“You always remain that monster.” Challenges to recovery-oriented care in forensic mental health services

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Abstract

Purpose – *Few studies have investigated the complexity that arises when applying recovery-oriented principles, such as hope and autonomy, in the context of forensic treatment. This study aims to explore these complexities.*

Design/methodology/approach – *Semi-structured interviews were conducted with 11 professionals and 9 service users from six different organisations providing low, medium or high-secure forensic mental healthcare. The interview transcripts were analysed using Consensual Qualitative Research in a team of three researchers.*

Findings – *Several challenges were identified in the analysis. These challenges include the often implicit focus on recovery, the need to have hope to give hope and the delicate balance between care and control. Whereas most of the barriers to recovery can be placed within forensic mental health services, stigma is a major barrier that can hinder social recovery.*

Practical implications – *Drawing on the CHIME framework, this study outlines key dilemmas in promoting recovery-oriented work within forensic mental health services. Heightened awareness of these challenges can inform the development of explicit strategies to maintain recovery principles, even in complex or adverse situations.*

Originality/value – *While the principles of recovery-oriented care fit well within forensic settings, their application occasionally presents considerable challenges. Navigating these challenges requires a lot from professionals. Therefore, strategies aimed at enhancing the psychological resilience of service providers are essential to sustain a recovery-promoting attitude towards service users.*

Keywords *Recovery, Forensic mental health care, Service users, CHIME model, Stigma, Resilience*

Paper type *Research paper*

In recent years, the importance of personal recovery has been increasingly recognised in forensic mental healthcare. Since 2011, there has been a notable increase in the number of studies on recovery-oriented forensic practices (Simpson and Penney, 2018). The conceptual framework of personal recovery, summarised as CHIME, introduced by Leamy *et al.* (2011), is largely applicable to forensic mental healthcare (Senneseth *et al.*, 2022). CHIME is an acronym for the five recovery processes: connectedness, hope and optimism about the future, identity, meaning in life and empowerment. These processes have a slightly altered meaning in forensic mental health services (FMHS) and also include, for example, connectedness with fellow service users on the units, coming to terms with past offences and experiencing a sense of empowerment within a framework of restrictions. Furthermore, safety and security are essential in FMHS and support recovery (Senneseth *et al.*, 2022).

Different developments within FMHS may also facilitate recovery-oriented practices. For instance, the inclusion of protective factors in violence risk assessment can stimulate

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clinicians to not only look at risks, but further develop service users' strengths and motivate both patients and themselves. Therefore, it is described as a way to promote recovery (Domjancic *et al.*, 2019; Doyle *et al.*, 2021; Royal College of Psychiatrists, 2019). Furthermore, the Good Lives Model is a strengths-based approach aimed at providing offenders with internal and external resources to live rewarding and offence-free lives (Ward *et al.*, 2007). This aligns with key recovery processes, such as hope and supporting offenders to live a meaningful life (Lutz *et al.*, 2022). These strengths-based approaches, both in violence risk assessment and in the general treatment principles of the Good Lives Model, provide a foundation for recovery-oriented practice. Importantly, the concept of recovery is broader in scope than solely personal recovery. In addition to personal recovery, the literature identifies several other forms of recovery, which are also important in forensic psychiatric treatment. These include clinical recovery, referring to the remission of illness; functional recovery or the capacity to take up daily activities again; and social recovery or social inclusion in society (Drennan and Alred, 2012).

Although different developments within FMHS may facilitate recovery, there are also challenges. Core processes of personal recovery, such as having meaningful relations, hope to reach a future goal and take control over one's own life, can be at odds with the restrictive framework of forensic mental healthcare, the relatively long treatment durations and the treatment goal that is ultimately focused on the safety of the public and not primarily on improving the well-being of the service users (Mezey *et al.*, 2010). Two key challenges are discussed in the literature, concerning the importance of interpersonal relationships and individuals' self-image (Clarke *et al.*, 2016).

In a synthesis of qualitative studies on patients' perspectives on recovery, the importance of being accepted is highlighted, both by others and by oneself (Clarke *et al.*, 2016). Achieving this can be difficult, as service users frequently have a history of harmful interpersonal experiences, both as victim and as perpetrator (McKenna *et al.*, 2019). Because service users in clinical settings have limited possibilities to establish relationships outside the unit, interaction with staff plays an especially crucial role (Mezey *et al.*, 2010). Consequently, lack of trust in staff, feelings of disrespect and insufficient collaboration act as major barriers to recovery (Lumén *et al.*, 2024; Senneseth *et al.*, 2022). This relates to the dual responsibilities professionals have of balancing both care and control and developing relationships with service users that are both trusting and corrective (Gildberg *et al.*, 2013).

Another key challenge involves identity loss, or service users primarily seeing themselves as offenders. For recovery to take place, service users must come to terms with their own harmful actions. This can be particularly challenging, considering that some service users develop post-traumatic stress disorder as a result of their own offences (Badenes-Ribera *et al.*, 2021; Chuan Soh *et al.*, 2023). Stigmatisation associated with both offending and mental health difficulties further complicates the development of a realistic sense of self and impede recovery (Senneseth *et al.*, 2022). Only a few studies have examined these difficulties, however. This requires further research on the tensions that may arise when recovery-oriented principles are implemented in forensic mental healthcare.

Aims of the present study

There are indications that recovery-oriented principles may both overlap and interfere with principles of forensic mental healthcare. Therefore, the present study aimed to explore the challenges that service users and professionals experience when working from a recovery standpoint in forensic mental healthcare. Insight into these challenges can contribute to the refinement of strategies that improve the treatment climate in FMHS.

Methods

Participants

Semi-structured interviews were conducted with 11 professionals and 9 service users from six Dutch forensic organisations. Professionals were used in low-, medium- and high-secure FMHS, a psychiatric facility inside prison and ambulatory FMHS. Further information about the respondents is provided in Table 1.

Procedure

This research was conducted as part of a larger project aimed at developing a guide that may assist professionals in promoting recovery-oriented working in Dutch forensic mental healthcare. The study was conducted in accordance with the ethical codes of the University of Applied Sciences Utrecht and the ethical principles established by the Word Medical Association in the Declaration of Helsinki in 1964. Based on existing literature, a topic list was developed with topics asking about challenges with personal recovery across the six domains of the CHIME-Secure framework (Senneseth *et al.*, 2022). The topic list was created in consensus between all authors and is available as a supplementary file on the website.

A maximum variation sampling strategy was used. This sampling strategy aims to explore variations that have emerged in adapting to different conditions (Palinkas *et al.*, 2015). It was used to capture a wide range of differences between types of forensic mental health services and treatment disciplines. To ensure variation between contexts, respondents were sampled from six different organisations, including ambulatory and clinical forensic mental health services, a penitentiary psychiatric centre and a forensic substance abuse treatment unit. To ensure variation between professional roles, treatment providers with different backgrounds were sampled, including a psychotherapist, treatment coordinator (psychologist), advanced nurse practitioner, social worker, peer support worker, manager and staff trainer that specialises in recovery-oriented care. The following inclusion criteria

Table 1 Overview of respondents

S.No.	*Function*	*Clinical or ambulatory FMHS*	*Type of FMHS*
Service providers			
1	Nurse (and studying for master degree in nursing)	A	FMHS 1
2	Treatment coordinator, nurse (master degree)	C	High-secure unit 1
3	Treatment coordinator, psychologist	C	High-secure unit 2
4	Psychologist	Both	High-secure unit 2
5	Trainer recovery-oriented practice in FMHS	C	High-secure unit 3
6	Social worker	A	FMH unit 2
7	Social worker	A	FMH unit 2
8	Psychologist	C	Substance abuse treatment unit
9	Treatment coordinator	C	Penitentiary psychiatric centre
10	Peer support worker	C	Penitentiary psychiatric centre
11	Psychologist/treatment coordinator	C	Substance abuse treatment unit
Service users			
12		C	High-secure penitentiary psychiatric centre
13		C	High-secure penitentiary psychiatric centre
14		C	High-secure penitentiary psychiatric centre
15		A	Substance abuse treatment unit
16		A	FMHS 2
17		A	FMHS 2
18		C	Low secure long care FMHS
19		C	Low secure long care FMHS
20		C	Low secure long care FMHS

were applied: participants were required to have at least one year of work experience in forensic mental health services and to have experience supporting the recovery processes of forensic service users.

All interviews were conducted individually by one of the first four authors. One dual interview was held with respondent numbers 5 and 6. The interviews with professionals lasted approximately 1 hour, and the interviews with service users lasted approximately 30 min. Interviews with service providers and users of ambulatory FMHS were held online, and interviews with users of clinical FHMS were held face to face in the facility. All respondents were informed about the research and were given a minimum of three days to consider whether or not they wanted to participate in the interview. All respondents provided informed consent, both for their participation in the interview and for audiotaping the interviews. Based on the audiotapes, anonymous *verbatim* transcripts were created, and, subsequently, the audiotapes were deleted.

Analysis

The interview transcripts were analysed using Consensual Qualitative Research (Hill *et al.*, 1997; Hill *et al.*, 2005) in Atlas.ti Version 24. The analysis was carried out by a primary team consisting of the first three authors. The analysis was conducted in two rounds. In the first round, three randomly selected interviews were analysed. The transcripted were segmented into fragments and each fragment was assigned a domain (main theme). The domains were coded based on a startlist consisting of themes from the literature and interview topics. These domains included, but were not limited to, the following topics: use and familiarity of the terminology, strengths-based practices, challenges, preconditions and the different CHIME-Secure domains. Each interview was coded by one of the three primary team members and then reviewed by the other two authors. In a consensus meeting between the primary team, a definitive list of domains was constructed. The definitive list was largely the same as the startlist, but stigma was added as an important separate domain. In a later stage, this was reformulated as a subtheme of the domain Identity. Subsequently, the domains were coded by the primary team in the remaining 16 interviews. The last two authors reviewed the domain coding. No changes were made based on this review. Next, the first author developed subthemes based on the fragments within each domain.

Results

Four main themes were identified in the analysis: recovery as an attitude, identity, remaining hopeful and fostering empowerment. Quotes from Respondents 1–11 are from service providers; quotes from respondents with numbers 12 and higher are from service users.

Recovery as an attitude

Respondents pointed out that all forensic treatment is aimed at preparing service users for a safe return to society. Therefore, personal recovery processes such as connectedness (being part of the community and establishing and maintaining meaningful relationships) and empowerment (i.e. learning to take personal responsibility) are automatically a focus in the treatment. Respondent 4 said, “I believe the entire plan focuses on recovery”. Nevertheless, she pointed out that it is difficult to identify specific parts of the treatment that promote personal recovery:

> I think it is more in our basic attitude than it is actively reflected in a treatment plan. We can make these plans even more extensive and complete, but I think your basic attitude in your interactions with your service user/client is the most important factor.

According to Respondent 11, the absence of a clear vision on how to facilitate recovery can result in missed opportunities: “A service user wants to become a cook. He wants this for a reason, probably because he wants to participate in society, to contribute something, to feel

good about himself. But the exact reason is unclear to us." Respondent 11 explained that it is important to be aware of the underlying values behind this goal: "You can celebrate so much better when you have reached it".

Identity

Respondents describe that it is difficult for service users to develop a realistic sense of self. The focus can sometimes lean too heavily towards service users' shortcomings, such as stigmatising views of offenders with mental health difficulties. At other times, their strengths may be overemphasised. Either imbalance may impede recovery.

Stigma. Stigma is seen as a barrier that greatly impedes rehabilitation and the development of a realistic sense of self. Service users described that forensic treatment provides them with a second chance. However, it does not always feel that way when reintegrating into society. Respondent 13 described it as follows:

> People know that my sentence has ended. 'The monster is coming out again'—that's the perception. You are a phantom from newspaper articles. Nobody knows that I have received treatment. Instead, the newspapers say 'the man has a high risk of reoffending,' 'he still needs to go to a clinic' or something similar, because that is what journalists heard in court. The fact that I was in therapy for three years, with three sessions per week has not been mentioned. [. . .] No one knows this, so you always remain a monster.

The stigma impacts his efforts to rebuild his life outside the clinic. The housing agency tried to prevent him from renting an apartment: "They make their own assumptions: 'We don't think you can live here because there's a playground 100 meters away.' But the local police has already checked it, the probation service supports it".

Stigma is not only present in cases that have been in the news and clinical forensic mental health care. Users of ambulatory FMHS also face stigma, described Respondent 6:

> Our ambulatory FMH unit is seen in the region as a facility where only high-risk cases are being treated. Service users feel this and sometimes experience difficulties because of it [. . .] both in getting things accomplished and in receiving and maintaining the appropriate help.

Respondent 7 confirmed this:

> I've encountered situations where clients, when they make telephone-calls and advocate for themselves, are treated in a way that makes me think, "Seriously, come on." When we advocate for them, suddenly, the situation, the case, or whatever is viewed differently. Some of my clients experience this too: they feel that when they make a call, they are not heard or helped.

Other forms of stigma. Some indications were found for other forms of stigma as barriers for recovery, such as self-stigma and stigma within forensic mental healthcare. Respondent 17 noted, for instance: "I'm so afraid of being that bad person and for me, that's a threatening thing".

In some cases, service users report stigmatisation within FMHS. Respondent 13 mentioned that it is challenging to be vulnerable in therapy when he feels misunderstood in other situations within the unit:

> Security officers in this facility are much more biased and more like how society is outside. When you say that you want to go to the unit for sexual offenders, they almost slam the door in your face, you know. Not directly because they would never say it like that, but that's the feeling you get.

Balance between strengths and risks. While stigmas around offending behaviours and mental health problems may hinder recovery, too much emphasis on service users' strengths is also unhelpful. A balanced understanding of the strengths and risk-increasing vulnerabilities of service users is, however, difficult to achieve. Respondent 3 described the case of a service user who used his strong points, such as high intelligence and excellent work and communication skills, to avoid difficult conversations. As some treatment

providers were mainly focused on these strong points, the respondent experienced tension with her colleagues, as she felt it was her responsibility to balance out the situation by consistently emphasising the risk factors. Respondent 9 also explained the importance of a balanced view of both risk and protective factors.

> Some coworkers keep saying, "I do not need to know what someone has done," but this is simply not true. What the person has done is part of their identity, and the circumstances leading up to the offense often arise from underlying problems. [. . .] Therefore, there is a lot of quality we can focus on, but if we set aside the offense and only focus on their strengths, we are not doing them justice.

Remaining hopeful

Professionals indicated that providing hope to service users is a crucial element of recovery-oriented practice: "As a therapist, you must always convey hope", Respondent 4 noted. Especially when difficult circumstances arise, professionals consider it important to support service users and provide hope, Respondent 4 continued: "By consistently working together, being present, and repeatedly engaging in the therapeutic relationship, I believe this significantly fosters hope, while also offering a sense of security". Respondent 13 described how important this was at the beginning of his detention period when he did not know what his sentence would be:

> It is the most uncertain of times and you have the darkest thoughts. That is when you need the most support. [. . .] My therapist sat me down on a bench and said: but in two or two and a half years, you will be outside again with your family, flying kites with your son. The fact that you are heard at such a moment instils hope.

Respondent 15 explained that this hopeful attitude motivated him to work on behavioural change: "By making better choices, you can manage things more effectively. Then, you will be able to see your children again and get your life back in order. If you keep drinking, you won't get anywhere".

Hope can be difficult to hold on to. Respondents describe that it is not always realistic to hope for treatment progress. Respondent 2 described the case of a service user who needed to be transferred to long term FMHS: "He has reached the limit of what treatment can offer. Multiple interventions have been implemented and no further progress is expected". In such cases, it can be difficult to remain positive. Respondent 3 described that it can be helpful to "keep ticking small boxes, recognising where someone is doing well and making progress". Remaining hopeful can also be difficult when service users have repeatedly engaged in rule breaking behaviour and a high level of control and supervision is considered necessary. Respondent 1 described that "when there are that many restrictions, it raises an ethical dilemma about whether strength-based and recovery-oriented practice is still possible". It becomes increasingly challenging. Respondent 10, peer support worker, warned for a potential self-fulfilling prophecy in the use of labels:

> Yes, people are often labelled as annoying or as "they will never learn." Hope and recovery can be difficult in such cases. Those people are then treated as if they are annoying and will never learn, and I believe no one improves from that.

Respondent 4 noted that motivational interviewing is needed with service users who show very little motivation for treatment: "In the end, there's always something someone wants, even if it's just a tiny thing to begin with".

Fostering empowerment

Service user autonomy is often restricted in forensic mental healthcare. Respondent 2 noted that "service users even have to ask the staff if they need toilet paper". Within this restrictive framework, however, service users are encouraged to take as much control over their lives

as possible. This varies from daily household activities to treatment engagement. Interviewed professionals describe how they try to refrain from taking over tasks that service users can do themselves, such as calling in sick or organising household tasks on the units. Respondent 11 explained that she tries to find common ground with service users about the treatment goals, even when service users are non-cooperative:

> I currently have someone in treatment. [. . .] He does not do much with homework assignments. Yes, I could say, well, you are not cooperating enough, so we will stop. Just to paint a very black and white picture, right? What I always try to do is address this and explore why they do not do these assignments. Can I support you with this? [. . .] Whether you continue or not with the treatment, that is at least a joint decision.

Professionals are not always able to explore ways to foster service user empowerment within the restrictive framework of treatment measures. Respondent 11 explained that, in some cases, it is necessary to restrict service users' autonomy for the safety of others: "Sometimes you have to restrict something, but not always. It is about finding a balance together and still being able to consider these aspects. That balance is under pressure". When the balance is lost, overly repressive behaviour may occur. The respondents explained that repression is in essence not reconcilable with recovery. However, Respondent 3 explained that, "of course, it does happen, in clinical practice, that someone might react a bit more repressively to service users or that they experience a bit of countertransference with someone and then perhaps approach service users a bit less supportively". Respondent 2 sees it as a much more prevalent phenomenon: "It is quite a challenge to prevent staff from constantly resorting to repression".

Various factors may contribute to insufficient recovery-oriented practices. A recovery-oriented approach can be experienced as too time- or energy-intensive under certain circumstances. In some cases, the need to intervene quickly can conflict with recovery-oriented practices. Respondent 4 described this as follows:

> To remain calm in the heat of the moment and keep the focus on "being there for the service user and tuning in to the service user." Sometimes, you only have a split second to decide how to react to another person's aggressive behavior. I think that's very challenging.

Fear of adverse consequences may have a similar effect, according to Respondent 11:

> When things get tense, like with suicide threats or other major risks, it certainly makes me, and I think many colleagues as well, anxious that something could go terribly wrong. Out of that fear, you might end up saying: no leave, or not this, or that. This often leads to more repression.

Finally, when teams experience exhaustion, Respondent 11 described that they may be more likely to lapse into repressive behaviour:

> Sometimes, you notice a bit of mental fatigue in a team around a certain case, which complicates things. If teams are not able to adequately handle something or someone, they might make a decision to enhance safety that they otherwise would not have made.

Discussion

In the current study, challenges when working from a recovery-oriented approach in FMHS were explored based on the experience of professionals and service users. The results indicated that there appears to be a paradox in which, on the one hand, most of the treatment endeavours are seen as part of the service users' recovery processes and, on the other hand, in some cases, opportunities to promote recovery are overlooked or only addressed implicitly. Consequently, recovery-oriented forensic practice remains suboptimal. Furthermore, important challenges were found across three of the five CHIME domains, i.e. hope, empowerment and identity. In the domain hope, it was found that professionals must have hope to give hope. It is not realistic, however, that professional always remain hopeful.

Different factors may lead to diminished hope from professionals, such as understaffing or continuous acting out behaviour of service users. Importantly, Flesaker and Larsen (2010) described, in a qualitative study on hope among social workers working with women on parole and probation, that hope is a skill that can be trained in cognition-based interventions, for instance, by asking oneself what a hopeful person would do in a particular challenging situations (Flesaker and Larsen, 2010). Hillbrand and Young (2008) pointed at the complexity of hope in forensic treatment and the parallel processes between service users and providers: both may experience tension between despair and hope. Hope, in this sense, is very much relational. Remaining hopeful, even when options seem limited, is not only important because it may spark behaviour change in service users it may also protect professionals against burnout (Flesaker and Larsen, 2010).

Challenges were also observed in the domain empowerment. When service providers fear adverse outcomes, such as aggression, suicide attempts or absconding, they describe that they sometimes pose more restrictions on service users than needed. Safety concerns lie at the heart of this challenge. This was also noted by Livingston *et al.* (2013) in a study on the effectiveness of a program that aimed to improve service users' engagement in a Canadian forensic hospital. The authors hypothesised that service providers, particularly frontline nurses, may perceive strategies that promote power-sharing with service users as risky (Livingston *et al.*, 2013). These findings highlight the underlying interconnectedness of the various recovery processes in the CHIME-secure model (Senneseth *et al.*, 2022) and underline the importance of a secure base as a starting point for recovery (Doyle *et al.*, 2017). Professionals describe that a secure base is necessary to support other recovery processes and enhance the empowerment of service users. Importantly, the question remains how these processes can progress hand in hand, ensuring that safety and other recovery processes can be addressed simultaneously.

In terms of identity, it was found that a balanced understanding of the strengths and risk-increasing vulnerabilities of service users is difficult to achieve. This relates to the dual role that professionals have, providing both care and control (Pedersen *et al.*, 2025). It has been found, both in the current study and in earlier work, that professionals use different caring approaches, with some who are more focused on building relationships and others more on order and safety on the units (Björkdahl *et al.*, 2010). Working from a recovery-oriented approach in forensic mental healthcare therefore requires a deliberate effort to bring together both perspectives, so that service users can learn to build a realistic sense of self. Societal stigmas associated with forensic service users can negatively affect this. Whereas the majority of the challenges found in this study can be placed within FMHS, these societal stigma's occur outside (the control of) FMHS and require a different course of action.

The CHIME domain "meaning" did not come up in the interviews. It remains unclear to what extent this reflects clinical practice, in which attention for this domain could be scarce. Possibly, meaning is a theme that frequently arises in practice but tends to remain embedded within other themes, and may not be sufficiently brought to the surface. It could also be unexplored due to methodological reasons, as the concept of recovery is very broad and not all relevant topics may have been discussed in the interviews due to time limitations.

Recovery is described in non-forensic literature as a "deeply personal, unique process" (Anthony, 1993). Service users are in charge of their own recovery process and treatment providers are meant to facilitate this process. The current findings, however, suggest that before professionals can effectively support service users in their recovery journey, considerable attention must be given to the well-being of service providers. Maintaining a recovery-oriented approach in these sensitive matters requires a lot from professionals in terms of time, patience, expertise and reflexivity. Having time and space to reflect with co-workers on the challenges relating to recovery in forensic mental health services is

important. Optimal working conditions and mentally resilient professionals are likely the key prerequisites for implementing a recovery-oriented approach in FMHS. This can be considered a major challenge in the domain connection between service users and providers.

Strengths and limitations

The present study is not without limitations. Firstly, the concept of recovery is broad, making it difficult to provide an elaborate analysis of all aspects of recovery. Secondly, a diverse sample of respondents was included in this study. This provided the opportunity to gain broad insight into barriers to recovery across different types of FMHS. Because of this choice, it was not possible to offer in-depth descriptions of experiences across all topics relating to recovery. For instance, the domain meaning remained relatively unexplored. Thirdly, due to the design and aim of the study, no insight could be provided into challenges to recovery for specific groups of service users, for instance, which service users may face societal stigma more often than others and what is needed to overcome this.

Implications for clinical practice

The findings of the current study highlight the necessity for explicit strategies that promote recovery-oriented practices in forensic mental healthcare. It is recommended that these strategies aim to translate abstract values as much as possible into concrete actions, as the present study indicated that recovery often remains abstract. The use of an instrument such as the Recovery-Oriented Practices Index (ROPI; Mancini and Finnerty, 2005) may be helpful in this regard. The ROPI is developed as a tool for evaluating the degree to which teams engage in recovery-oriented practices. It consists of 12 themes, such as the extent to which the organisation has adopted a recovery-oriented vision and teams operate based on this vision. In this research, it was found that these visions are often lacking. Nevertheless, developing such a vision is recommended, as it can serve as a valuable anchor point for teams when shaping recovery-oriented care. This is in line with the recommendation of Møllerhøj (2021), who point at the importance of organisational factors impacting recovery.

In shaping these visions on recovery-oriented forensic mental healthcare, it is advisable to take current practices into account that promote the application of recovery-oriented principles. Principles of recovery-oriented care, such as hope and empowerment, are difficult but not impossible to reconcile with the mandated nature of treatment in FMHS. Shared decision-making has increasingly become standard practice in general healthcare (Joosten *et al.*, 2008; NICE, 2021) and can, within defined boundaries, also be incorporated into forensic contexts; it has even been explored in the field of violence risk assessment (Ter Horst *et al.*, 2023). In this way, the perspective of service users, who are responsible for their own recovery processes, can also be integrated in interventions that are needed to manage risks. Relational security frameworks, such as *See Think Act* (Department of Health, 2010) further facilitate the alignment of therapeutic care with safety requirements (Chester *et al.*, 2017). Relational security refers to "the knowledge and understanding staff have of a patient and of the environment, and the translation of that information into appropriate responses and care" (Department of Health, 2010), with the aim of ensuring safety in secure settings. The framework outlines eight themes across eight domains that describe how the quality of relationships between service users, staff and other involved parties, such as families and friends, affect security.

Whereas the majority of the challenges found in this study can be placed within FMHS, these societal stigma's occur outside FMHS and require a different course of action. The reduction of stigmas deserves special attention, as the double stigma of an offender and psychiatric patient can hinder both personal and social recovery. Recent studies

demonstrated that, for instance, educational videos that challenge myths about forensic service users could be effective in decreasing stigma towards forensic service users (Doyle *et al.*, 2025). In a study on stigma management during the reintegration of older service users, it was found that developing and investing in relations with partner institutions is a crucial strategy in managing stigma. Education about stigmatic labels can be part of this strategy after, first, contact is established (Seaward *et al.*, 2023).

In addition, investing in professional well-being is necessary to enable professionals to maintain a recovery-promoting attitude towards service users. Only when professionals are well equipped for their job, they can support service users in their personal recovery processes. This means that investments in the psychological resilience of professionals are also investments in the recovery of service users and their treatment progress.

Finally, it is important to remain aware of the power relations in FMHS. Every effort to work together with the service users is crucial. However, these efforts do not eliminate the underlying power struggle where service users must ultimately adhere to what society views as best for them and/or for society. Awareness of this conflict is important because it provides insight into the experience of service users, which is in itself an important requisite for recovery-oriented work (Johansson and Holmes, 2022).

Suggestions for further research

Based on the current study, it is advisable to conduct further research on the needs of professionals to facilitate the recovery process of service users. How can they be equipped to remain hopeful and resourceful when working with a demanding population? Furthermore, it is advised to research how stigma, both in society and in forensic mental health services, may affect both the personal and social recovery of forensic service users. Finally, more in-depth qualitative research is needed on the question to what extent considerations about safety and security (in the CHIME-secure framework described as a sixth process; Senneseth *et al.*, 2022) are intertwined with the other five recovery processes in the CHIME framework (Leamy *et al.*, 2011). Is the feeling of being safe and secure and the self-management of risk a separate process, or is it the pillar that underlies all actions in FMHS and, therefore, stretches out to all recovery processes? In-depth interviews with service users and providers can shed light on this and more importantly, what professionals need to simultaneously provide care and control. Empirical studies on limit-setting can be useful starting point, exploring how professionals engage in corrective behaviours while maintaining as much as possible trusting relationships. Research on limit setting is scarce, while limit setting is a daily occurrence in forensic mental health services and is one of most common precipitants of aggression towards professionals (Roberton *et al.*, 2012).

Conclusion

The importance of recovery has been increasingly recognised in forensic mental healthcare. Simultaneously, there are several challenges when working from a recovery standpoint in such settings. These challenges include the often implicit focus on recovery, the need to have hope to give hope and the delicate balance between care and control. Navigating these challenges requires a lot from professionals. It is imperative, therefore, to invest in the needs of service providers first. Strategies aimed at enhancing the psychological resilience of service providers are essential to sustain a recovery-promoting attitude towards service users. In short:

- Explicit policies are needed that promote personal recovery of forensic service users. Otherwise, opportunities to facilitate personal recovery are overlooked or only addressed implicitly.

- Working from a recovery-oriented perspective in forensic mental health services requires a constant juggling between caring and controlling interactions with service users. This demands methodical training, practical guidance and sustained attention to professionals' resilience due to the challenging nature of the work.
- Addressing stigma and helping service users build a realistic, balanced self-image is difficult, yet essential for fostering recovery.

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Supplementary material

The supplementary material for this article can be found online.

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