

Transitional experiences of men with intellectual disabilities and offending histories who have resettled into the community from secure settings

Shaw Tearle and Gareth Hickman

Abstract

Purpose – *The purpose of this paper is to better understand the transitional experiences of adult men with mild intellectual disabilities (ID) and histories of sexual/violent offending, as they resettle into the community from secure hospital settings.*

Design/methodology/approach – *This study used Interpretative Phenomenological Analysis (IPA) to explore the experiences of eight men with mild ID aged between 28 and 60 who, following confinement to secure hospitals under the Mental Health Act for sexual/violent offences, had been living back in the community under conditions of restriction for a minimum of six months and a maximum of 56 months. Two one-to-one semi-structured telephone interviews were conducted with each participant.*

Findings – *Three superordinate themes emerged following IPA analysis: "A chance to 'turn my story around'" (hopefulness about achieving freer community lives and a renewed identity), "Feeling 'torn apart'" (interpreting numerous losses as abandonment) and "The cost of 'trying to please others'" (satisfying imposed community restrictions led to a restricted identity).*

Research limitations/implications – *These findings suggest that the transitional experience is problematic. It highlights the need for more holistic and psychologically informed support to address the psychosocial needs of men with ID and forensic histories, to then help them achieve improved self-esteem, self-efficacy and meaningful participation during the transition towards community resettlement.*

Originality/value – *This paper gives a voice to a marginalised group whilst adding to the literature and addressing the limitations of earlier publications.*

Keywords *Intellectual disability, Forensic, Offending behaviour, Transition, Resettlement, Qualitative, IPA, Experiences*

Paper type *Research paper*

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Introduction

While national intellectual disabilities (ID) forensic-specific data is limited, 1,235 people with ID (PWID) were in secure hospitals in 2017, with an average length of stay of 1,970 days (National Health Service Digital, 2017). Approximately 40% of low secure and 32% of medium secure ID patients were subject to Restriction Orders (National Health Service Digital, 2017). However, in 2020 NHS England commissioned fewer secure beds (1,042) for this cohort (83% were males). Following discharge patients typically move into semi-independent supported living, however supervision arrangements vary and can include the application of Treatment Orders and Ministry of Justice (MoJ) Restriction Orders if patients pose a public risk. Post-discharge, there is about a 20% readmission rate due to order violations (Wooster *et al.*, 2018).

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Deinstitutionalisation, the 2011 Winterbourne View scandal and the Transforming Care Agenda (TCA) gave increased impetus to closing inpatient beds and to developing specialist community ID services (National Health Service England, 2015). However, this national plan is criticised for not meeting the distinct needs of PWID who offend (Taylor *et al.*, 2017a, 2017b). There are likely to be psychosocial challenges to successful community resettlement, including stigmatisation, learned helplessness and anxiety (e.g. Giebers *et al.*, 2018; Chester *et al.*, 2017). However, there are limited first-hand accounts in the literature about this cohorts lived experience.

Ellem (2012) interviewed 10 ex-offenders with ID to investigate their experiences of leaving prison. Thematic analysis showed that participants experienced community resettlement as overwhelming due to reported fears of marginalisation and feeling unprepared for aspects of community living. This increased a sense of loneliness, difficulties securing meaningful occupation and their “resentment” towards supervision. Chiu *et al.* (2019) also interviewed 10 men with ID to explore post-prison life. Interpretative Phenomenological Analysis (IPA) revealed that, despite hopes of increased community-based autonomy, participants felt obliged to “keep out of trouble” and led risk-averse lives.

Head *et al.* (2018) interviewed 11 PWID about their experiences of leaving hospital under the TCA. A Grounded Theory approach revealed that PWID can live well in the community after feeling “controlled” in hospitals that made them identify as “bad”. While participants seemed to lose some “trusting” relationships with hospital staff, community living was described as an opportunity to develop new networks.

Davis *et al.* (2015) conducted semi-structured interviews with 10 legally restricted male ID offenders, all of whom were diverted away from hospital to community-based rehabilitation. Although community support sometimes seemed protective, IPA revealed themes concerning participants’ “taste of freedom” and simultaneous “lack of control”.

While previous research has attempted to explore the lived experiences of men with ID as they transition towards community resettlement, there appear to be at least three limitations:

1. Firstly, most research has tended to largely focus on the transitional experiences of PWID without forensic histories (e.g. Head *et al.*, 2018), or only emphasised offenders’ experiences following mainstream imprisonment (e.g. Ellem, 2012).
2. Secondly, the emphasis of previous studies has been on public risk and the impacts of hospital-based treatment outcomes, with a specific focus on improving community risk assessment/management.
3. Thirdly, earlier research has inadequately explored expectations of community support or opportunities.

To address this, the current study investigates individual experiences of community relationships, preparedness and meaningful participation.

The current research seeks to address these limitations and answer the following question:

- Q1. What are the transitional experiences of men with mild ID and histories of sexual/violent offending who have resettled into the community from secure hospital settings?

Method

Research design

This study uses an interpretivist position and an IPA (qualitative) research design. Therefore, the research explores participants’ experiences from their perspectives rather than describing phenomena according to predetermined categorical scientific criterion (Smith *et al.*, 2009).

Sampling design

A non-probability sampling design organised around the purposive sampling method was used to establish a homogeneous sample with experience of the phenomenon of interest (see [Table 1](#)).

As a multisite study, local gatekeepers from different Mental Health Trusts helped the researchers to identify and approach eligible and capacious participants. Thereafter, potential participants self-selected by contacting the lead researcher with their expressions of interest (with support from a gatekeeper if necessary). In total, eight male adult participants with mild ID were recruited from three NHS Trusts (see [Table 2](#)). All participants had been involuntarily detained within English secure hospitals under forensic sections of the MHA and were currently living in the community with support.

Measuring instruments

A semi-structured interview guide was used with questions themed around experiences of relationships ([Head et al., 2018](#); [Davis et al., 2015](#)), expectations of community living and preparedness ([Hickman et al., 2018](#)), safety and contact with professional services ([Chester et al., 2017](#)), self-esteem/identity ([Johnson, 2012](#)) and lifestyle and community participation ([Davis et al., 2015](#)).

Methods of data collection

The research presented in this article was conducted during the period of a national pandemic which meant that in-person interviews could not be conducted. Making reasonable adjustments was particularly important in the context of increased COVID-19 health risks experienced by PWID ([Public Health England, 2020](#)). To enhance participation, two well-paced audio recorded (45-min each) individual semi-structured telephone interviews were conducted with each participant.

Table 1 Inclusion and exclusion criteria

Criteria	Inclusion	Exclusion
Gender	Males	Females
Age	18 and above	Children < 18
Diagnosis	Mild ID (full scale IQ between 50 and 70), with a co-morbid Autism Spectrum Disorder and/or Personality Disorder diagnosis	Uncapacitous patients with moderate to profound ID (full scale IQ < 49). Non-English speaking and/or non-verbal
Offence	Convicted for sexual misconduct (including non-consensual crimes like rape, assault and sexual harassment) and/or violent offences (including harassment, common assault and grievous bodily harm)	No evidence of sexual and/or violent offending
Sentence	Detained within low, medium or high secure hospitals under the Mental Health Act	Detained and discharged from non-hospital secure settings (including her majesty's prison services)
Communityrestriction/arrangements	Patients discharged into the community with conditions of restriction (e.g., Conditional discharges and community treatment orders)	Not in contact with the NHS or third sector health/social care community services
Time within community	Minimum of 6 months and a maximum of 56 months	< 6 months or > 56 months
Source(s): Table 1 by Tearle and Hickman (2025)		

Table 2 Participant characteristics

<i>Pseudonym</i>	<i>Gender</i>	<i>Age</i>	<i>Diagnosis</i>	<i>Ethnicity</i>	<i>Index offence type</i>	<i>Secure setting(s)/length of hospital admission</i>	<i>Community setting(s)/time since discharge</i>	<i>Community arrangements</i>
John	Male	54	Mild ID	White British	Violence	HMP; MSU; LSU / 14 years	Supported living / eight months	Life license
Sam	Male	28	Mild ID; ASD	White British	Sexual	MSU; LSU / four years	Supported living / 34 months	Community treatment order
Ben	Male	54	Mild ID; EUPD	White British	Violence	MSU; LSU / six years	Supported living / 17 months	Conditional discharge
Carl	Male	49	Mild ID; ASD	White British	Sexual	LSU / 4.5 years	Supported living / 44 months	Conditional discharge
Ian	Male	60	Mild ID	White British	Violence	HMP; MSU; LSU / 11 years	Supported living / 36 months	Life license
Tom	Male	28	Mild ID	White British	Violence	LSU / two years	Supported living / 28 months	Guardianship order
David	Male	35	Mild ID; ASD	White British	Violence	MSU / three years	Residential placement / 15 months	Community treatment order
Jim	Male	31	Mild ID	White British	Sexual	MSU; LSU / five years	Supported living / 27 months	Conditional discharge

Note(s): *Medium secure unit (MSU); Low Secure Unit (LSU); her majesty's prison services (HMP); emotionally unstable personality disorder (EUPD)

Source(s): Table 2 by Tearle and Hickman (2025)

Ethical considerations

This study was ethically approved and registered by Coventry University’s Ethics Committee, the Health Research Authority and each NHS Research/Innovation and Development Team. PWID are classified as “vulnerable adults”, thus the British Psychological Society’s (BPS) Code of Human Ethics (BPS, 2014) was adhered to, and data is anonymised using pseudonyms.

Method of data analysis

Audio recordings were transcribed and analysed in line with the six stages of IPA data analysis (Smith et al., 2021). This idiographic process began with analysing the first individual case in its unique context before analysing other cases and making general claims. Thematic maps were produced to identify final superordinate and subordinate themes. The researcher’s reflexivity was important in exploring bias so reflective logs and supervision were used. The credibility checking of superordinate themes were assessed by presenting the final master-list to the research team and consenting participants; efforts were made to present this information in easy-read format. Three participants provided verbal feedback confirming that they felt each superordinate theme accurately reflected their experiences of community resettlement.

Results

Three overarching themes emerged from an interpretation of participant accounts (see Table 3). Theme one, *a chance to ‘turn my story around’*, reveals how participants experienced community resettlement as an opportunity for freedom and a renewed identity. Theme two, *feeling ‘torn apart’*, explores distressing experiences of loss and how this was made sense of. Theme three, *the cost of ‘trying to please others’*, voices participants’ sense of how complying with community-based restrictions meant negotiating freedoms and not fully renewing their identities (see Table 4).

Theme one – “a chance to turn my story around”

This superordinate theme was interpreted from the experiences of seven participants who talked about a sense of freedom and the opportunities community living presented to enable self-change.

“A chance for a freer life”.

Freedom was powerfully expressed as being able to exercise autonomy over what seem the most ordinary of everyday situations:

On the unit you’re locked up and have to do the rules [...] like making drinks when they say. Here where I live now... I knew would, err, be better because I watch TV and cook when I want.

(Ben)

Table 3 Superordinate and subordinate themes	
Superordinate theme	Subordinate theme
Theme One - A chance to “turn my story around”	1. “A chance for a freer life” 2. “I’m not the same person I was”
Theme Two - Feeling “torn apart”	1. “I felt destroyed” 2. “I got left on my own”
Theme Three - The cost of “trying to please others”	1. “I have to show I’m safer” 2. “I feel cut-off”
Source(s): Table 3 by Tearle and Hickman (2025)	

Table 4 Participant experiences within each theme

Superordinate theme	A chance to “turn my story around”		Feeling “torn apart”		The cost of “trying to please others”	
	“A chance for a freer life”	“I’m not the same person I was”	“I felt destroyed”	“I got left on my own”	“I have to show I’m safer”	“I feel cut-off”
John	X	X	X		X	X
Sam	X		X	X	X	X
Ben	X	X	X	X	X	X
Carl	X	X	X	X		X
Ian	X	X	X	X	X	X
Tom	X	X	X		X	
David	X	X	X	X	X	X
Jim		X	X	X	X	X

Source(s): Table 4 by Tearle and Hickman (2025)

Participants seemed prepared to accept some control over their liberty which comes with supported community-based care. Rules were viewed as helpful safety nets, at least at the start of the transition:

Them rules are good. . . they told me what I needed to do to be alright.

(Ben)

“I’m not the same person I was”.

Participants also saw the transitional experience as an opportunity to become “better” (David) and safer versions of themselves:

Moving on I feel. . . better in myself. . . I’m not perfect but I think I’ve changed to being a better man who people like.

(Carl)

Furthermore, participants expressed the need to belong and be accepted within the “right” communities:

My life was with lots of not nice people. . . now I can make new friends.

(Ben)

Theme two – “feeling torn apart”

This superordinate theme was interpreted from the experiences of eight participants who spoke about losing meaningful relationships and perceived containment, and the ways in which loss facilitated feelings of loneliness.

“I felt destroyed”.

A sense of loss was expressed by participants who found permanently saying goodbye to informal and formal hospital-based support “upsetting” (Carl):

[. . .]I’d been there [hospital] a while and. . . I felt close to them [fellow patients]. It felt hardest when I was doing the transition. . . I was missing them.

(David)

Others experienced this as losing a sense of containment. This seemed particularly significant for participants with longer inpatient stays who were perhaps accustomed to confined living:

I felt like it [hospital] was more protected. . . it was never the same here [community].

(Ian)

"I got left on my own".

This sense of having been left alone was experienced as an awareness that transitioning was "lonelier" (Ian) than expected. This seemed especially true for those who felt "*leaving [hospital] happened too fast*" (Carl). Some participants experienced this as abandonment:

. . . [hospital staff] made it bloody terrible! . . . I got left here! [at supported living].

(Tom)

Loneliness appeared to be amplified by an unpreparedness for semi-independent community living and some participants questioned their own readiness for increased independence, even attempting to escape their new living situations by means of challenging behaviour:

I'd play up and try and get moved.

(Sam)

I was naughty. . . setting off fire alarms to escape and hide in the garden.

(Ian)

Theme three – "The cost of trying to please others"

This superordinate theme was interpreted from the experiences of seven participants who described a drive to satisfy imposed rules to evidence their reduced risk to others, and to avoid recall, which was experienced as isolating and restrictive.

"I have to show I'm safer".

Participants expressed a sense of needing to comply with community restrictions and others' expectations to "prove" (Ian) their "safety". This often seemed motivated by fear/anxiety and feeling controlled:

I don't want to do. . . wrong and end up going back to a locked unit.

(Sam)

Participants also commented that showing they could be safer was often about negotiating freedoms:

I . . . feel like I'm tryin' to please people. . . so I can get things. . . like being allowed to go out alone.

(Carl)

Ben described this as treatment compliance:

Doing the courses meant they [professionals] thought I was alright to have free time.

(Ben)

"I feel cut-off".

While complying with restrictions the participants seemed to experience transitioning towards community living as feeling isolated and *"left behind"* (John). Some talked about restricting/sacrificing social opportunities to safeguard others:

It's hard to meet people. . . [with] staff around you. But err, I have to have them with the rules. . . so I just keep clear of people.

(David)

I don't want friends now. . . it's risky because of the stuff I got into trouble for.

(Sam)

Participants also expressed that experiencing isolation involves becoming increasingly dependent upon services, staff and community restrictions. Whilst limiting, this invites safeness:

. . . having these community laws, umm, means I know exactly what to do to get safe.

(John)

This was especially the case for those who had been discharged to areas without specialist community ID forensic services. An unintended consequence of a *"use it [support] or lose it"* mentality (John) included feeling burdensome:

. . . I'd wanna see them [community nurse] more. . . but I don't wanna take up her time.

(Ben)

Discussion

Three superordinate themes emerged from the transitional experiences of men with ID and histories of sexual/violent offending who had resettled into the community from secure settings.

Transitional experiences in context

Theme one found that participants experienced the transition as an opportunity to move from restricted hospital environments to more hopeful and freer community lives, where they could become safer people. This supports previous forensic and non-forensic ID studies which also note aspects of hoping to become "better" people by belonging to protective "in-groups" and being treated "normally" ([Head et al., 2018](#); [Chiu et al., 2019](#); [Davis et al., 2015](#)). The current findings extend previous research by offering insights into why restrictions are initially appreciated for how they clarify the boundaries to unfamiliar freedom, which helps individuals explore it more confidently with a greater sense of what is acceptable and unacceptable. Perhaps this explains why some PWID have found supervision protective (e.g. [Chester et al., 2019](#)).

Theme two suggests the transition is experienced as the loss of meaningful relationships and hospital containment. This supports studies which found that offenders have difficulties adjusting to a life beyond confinement ([Ellem, 2012](#)). Current findings also support previous research suggesting that loss is associated with loneliness and feeling unable to cope ([Hollomotz, 2021](#)), perhaps because other patients and hospital staff can become significant attachments for emotional support ([Heppell and Rose, 2021](#)). The current

findings add to this research by capturing participants' experiences of feeling abandoned when their relationships with hospital staff ended.

Theme three found that participants experienced the transition as needing to satisfy restrictions, which impeded their ability to lead freer lives or renew their identities. This supports earlier findings suggesting that forensic populations lead risk-averse community lives post-confinement (Chiu *et al.*, 2019), and that PWID are motivated to comply with treatment/supervision to avoid recall (Chester *et al.*, 2019). Moreover, the current finding that participants were influenced by professionals' expectations supports self-concept theories, which propose that others' perceptions/actions shape how PWID view themselves (e.g. Argyle, 1983).

Problematic transitional experiences

The three superordinate themes show that this population encounter a range of significant interpersonal and intrapersonal difficulties when trying to re-establish themselves in the community.

A potentially psychologically harmful juxtaposition seems to exist between theme one (where participants experienced a hopefulness about freedoms and renewing their identities) and theme three (where participants felt the need to satisfy imposed expectations/restrictions). This contradicts some of the non-forensic ID literature that suggests an individual's optimism for change and social inclusion is usually actualised. Participants in the current study felt unable to fully live freer lives and renew their identities. Perhaps not all previous research has sufficiently captured the cognitive and emotional consequences of this particular transition. As with Labelling Theory (Becker, 1963), the current participants appeared to internalise restrictions/professionals' expectations as indicators of risk, which was self-fulfilled by an awareness of self-monitoring and self-limiting employment and/or relationship opportunities; this is replicated in mainstream offenders (e.g. Barnett *et al.*, 2022). Consequently, this perpetuates their "spoilt identities" (Goffman, 1963) as men who remain a public risk, as well as feeling hopeless. This study's findings significantly extend previous research (e.g. Hollomotz, 2021), which looked favourably upon the notion that PWID proactively engage in risk management during transition to achieve "prosocial" identities; paradoxically, the current findings suggest that forensic ID patients' longer-term tendency to passively comply with supervision actually impedes this new identity.

The findings of theme three suggest that for a forensic ID population the transition can somewhat be experienced as institutionalisation in the community. Despite the perception that community living is preferable, as well as a drive to reduce inpatient beds (National Health Service England, 2015), previous research has failed to adequately note how forensic ID patients may experience restrictive community contexts as extended confinement. This lived experience is potentially psychologically harmful; in response to high levels of supervision participants reported still feeling controlled by professionals and increasingly burdensome upon services/society (e.g. Barnett *et al.*, 2022). Arguably, some "least-restrictive" community models may equate to deprivations of rights/liberty, and amount to a "professional paternalism" (Graham, 2006) that perpetuates isolation, low self-efficacy and low self-esteem.

The findings of themes two and three suggest the transitional experience may paradoxically increase challenging behaviour in PWID and offending histories (e.g. Griffith and Hutchinson, 2013). Arguably, because of a pre-occupation with imposing restrictions for understandable public protection reasons, the safety needs of PWID themselves can become inadvertently overlooked; most participants in the current study described their transitional experience as feeling rushed and/or uncontained, with several engaging in behaviours of concern while feeling distressed, including

disengaging from support plans and hiding from staff. This raises concerns about whether being unprepared for the transition leads to psychologically unhelpful experiences of loss, abandonment, helplessness and loneliness, which then potentially contribute to elevated readmission rates.

Clinical implications

To improve the transitional experience, and in turn reduce the risk of a resettlement crisis, policy and practice changes are needed.

Firstly, to relieve the contradiction found between themes one and three, and to reduce the psychological harm of feeling hopeful but continuing to be restricted, both health and social care services are encouraged to consider whether to adopt a coordinated trauma-informed care approach. As part of this formulations and care plans should recognise and address the psychosocial needs that arise from the impact of the transition (e.g. experiencing loss/abandonment and feeling marginalised). Moreover, policy should facilitate more person-centred and therapeutic discharge pathways in which PWID transition at a pace that feels manageable and containing. To align this with the government's "Building the Right Support" ([National Health Service England, 2015](#)) initiative, this could include adequately funded "transition windows", greater continuity (e.g. retaining the same Responsible Clinician) and longer aftercare community follow-up.

Secondly, to avoid the community feeling like an institutional extension of secure settings, and to support PWID to prepare for semi-independent living, clinicians should implement national standards for person-centred pre-discharge "exit planning". In line with evaluated "leavers" groups (e.g. [Hickman et al., 2018](#)) and "transfer" interventions (e.g. [Adshead et al., 2017](#)), which aim to address anxieties and preparations for moving, the current findings suggest that holistic multi-disciplinary programmes should offer independent living skills support and relapse prevention. In addition, a greater emphasis could be placed on community teams assisting in integrative discharge preparations (i.e. providing more in-reach support and consultation to secure settings).

Moreover, PWID and forensic needs should be supported to access meaningful opportunities for community engagement. For instance, commissioners and local authorities should continue developing community-based services for PWID and forensic histories, whilst also helping PWID to access mainstream occupational experiences whenever possible.

Thirdly, as shown in theme three, there is a need to manage risk in a nuanced way. Clinicians could engage in regular reflective supervision/training to increase awareness of how their attitudes and restrictive practices may impact PWID. Moreover, because offence-specific interventions may reinforce negative self-views in PWID who offend (e.g. [Melvin et al., 2020](#)), treatment should align with the "Good Lives Model" ([Aust, 2010](#)) and focus on positive risk-management and address quality-of-life needs associated with semi-independent living. For instance, the group-based EQUIP programme, which has been trialled within secure settings ([Langdon et al., 2013](#)) and provides opportunities for a "positive peer culture" ([Devlin and Gibbs, 2010](#)), has been used successfully in a community ID forensic service to facilitate resettlement ([Tearle et al., 2020](#)).

However, the study's findings validate concerns about a TCA that promotes shorter hospital rehabilitation in the absence of sufficiently funded ([National Audit Office, 2017](#)) or fully developed community provision ([Taylor, 2019](#)). This impedes the ability to implement the above recommendations; notably, participants who felt most restricted and burdensome were discharged to areas without specialist forensic services, where there appeared to be less collaboration between health and criminal justice teams. Therefore, commissioners must continue investing in a community-based multi-disciplinary workforce that is

specifically trained to support the positive risk management and psychological wellbeing of PWID and forensic needs.

Limitations

A qualitative methodology and relatively small sample size means the findings are not generalisable to the experiences of all adult men with ID and offending histories. Similarly, this was a homogeneous sample of White British men with mild ID; the experiences of those with more profound ID are not represented and there is a need to look at wider socio-demographic populations.

Furthermore, length of stay within secure services varied from 2 to 14 years, and time spent back in the community ranged from 8 to 44 months. Hypothetically, a longer detention may have increased the likelihood of a participant feeling institutionalised, which may have made the transitional experience particularly challenging; this might not reflect the experiences of participants with relatively shorter stays.

Future research

Further qualitative research may investigate the juxtaposition between how PWID and forensic needs hope to renew their identities during community resettlement but ultimately feel unable to do so. This may encompass the exploration of a recent drive to use “extended section.17” leave as part of a model for discharging restricted ID forensic patients. In addition, a broader survey methodology exploring transitional experiences may generate more representative data from across different demographic/cultural groups.

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