieties around what happened to them,
 634 you don't take that personally. I have
 635 learnt never to take that personally but to
 636 be very open and honest about
 637 challenging people [...].

638 The majority of the participants spoke
 639 positively and in detail about their knowledge
 640 of, and comfort with, assessing and managing
 641 the risk of institutional and community vio-
 642 lence. A minority of the participants who were
 643 in nursing or support roles indicated less fami-
 644 liarity with risk assessment and management,
 645 although all participants had a consciousness
 646 of the general risk of harm to others associated
 647 with the client population:
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649 I have been nursing for coming up 25
 650 years now so for me it has given me a
 651 group broad scope of knowledge of
 652 wellness, having a balance, recovery and
 653 healing processes.

654 Also challenging was the requirement in
 655 some roles (e.g. psychiatry) to manage the
 656 demands of treating an individual whose
 657 behaviour, illness and/or medico-legal status
 658 necessitates finding a balance between oppos-
 659 ing criminal justice and mental health impera-
 660 tives. Participants for whom this was a
 661 concern noted the challenge of this duality but
 662 also cited the training, supervision and colle-
 663 gial advice that they used to navigate these
 664 seemingly contradictory demands:

665 You are constantly juggling the rights of
 666 society and the community and the rights
 of the individual patient, and in forensics

by definition mostly patients forfeit some of their rights because of the risky nature of their behaviour. How do you resolve that? Well, that is something that you wrestle with, you discuss with colleagues, it's the court that decides whose rights are going to predominate.

Some nursing participants expressed discomfort with exploring issues to do with the offending or with managing aggressive behaviour, explaining that they thought such exploration was the role of their psychology and psychiatry colleagues and that their training and experience had not prepared them for such work:

Follow the documents rather than using our initiatives. I think there is fear as well – delving into clients' forensic history. There might be the fear that we are overstepping our mark or working outside of our professional discipline. I think there is fear in that.

Obstacles to providing an individualised service were highlighted in the majority of the participants' narratives, including a lack of training, limited access to information, a lack of consistent and clear pathways, under-resourcing and a lack of responses from management when specific resources were requested or clinical innovations were proposed. These obstacles forecast some of the problematic issues and behaviours reported by the participants about their colleagues, although less than satisfactory practice was seen in only a minority of staff, and such practice – while unsatisfactory – was not of an abusive nature. Many participants reported attitudes and behaviours observed in their colleagues that they viewed as not being conducive to rehabilitation, including perceived pessimism and burnout that manifested as resistance to innovation and change. Some participants offered opinions on the factors that might have underpinned these issues, and offered some solutions to support positive change in staff behaviour:

You very much see here people getting burned out, and they have the whole 'I'm burnt out; this is what I am going to do, I am going to be here ... I don't want to do anything else ... I don't want to do this ... I don't want to invest my energy because I've tried to do it before and it didn't work ... who cares ... what is the point?'

I think it needs to have a pretty good shake up but not as in telling staff how it appears but giving them training, bringing them on board and getting them to give ideas of how we can do it so they get buy-in in the work.

Although the participants acknowledged a comparative resource advantage in the forensic context, they still expressed frustration with the resourcing of what they saw as basic rehabilitation requirements. Difficulties with obtaining resources such as sporting equipment, staff escorts and transport for clients were noted. Some of these resourcing difficulties were attributed to working with both clients with acute care needs and those with long-term rehabilitation needs. Some participants were of the view that the rehabilitative innovations they had proposed had not been actioned:

I think that part of the issue of the active stuff not happening is that people are burnt out from having been told no all the time – 'yeah it sounds like a good idea but there is no money, sounds like a good idea, go and write a proposal for it'. All that no 'putting your money where your mouth is'.

3.1.3. Philosophies, values and frameworks

Some participants reported that their practice was guided by professional frameworks that they had encountered in their academic learning, professional training and/or work experience. These frameworks tended to reflect the participants' respective professional backgrounds (e.g. a medical model for doctors, cognitive behavioural therapy for psychologists, a model of occupational

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functioning for occupational therapists, etc.) and were not specific to forensic mental health. In addition to the models allied with their professional groups, some participants' use of a framework appears to have been determined by its personal appeal to them. The majority of participants reported that their practice was not guided by a sole model but instead by an eclectic mix of models and philosophies that appears to be implicit and not clearly delineated:

I don't know if one specific model would be right, it is not going to fit everybody and it is good when you have a bit of knowledge – good to have an in-depth knowledge of a lot of models.

Some participants promoted the value of comprehensive frameworks in ensuring that each client's needs were viewed more broadly and that specific needs were not overlooked. It was also suggested that an overarching framework could help to ensure that more salient issues such as mental illness and risk of harm were not overemphasised to the detriment of other areas of a client's life:

I think I need a framework – they help me check-up I am doing things the right way. I would be an island in the stream if I didn't have that [...] I have to be accountable, if I don't have a framework I wouldn't be very accountable for what I am doing.

Most participants noted the need for culturally specific models of well-being to be used when working with clients of a different culture. The Te Whare Tapa Wha Model of Maori (indigenous) well-being was frequently mentioned as crucial when working with Maori clients. The medical model was referred to with ambivalence within this context by some participants – particularly those in allied health roles whose practice was perceived as more holistic, but also some of those with nursing backgrounds – because of its perceived dominance and the culture that supports it. These participants acknowledged that the medical model was a necessary but insufficient aspect of rehabilitation.

The importance of the personal values underpinning the way in which clients are viewed and treated is also a feature of many of the participants' accounts. Almost all the participants directly expressed a positive regard for the client group, with some articulating the client-centred, humanistic philosophies and values underpinning their care practices and their views of their clients. These participants outlined philosophies of viewing the forensic client as being the same as them. Humanistic concepts were expounded by many participants, who stressed the need to take a non-judgemental approach to the forensic client and to adopt a philosophy of viewing and treating them as a family member. These values and philosophies determined their views of clients' histories and presentations, and guided them in their interactions with clients. The participants suggested that these philosophies and values are anchored in how they were brought up and have been developed through personal experience, rather than arising out of the philosophies, codes of practice and values of their professions and organisations:

I have always believed that the person in front of me could easily be my brother, and how would I like him to be treated?

I think sometimes it is about who you are as a human being and your own philosophy on life, and maybe experience as well.

By contrast, some participants commented on the more judgemental personal philosophies of staff that regarded forensic service users as being different or inferior and being primarily culpable for their offending:

I think that there is judgement amongst staff that they [the clients] are worse than other people.

3.2. Formulation precision

The themes under this rubric are *Formulation Product*, which describes the explanation that

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the participants gave of their clients' trajectories to offending while mentally unwell, and *Rehabilitation Provision*, which encapsulates the participants' observations of what rehabilitation is actually provided to the clients and the extent to which it is perceived to meet their needs.

3.2.1. Formulation product

It was considered essential by many participants to gain a comprehensive understanding of the factors that led to each client's offending while mentally unwell, and thereby form a consequent understanding of their rehabilitation requirements. This was deemed particularly important for those whose roles involved clinical leadership, client treatment and/or legal responsibility. These participants – from the psychiatric and psychological disciplines – gave cohesive and detailed accounts of how illness and other factors had aligned to result in serious crimes being committed by the clients in their care, along with an articulation of what interventions would be needed for them to lead healthier, offence-free lives;

you treat the acute illness and get them as well as you can mentally, and then you start dealing with the other stuff that needs dealing with – the issues like dysfunctional attachment issues, alcohol and drug issues, antisocial personality, other personality dysfunction issues – all of the other factors that are disabling in their lives apart from illness.

In addition to the salient offending and mental illness factors, the participants also highlighted the importance of ascertaining and harnessing clients' strengths, as well as their interest in being rehabilitated, noting that individual strengths are often discovered in conversation rather than during purposeful assessment.

The participants' formulation of their views of the clients and the reasons why they came to offend was arrived at primarily through formal client interviews, reference to

documentation and file information and input from other members of the team, as well as through individual assessments and discussion in routine meetings. Although many participants noted the desirability of having shared assessment and rehabilitation frameworks, very few indicated that these were in place. While case formulations were being shared with teams and documented in reports and plans, as well as existing as mental representations in the minds of their formulators, they were – according to some participants – not systematically created, universally shared, consensually understood or embedded as foundations of rehabilitation planning, pathways or programme selection:

I really do think it is a team approach, and this is where your weekly team meetings should be helping you to understand this person's illness and how it fits into the index offence and how it fits into everything.

Some of the participants suggested that an inadequate formulation of individual clients' issues or even a generic understanding of offending in the context of mental disorder underpinned staff countertransference and the inappropriate attitudes and behaviours towards clients that they had observed. In contrast to those who conveyed a comprehensive and individualised understanding of each client's pathway into forensic mental health care and of their current and future rehabilitation needs, a significant number of participants had only a generic formulation that they applied to all the clients. This group of participants – who were primarily from nursing backgrounds – proposed a generalised pattern of illness, offending and legal factors that led to individuals coming into the forensic mental health care system. Some of these participants explained that their generalised understanding was also supplemented by information obtained from interactions with clients, reading available documentation and exposure to team discussions. A small number of participants, who

tended to be in support roles, had an even more generalised understanding of forensic clients' needs, asserting that clients were in forensic mental health care due to mental illness and a loss of functioning that would respond well to good self-care, staff guidance and participation in structured vocational and other activities:

For forensic clients it's really simple; you adhere to your leaves, you get more, you understand your early warning signs, you understand why the index offence happened and how to prevent it happening again – basically you put in the work and you progress and you leave.

For many participants, the treatment plans and pathway documentation were neither clear nor specifically tailored to what was known about the clients' needs. As the documentation and treatment did not appear to relate to specific client needs, some participants said that the client pathways were opaque to them. These participants also emphasised the changing nature of the clients' rehabilitation goals and the difference that a change in key clinicians could make to the duration of hospitalisation. Some of the participants claimed that there did not seem to be consistency in the rehabilitation protocols or the responses from clinicians to clients, and that the rehabilitation aims seemed to change arbitrarily:

the client needs to have a good understanding of the formulation, which is not just [...] having a good understanding of their illness but also the overarching formulation of why they are here now – why they are presenting, what has led up to their issues, background factors that insight can be quite healing, lessens the confusion and validates their life experience and sees them as a whole person [...] At the moment it is probably more haphazard and it depends on who the client is and who is involved and what we know.

I feel very ashamed, I think it is very grey myself, I sort of think the goalposts keep changing.

Most commonly, the participants' understanding of the clients' rehabilitation needs was based on generalised clinical areas (mental illness, substance abuse) and pathways associated with their legal status (increasing community leaves) or what constituted 'good behaviour'. Although an understanding of clients' strengths was viewed as essential by all participants, these strengths were uncovered via informal talks with clients rather than as part of any systematic case formulation. The need for client-centred processes was clearly and repeatedly stated by the participants, who used words and phrases like '*walking with*' the client and '*sharing a journey*'. Some of the participants believed that a lack of client-centredness could lead to problems such as ongoing substance abuse and a lack of adherence to medication and legal requirements:

The patient says 'I am going to do what I have done in the past because I don't want to do what you have set up for me to do. You have set me up to fail – you should have asked me first'.

3.2.2. Rehabilitation provision

All the participants acknowledged the value of the programmes, activities and therapies that made up the clients' rehabilitation schedules, and were highly appreciative of the staff involved in their provision. They explained that these programmes and activities were beneficial and provided clients with skills and opportunities that would be helpful to them when they re-entered the community.

The participants asserted that each client needed an individualised, step-wise approach to rehabilitation that met their unique needs. However, they further explained that clients might need the most basic level of support and encouragement in order to progress, and that this support – in addition to appropriately graded and sequenced rehabilitation content – should primarily use the therapeutic

relationship as the vehicle. Some of the participants asserted that helping clients to attain skills was akin to proficient parenting, requiring the development of skills, nurturing, the teaching of appropriate behaviour and limit setting. It was also suggested that all aspects of rehabilitation, including the therapeutic relationships, needed to be tailored to each client's culture and life experiences, and that this would help them to engage in the necessary therapies, programmes and activities:

You need to tailor every conversation you are having in a slightly different way, even the language you use is different. Sometimes the tone is different.

While most participants were clear that interventions needed to address the issues related to each client's mental illness and offending, they reported that the range of activities and programmes that were offered was limited and therefore did not necessarily cater to specific goals, needs or interests:

All [the programmes] are doing is just playing custodians while their time is being served. I think that is why we just have a lot of clients returning or you hear about them in different wards or you hear about them being in prison again. I don't think we are doing anything to prepare them.

The participants spoke about the need for rehabilitation content to replicate community-based activities and for clients to experience the normalcy of universal human experience, including work, leisure and relationships. Some participants expressed concern that programmes were often prescribed to clients due to their availability or the interests of the facilitators rather than any specific rehabilitation need ascertained from an assessment process, and that the benefits of some groups were unknown. They also noted that many of the clients appeared to be undertaking little to no rehabilitative activity, and some referred to the benefits associated with the days of the old

psychiatric institutions, where there were several businesses operating to afford clients with opportunities to experience much more vocational activity. The undesirability of compulsory programmes was also asserted – particularly those that appeared to be unrelated to clients' needs, wishes or goals:

How can you rehabilitate someone when they are totally told what they can do and when and this is totally in the control of the nurse?

4. Discussion

This study sought to explore how forensic mental health care clinicians viewed care and rehabilitation in an inpatient forensic service. It also aimed to clarify whether or not these clinicians' views are consistent with the literature in this area, which has highlighted the professional and personal challenges faced by clinicians working on the rehabilitation of individuals whose mental illness has a nexus with criminal behaviour.

On a high note, the participants' narratives suggest a universally held positive view of their work in forensic mental health care, as well as positive views about the ways in which mental illness and risk of violence were managed – particularly at an acute level. Similarly, appreciation was expressed for the value of multidisciplinary practice, culturally appropriate input and interventions provided by all disciplines. A shared regard for the humanity of the forensic service users was also conveyed.

Although positive views were held by all the participants, there was also a consensus that they were not working in a forensic environment wherein the clients were systematically assessed by sound multidisciplinary team processes that led to the formulation of clear individualised rehabilitation plans. Similarly, the participants were mostly concerned that there were insufficient rehabilitation programmes, therapies and interventions that would enable the clients to return to community living.

Perceptions of forensic rehabilitation can be viewed as falling along a continuum from optimal to woefully inadequate. As noted, none of the participants' views fell at the optimal end but also none fell at the woefully inadequate end. Most of the narratives highlight some shortfall between how forensic mental health care should be provided and the realities of service provision. There was a shared perception that rehabilitation was provided in an inconsistent manner, with clinical decision-making falling largely into the hands of a select few. It was also widely perceived that the institutional environment and its processes were not conducive to dynamic, client-centred clinical practice, appropriately paced rehabilitation and beneficial therapeutic relationships. Essentially, the key area of shortfall noted was the lack of clarity and robustness surrounding rehabilitation planning and programme selection, and this perception was unsurprisingly considered by the participants to be shared by the clients. Also considered suboptimal was the way in which decision-making about client care was undertaken – often in the absence of real multidisciplinary participation and evidence-based practice. Indeed, the lack of reference to an evidence base is notable, although perhaps not surprising given the limited empirical knowledge in this area (Keune, de Vogel, & van Marle, 2017). Overall, the participants' comments suggest that while there were pockets of sound rehabilitation and assessment, these appeared to be tethered to specific individuals, subsystems and/or points in time rather than anchored to unyielding clinical philosophies and organisational frameworks and procedures.

The current findings are consistent with other recent research undertaken with forensic mental health staff (e.g. Kurtz & Jeffcote, 2011) which has identified generally positive attitudes towards clients and clinical work but has also found that organisational issues can be perceived as more stressful than working with clients. Recent research has also suggested that staff members appreciate working

in multidisciplinary teams but perceive that the hierarchies within them can exclude some individuals from participating in clinical decision-making and being more involved in treatment planning (Livingston & Nijdam-Jones, 2013). Although in the current study the participants reported having positive attitudes towards their clients, they did report a minority of colleagues who appeared to have some negative attitudes towards clients and their violent offending. The need for such issues to be managed is similarly observed by Harris, Happell, and Manias (2015), who recommend service support including supervision, more effective communication and improvements in the functioning of multidisciplinary teams.

Parallel research conducted in the same service as the present study suggests that, from the perspective of the clients, rehabilitation pathways were not clear, rehabilitation programmes were not tailored to the clients' individual needs and there was a lack of client-centred care (Barnao et al., 2015). Barnao et al. (2015) assert that the lack of a rehabilitation framework to guide all aspects of forensic care has resulted in a reliance on the traditional biomedical model that was embedded in the institutional culture. The participants' reported reliance on their own internal philosophies and frameworks is also consistent with Beryl, Davies, and Volm (2018), who found that staff needed to synthesise information in order to manage the emotional and practical aspects of forensic mental health care.

Faced with the question of how forensic mental health services could entrench the positive practices outlined in the research while also ameliorating the clear areas of suboptimal functioning, it is suggested that a superordinate framework is needed to guide the cultural, contextual and formulation factors outlined by the participants of this study (see Figure 2). Such a framework would ideally guide all aspects of forensic rehabilitation – that is, not only the rehabilitation needs of the clients but also the systemic and professional factors noted by the participants as being integral to

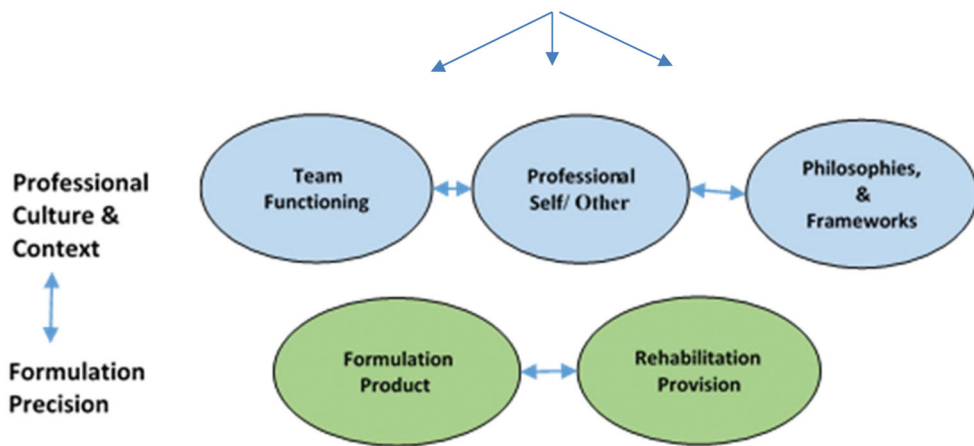


Figure 2. A superordinate framework (e.g. the Good Lives Model/Secure Recovery Model) to guide forensic rehabilitation.

best practice. With respect to the results of this study, it is apparent that in addition to answering the questions of how forensic clients' needs might be formulated and how rehabilitation might be provided, a superordinate framework that directs interventions based on clients' rehabilitation needs could also assuage – if not eliminate – some of the issues noted by the participants. Having a rehabilitation framework in place would mean a systemic shake-up with regard to roles, responsibilities, priorities and resourcing. In the absence of an explicit framework, there appears to be a constantly shifting constellation of parts that comprise the medical model, risk management procedures, managerial/clinical leadership and direction, political pressures and governmental priorities. As noted by the participants, this *mélange* can sometimes hit the mark but at other times can be way off target.

It may seem like a grandiose goal to suggest that a client-centred framework could guide all rehabilitation practice while incorporating best clinical practice and risk management. Until recently, client-centred approaches have been lauded in mental health but usually marginalised in forensic services because of their perceived inability to theoretically and operationally synthesise the risk management and mental illness treatment needs with the

client-centred aspects of the strength-based models. More recently there has been adaptation and use of the recovery approach in forensic mental health. The potential tension inherent to the recovery approach in seeking to empower the individual whilst also managing risk (Pouncey & Lukens, 2010) has been explored and is seen as resolvable. From a recovery perspective, the forensic client is viewed as a lead participant in their own risk management as well as their recovery (Adshead, Ferrito, & Bose, 2015; Drennan & Elred, 2013). There has been little empirical research conducted on recovery in a forensic population to date (Vandeveldt et al., 2016); however, the recovery model has been explored, developed and applied in several forensic settings, with promising preliminary results reported (Adshead et al., 2015; Drennan & Elred, 2013).

The Good Lives Model (GLM; Ward & Stewart, 2003) of offender rehabilitation, originally applied to sexual offenders, has now been developed and applied to the forensic population and is considered to be gaining traction in the forensic area (Barnao et al., 2015; Barnao, Robertson, & Ward, 2010; Robertson et al., 2011). Furthermore, it has been suggested that the GLM is consistent with rehabilitation theory (Ward & Maruna,

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2007) and has the threefold capacity to delineate the general principles and values underpinning rehabilitation, provide a generalised etiological explanation of behaviour and direct interventions. In terms of practice implications, the GLM specifies the collaborative way in which the client is worked with to develop a 'Good Lives Plan' that incorporates their preferences, with interventions tailored to provide them with the skills and opportunities to lead a better life – as well as a lower risk one. In contrast with current practice, the GLM specifies the what, why and when of forensic interventions based on client preferences, but also in a way that is consistent with the interests of society. Such specificity of formulation and intervention could potentially eliminate the inconsistencies and delays raised as concerns by the participants of the present study, which are likely rooted in the current lack of guidance on forensic rehabilitation.

Q4

There are several limitations that need to be borne in mind when considering the findings of this study, including the small sample size and also the fact that while every effort was made to facilitate participation, those who did elect to take part may not be representative of the population at large. Furthermore, although the lead author had limited professional contact with the participants, his dual role as both a researcher and a clinician working in the service might, nonetheless, have influenced what was said or not said by the participants. Additionally, whilst thematic analysis methodology is considered to be appropriate for exploratory research such as this, it is not designed to produce generalisable conclusions; therefore, no inferences should be drawn about the prevalence of the observed phenomena beyond the confines of the study.

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5. Conclusion

While it is acknowledged that there is a multitude of factors underlying optimal forensic mental health care practice, it is suggested that a well-fitting rehabilitation model would go a long way towards guiding best practice and

ameliorating some of the challenges noted in this study. An appropriate overarching rehabilitation model could help to ensure that clinicians, teams and services are all working from the same blueprint. It could essentially incorporate the humanistic philosophies and evidence-based interventions and practices that were highlighted as positive by this research, as well as providing a means of ameliorating some of the concerns about team functioning, professional roles and rehabilitation pathways and content. Crucially, a rehabilitation framework would also necessitate and at times prioritise approaches other than the default traditional pharmacological and therapeutic ones that are almost always necessary but are often neither successful nor sufficient. This would in turn lead to a greater valuing of the practitioners whose roles in multidisciplinary teams are not currently prominent, and could provide a platform for more resourcing of those activities that may be as necessary as medication in reducing risk and promoting well-being. It is likely that some of the perceived rehabilitation pathway and process limitations highlighted herein are due, in the absence of other paradigms, to a reliance on generalised treatment and risk-management protocols that simply do not meet the needs of the forensic client. Future research needs to examine the use of potential fit-for-purpose frameworks, including the GLM and the recovery models adapted for use in forensic settings.

Ethical standards

Declaration of conflicts of interest

Peter Robertson has declared no conflicts of interest.

Mary Barnao has declared no conflicts of interest.

Tony Ward has declared no conflicts of interest.

Astrid Birgden has declared no conflicts of interest.

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1435 Sharon Casey has declared no conflicts
1436 of interest.
1437 Belinda Guardagno has declared no conflicts
1438 of interest.
1439

1440 **Ethical approval**

1441 All procedures performed in studies involving
1442 human participants were in accordance with
1443 the ethical standards of the Deakin University
1444 Human Research Ethics Committee and the
1445 Central Regional Ethics Committee of the
1446 Ministry of Health in Wellington, New
1447 Zealand, and with the 1964 Helsinki declar-
1448 ation and its later amendments or comparable
1449 ethical standards.
1450

1451 **Informed consent**

1452 Informed consent was obtained from all indi-
1453 vidual participants included in the study.
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1455

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