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South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol



RECOVERY IN MENTAL HEALTH: MULTIPLE PERSPECTIVES

Thesis submitted in partial fulfilment of the requirement for the degree of Doctorate of

Clinical Psychology (DClinPsy)

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Kim Jackson-Blott

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Thesis Summary

Recovery in Mental Health: Multiple Perspectives

Kim Jackson-Blott

Doctorate of Clinical Psychology

Cardiff University; South Wales Doctoral Programme in Clinical Psychology

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Recovery has become a guiding principle for mental health service delivery. This thesis aimed to address gaps in the recovery literature and is presented as three papers: (1) a systematic literature review, (2) an empirical study and (3) a critical reflection.

The systematic literature review used narrative synthesis methodology to explore and consolidate the quantitative literature regarding recovery-oriented training programmes for mental health professionals. Sixteen studies of variable methodological quality were included. The heterogeneity among study designs and training programmes limited the conclusions that could be drawn. Recovery training appeared somewhat effective in improving recovery-oriented outcomes for mental health professionals, however the evidence regarding service-user and service-level outcomes was inconclusive. The review concludes that staff recovery training may have limited capacity to influence clinical practice if implemented in isolation. Key implications for clinical practice and future research are identified.

The empirical study used Q methodology to explore staff and service-users' views on factors deemed important to recovery from psychosis in a forensic setting. Four distinct perspectives were identified: (1) *Personal growth and psychosocial aspects of recovery*, (2) *Gaining insight and reducing recidivism*, (3) *Self-focused aspects of recovery*, and (4) *Making amends and service engagement*. The heterogeneity of recovery beliefs indicated that multiple dimensions of recovery are important within clinical practice, however the bio-medical model of care appeared most prominent. Notions of 'personal recovery' (aligning with the recovery movement) were most strongly expressed in factor 1, which was not endorsed by psychiatrists or service-user participants. The findings highlight important considerations for clinical practice and future research.

The final paper includes a critical reflection on the research process. This entails an appraisal of the decision-making processes and of the research conducted. Consideration is also given to the thesis as a whole with reference to its strengths, limitations and implications.

DECLARATION

This work has not been submitted in substance for any other degree or award at this or any other university or place of learning, nor is being submitted concurrently in candidature for any degree or other award.

Signed (candidate) Date

STATEMENT 1

This thesis is being submitted in partial fulfillment of the requirements for the degree of(insert MCh, MD, MPhil, PhD etc, as appropriate)

Signed (candidate) Date

STATEMENT 2

This thesis is the result of my own independent work/investigation, except where otherwise stated. Other sources are acknowledged by explicit references. The views expressed are my own.

Signed (candidate) Date

STATEMENT 3

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

Signed (candidate) Date

STATEMENT 4: PREVIOUSLY APPROVED BAR ON ACCESS

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Paper 1: Systematic Literature Review

Recovery-Oriented Training Programmes for Mental Health Professionals: A Narrative Literature Review

Manuscript prepared in accordance with the *Psychiatric Rehabilitation Journal* guidelines
(Appendix 1)

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Abstract

Objective: There is a recognised need to ensure the provision of recovery-oriented mental health services. Resultantly, a number of recovery-oriented training programmes have been implemented across a range of mental health settings. This review explores the quantitative literature regarding recovery-oriented training programmes for mental health professionals. The main objectives were to determine the methodological quality of studies, identify the characteristics of training programmes being implemented, and explore the effects of recovery-oriented training on recovery-related outcomes.

Methods: A systematic literature search of six databases resulted in the identification of 16 studies, which were reviewed using narrative synthesis methodology.

Results: The identified studies were of variable methodological quality and a number of weaknesses were acknowledged. The heterogeneity among training programmes limited the ability to draw firm conclusions, however training that included experiential learning and service-user involvement may have had additional benefits. Recovery-oriented staff outcomes were the most commonly reported measures of training effectiveness, with results indicating that recovery training has the potential to improve recovery-consistent knowledge, attitudes and competencies of mental health professionals. However, there is limited evidence relating to service-user and service-level outcomes, suggesting that staff recovery training may have limited influence on clinical practice.

Conclusions and Implications for Practice: Due to the heterogeneity among the identified studies, the effectiveness of staff recovery training is inconclusive. Whilst recovery training may have some utility in improving recovery-oriented staff outcomes, training needs to be provided as part of wider organisational change to ensure this translates into clinical practice.

Key words: recovery, training programme, staff education, mental health professionals, review

Introduction

The promotion of recovery-oriented mental health services continues to gain prominence in international research and policy (Department of Health [DoH], 2009; Frost et al., 2017; Mental Health Commission [MHC], 2001; MHC, 2007; MHC, 2012; Pincus et al., 2016; World Health Organisation, 2013). Whilst there is no single definition of recovery, there is consensus that recovery is focused on personal growth, hope and autonomy (Meehan, King, Beavis, & Robinson, 2008). Accordingly, recovery is based on the service-user's perspective (Young & Ensing, 1999) and involves a continuing process of change, which may or may not be illness focused (Anthony, 2000; 2004). This notion of 'personal recovery' differs from the traditional bio-medical approach of 'clinical recovery', which refers to a reduction or elimination of clinical symptoms as determined by mental health professionals [MHPs] (Slade, 2009a). Despite calls for reform, bio-medical views of recovery still prevail amongst MHPs (Morera, Pratt, & Bucci, 2017) and provision of recovery-oriented services remains sporadic (Le Boutillier et al., 2014; Perkins & Slade, 2012; Pincus et al., 2016; Tse, Siu, & Kan, 2013). Critics suggest the concept of recovery has been colonised by mental health services, commissioners and policy makers, who are using it as a 'cover' for service reduction and reduced welfare support (Mind, 2008; Recovery in the Bin, n.d.; Slade, Adams, & O'Hagan, 2012).

The successful implementation of personal recovery requires traditional mental health services to adopt a different values base (Slade, 2009b). Professionals need to shift from a position of expertise and authority to one in which they provide coaching directed towards the goals of service-users (Roberts & Wolfson, 2004; Slade 2009a). MHPs therefore require support to develop core recovery competencies (Borg & Kristiansen, 2004; Clasen, Meyer, Brun, Mase, & Cauley, 2003) and emphasis should be given to professional's belief in and understanding of recovery (Cleary & Dowling, 2009). In addition, Del Vecchio (2015) recognised the need to prepare MHPs with recovery-based clinical skills and practice delivery approaches. Despite difficulties with uptake and maintenance of behaviour change, staff training programmes continue to be a key approach to developing knowledge, skills and practices within workplace environments (Williams et al., 2016). Consequently, recovery-oriented staff-training programmes have been implemented across a range of mental health settings. However, to the best of the author's knowledge, there has been no systematic review of these interventions. Whilst much of the recovery evidence is of a narrative nature, more empirical-based data are required to validate the new recovery approach (Clasen et al., 2003; Wilrycx, Croon, van den Broek, & van Nieuwenhuizen, 2012). Thus, this research aimed to systematically review the quantitative literature relating to recovery-oriented training programmes for MHPs. The main objectives were to determine the methodological quality of studies, identify the characteristics of training programmes being implemented, and explore the effects of recovery-oriented training on recovery-related outcomes.

Methodology

Search Strategy

A systematic literature search was conducted in January 2018 using ASSIA (1988-), PsychINFO (1988-), MEDLINE (1988-), CINAHL (1988-), Scopus (1988-), and Web of Science (1988-). Keywords were entered to fulfil the following criteria: staff training interventions (*staff training* OR *staff education*) AND recovery focused (*recovery* OR *recovery orient**) AND within a mental health context (*mental health* OR *mental illness* OR *mental disorder* OR *psychiatr** OR *psychosis* OR *schizophren**). Database searches were defined to identify these terms within the studies title, abstract or keywords.

The search strategy was completed in line with PRISMA guidance (Moher, Liberati, Tetzlaff, Altman, & Prisma Group, 2009). Studies identified from each database were combined and duplicates removed. The titles and abstracts of remaining studies were screened for relevance and full texts were assessed for eligibility according to the inclusion and exclusion criteria. A manual search of reference lists identified additional relevant studies. An overview of this sampling process is displayed in Figure 1.

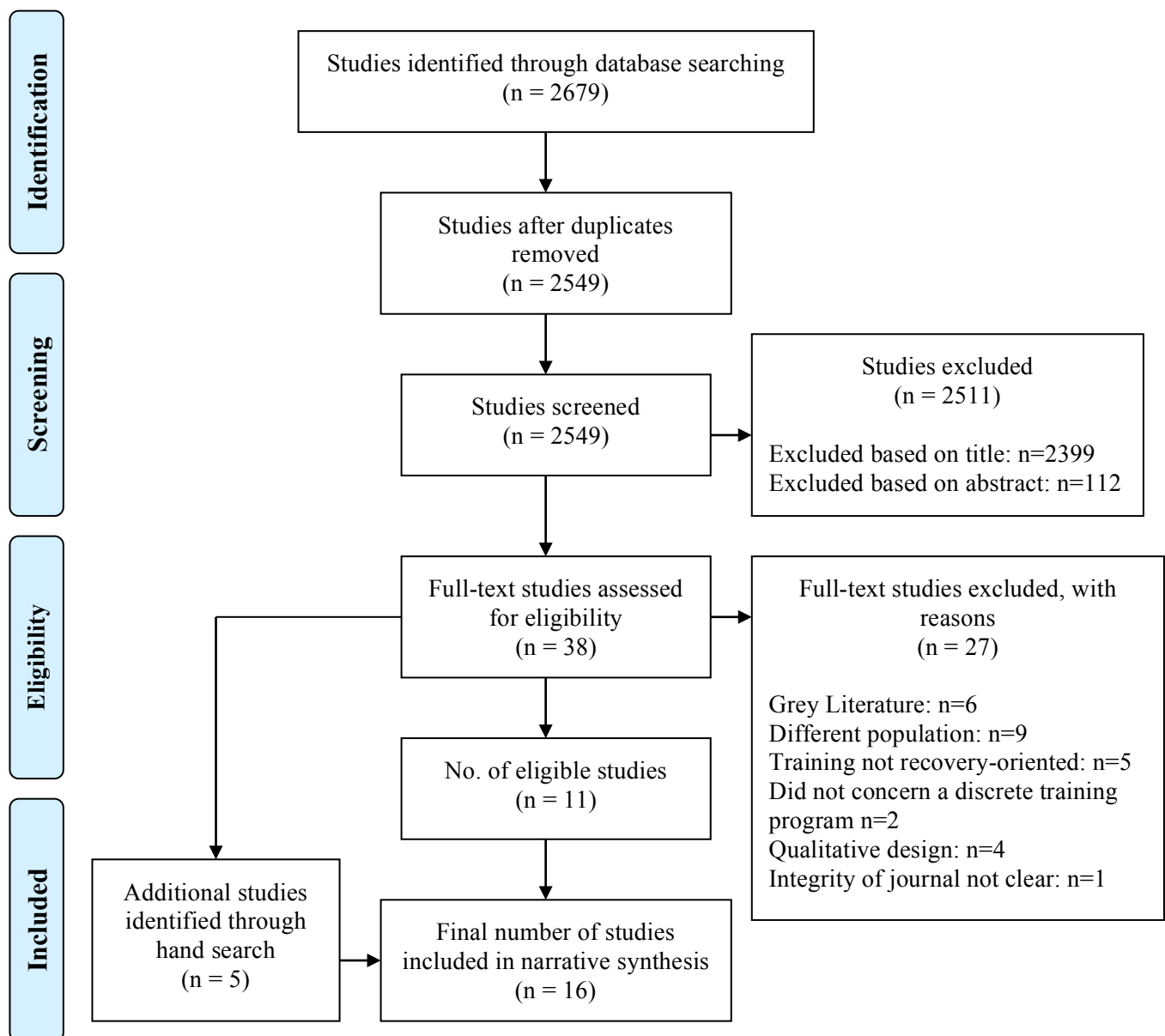


Figure 1: PRISMA diagram depicting search and screening process

Inclusion and Exclusion Criteria

The notion of recovery within mental health is a relatively recent concept, thus the review was limited to papers published in English from 1988 onwards. Only peer-reviewed articles were included and ‘grey literature’ was excluded. Studies were required to describe and

evaluate a discrete recovery-oriented training programme delivered to MHPs. In addition, the inclusion of quantitative outcome data was a prerequisite.

Quality Assessment

Studies were assessed for methodological quality using the Quality Assessment Tool for Studies with Diverse Designs (QATSDD; Sirriyeh, Lawton, Gardner, & Armitage, 2012), which has demonstrated good validity and reliability (Sirriyeh et al., 2012). Studies were given a quality score based on the 14 quantitative criteria, which were each scored on a four-point scale (from 0 to 3) with a maximum total score of 42. The author (KJ) assessed all studies against the 14 criteria, and an inter-rater reliability of 71% was obtained between reviewers (KJ, SM) on a random sample of four papers (25%).

Data Synthesis

Acknowledging the limited number of relevant studies, quality ratings were not used to exclude studies but rather to aid interpretation of the results. Due to the diversity of study designs, meta-analysis was considered inappropriate. A narrative synthesis was therefore conducted in line with published guidance (i.e. Popay et al., 2006).

Results

Study Design Characteristics

The search strategy identified 16 eligible studies published between 2005 and 2017. Study design characteristics are summarised in Table 1. Studies spanned nine countries and had diverse study designs: pre-test/post-test (1, 2, 3, 4, 6, 8, 10, 11, 12), quasi-experimental (5, 7, 8, 13, 15, 16), repeated measurement (14), and a RCT (9). Paper 8 included two separate components as was thus counted twice. Service contexts also varied, comprising psychiatric inpatient units (1, 2, 9, 10, 16), community-based mental health services (3, 15), and an academic medical institution (8). Eight studies (4, 5, 6, 7, 11, 12, 13, 14) took place across a range of mental health organisations. The majority of studies (n=12) focused on training MHPs with varying professional backgrounds, and two (4, 6) trained MHPs alongside carers and/or service-users. A further two studies focused exclusively on training mental health nurses (10, 16) and one targeted Doctoral trained professionals (8).

The quality ratings of studies were variable, with scores on the QATSDD (Sirriyeh, et al., 2012) ranging from 19 to 31 (see Appendix 2 for individual quality scores of reviewed studies). Studies consistently scored highly on criteria 12 (i.e. fit between research question and method of analysis) yet poorly on criteria 4 (i.e. evidence of sample size considered in terms of analysis), thereby raising questions concerning the evaluative power of the studies. All studies received low scores on criteria 15 (i.e. evidence of user involvement in design) and all but two (1, 2) obtained low scores on criteria 1 (i.e. explicit theoretical framework). Potential sources of detection and performance bias were also identified. The only study to use randomisation (9) failed to report on participant recruitment, blinding procedures and method of allocation to treatment conditions. In addition, the potential for attrition bias was acknowledged: four studies (1, 2, 6, 9) did not report on attrition rates and the remaining studies reported rates ranging from 0% to 73%.

Table 1: Study Design Characteristics

[Study Number] Authors	Country	Study Design	Setting/Sample	Sample Size [Attrition]	Quality Rating
[1] Chang et al. (2013)	USA	Pretest/posttest design	Urban acute psychiatric inpatient unit/ Mental health staff	N=29 [ns]	28
[2] Chen et al. (2014)	Canada	Pretest/posttest design	Tertiary care psychiatric inpatient units/ Mental health staff	N=26 [11.5% post part 1; 73% post part 2]	19
[3] Crowe et al. (2006)	Australia	Pretest/posttest design (within-and-between groups)	Community based mental health organisations/ Mental health staff from government & non-government organisations	N= 147 [ns] government staff; N=101 [ns] non-government staff	23
[4] Doughty et al. (2008)	New Zealand	Pretest/posttest design	Mental health organisations/ SU & mental health staff	N=50 [nc] SU; N=75 [nc] staff	21
[5] Gilbert et al. (2013)	UK	Quant component: Quasi-experimental design (pretest/posttest, non-equivalent control group)	Community & in-patient rehabilitation teams/ Impact of training for mental health staff on SU care plans	N=342 [50.4%] staff receiving training; IG: N=385 (SU of trained staff); CG: N=288 (SU of staff who did not receive training)	22
[6] Higgins et al. (2012)	Ireland	Quant component: Pretest/posttest design	Mental health organisations/ various combinations of people identifying as mental health staff, carers &/or SU	N=194 [ns] attended 2-day training; N=59 [ns] attended 5-day training	22
[7] Meehan & Glover (2009)	Australia	Quasi-experimental design (pretest/posttest, non-equivalent control group)	Inpatient & outpatient mental health services / Mental health staff	IG: N=114 [53.9%] staff receiving training; CG: N= 64 [ns] staff from different district attending different training	20
[8] Peebles et al. (2009)	USA	Pretest/posttest design & Quasi-experimental design (non-equivalent control group)	Academic medical institutions (MCG & USC)/ Doctoral trained mental health professionals (i.e. psychologists & psychiatrists)	IG: N=46 [28.3%] practitioners from MCG; CG: N=34 [0%] practitioners from USC	29
[9] Pollard et al. (2008)	Israel	Randomised controlled trial	Acute & chronic psychiatric inpatient units / Mental health staff	IG: N=28 [ns]; CG: N=27 [ns] wait-list	19
[10] Repique et al. (2016)	USA	Quant component: Pretest/posttest design	Private psychiatric inpatient units / nurses	N=42 [25%]	28
[11] Salgado et al. (2010)	Australia	Pretest/posttest design	Government & non-government mental health organisations / Mental health staff	N=103 [27.2%]	30
[12] Walsh et al. (2017)	Ireland	Pretest/posttest design	Mental health organisations (e.g. community &/ inpatient)/ Mental health staff	N=101 [28.7%]	31
[13] Wilrycx et al. (2012)	The Netherlands	Quasi-experimental: Two-group multiple intervention interrupted time-series design	The department for long-term mentally ill people (inpatient & outpatient settings) / Mental health staff	N=210 [54.3%]	30
[14] Wilrycx et al. (2015)	The Netherlands	Repeated measurement design with six measurement occasions	The department for long-term mentally ill people (inpatient & outpatient settings) / SU rated outcomes of training for mental health staff	N=142 [nc] SU	32
[15] Young et al. (2005)	California	Quant component: Quasi-experimental design (pretest/posttest, non-equivalent control group)	Community mental health organisations / Mental health staff	IG: N=151 [22.5%]; CG: N=118 [33.9%] clinicians from a different mental health organisation	25
[16] Zuaboni et al. (2017)	Switzerland	Quasi-experimental design (pretest/posttest, non-equivalent control group)	Acute psychiatric inpatient units / nurses & SU	IG: N=73 [11%] SU & N=43 [11.6%] nurses; CG: N=29 [51.7%] patients from different wards & N=19 [52.6%] nurses from different wards	29

N: number of participants; IG: Intervention Group; CG: Control Group; ns: not stated; nc: not clear; SU: Service-Users; Quant: Quantitative

Training Programme Characteristics

Training attendance was mandatory in five studies (1, 5, 12, 13, 14) and voluntary in seven (2, 4, 6, 8, 10, 15, 16). The remaining four studies failed to provide this information. Characteristics of training programmes are displayed in Table 2. Training ranged from one hour to five days of contact time, and the number of sessions ranged from one to 12. Only three studies provided previously established training: two (3, 11) provided The Collaborative Recovery Training Program (Oades et al., 2005) and one (11) provided Recovery to Practice (SAMHSA, 2010). A further study (5) incorporated an established training package (i.e. Basset et al., 2007) into a wider training programme, while two studies (4, 6) reported the development of training based on the Wellness Recovery Action Plan (WRAP; Copeland & Mead, 2004). Training programmes were broadly homogenous in that they all provided a group-based educational component, providing information on recovery principles and strategies to inform recovery-oriented practice. However the components of training programmes differed across studies. Moreover, two studies included additional strategies in the form of organisational support: one (9) established an on-going forum for professionals and the other (15) supported the development of service-user-led mutual support groups.

Whilst five studies (3, 11, 13, 14, 16) did not provide sufficient information regarding delivery style, all remaining studies (except study 10) reported the inclusion of interactive learning components. Seven (1, 2, 5, 7, 8, 9, 15) included experiential learning (e.g. skill practice, role plays and/or establishing action plans), providing participants with opportunities to develop practical skills. Nine studies (4, 5, 7, 8, 9, 12, 13, 14, 15) included people with lived experience in the delivery of training, providing opportunities to hear

personal experiences of recovery. In total, only three training programs made use of multi-media. One used an interactive DVD to promote self-paced learning (2) and another showed a video lecture (9), both of which formed part of a wider training package. One training programme consisted solely of a 1hr didactic webinar (10).

Table 2: Training Programme Characteristics

[Study Number] Authors	Title/Contents	Training Attendance / Delivery style	SU &/ Carer Involvement	Duration
[1] Chang et al. (2013)	<ul style="list-style-type: none"> Recovery-oriented Cognitive Therapy (CT-R) milieu training: CT-R formulations & strategies to inform treatment planning (engagement, collaboration, goal setting, crisis de-escalation, treatment non-adherence & relapse prevention); techniques for avoiding staff burnout 	Mandatory / Lectures, discussions, visual aids & interactive exercises (skill practice, role plays & establishing action plans)	Design: ns; Delivery: ns	8-h (2-h weekly sessions over 4 weeks)
[2] Chen et al. (2014)	<ul style="list-style-type: none"> Self Learning Program (Part 1): Basic recovery concepts; the tension-practice-consequence model (factors impacting recovery orientated care); recovery competency framework (8 core competencies) 	Voluntary / User manual & interactive lesson on DVD	Design: ns; Delivery: no	Self-paced learning
	<ul style="list-style-type: none"> Group Learning Program (Part 2): Two modules ('encouraging participation' & 'strength-based practice') applying the 4-D cycle of Appreciative Inquiry to manage clinical dilemmas 	Voluntary / Group discussion & action planning	Design: ns; Delivery: ns	6 sessions over 6 weeks
[3] Crowe et al. (2006)	<ul style="list-style-type: none"> The Collaborative Recovery Training Program (Oades et al., 2005): Recovery as an individual process; change enhancement; collaborative needs identification & goal striving; collaborative task striving and monitoring 	ns / ns	Design: ns; Delivery: ns	2 days
[4] Doughty et al. (2008)	<ul style="list-style-type: none"> Wellness Recovery Action Plan (WRAP) Workshop: Basic recovery concepts; medical care and how to manage medications; developing a set of 'tools' to enhance 'wellness'; identifying triggers and symptoms; developing personal crisis plans 	Voluntary / Didactic presentation, small group discussion & sharing of recovery experiences	Design: yes; Delivery: yes	1 or 2 days
[5] Gilbert et al. (2013)	<ul style="list-style-type: none"> Developed by researchers (no title stated): Introduction to recovery; elements that constitute a recovery approach; an established recovery training package (Psychosis revisited - a psychosocial approach to recovery; Basset et al., 2007); assessment & care planning from SU perspectives; social inclusion/vocational activities; carer perspectives; personal values, strengths-based approaches & the role of hope; incorporating recovery concepts within individual teams 	Mandatory / Didactic, experiential learning, SU accounts & reflecting on practice	Design: yes; Delivery: yes	4 days training & 1 half-day in-team consolidation meeting
[6] Higgins et al. (2012)	<ul style="list-style-type: none"> The recovery and WRAP education programme: Overview of recovery principles; introduction to developing individual WRAP's (covered in 2-day training); helping others learn about recovery & WRAP (covered in 5-day training) 	Voluntary / Didactic presentation & collaborative discussion	Design: ns; Delivery: ns	2 or 5 days
[7] Meehan & Glover (2009)	<ul style="list-style-type: none"> Consumer-led recovery training program: Building structure' (basic recovery concepts and principles of recovery oriented practice); 'New ways of relating to people with mental illness' (role of service providers in supporting recovery); 'Doing things differently' (developing clinical skills in recovery based practice) 	ns / Didactic lectures, problem solving in small groups, demonstrations & role plays	Design: yes; Delivery: yes	3 days (1 day each month over a period of 3 months)
[8] Peebles et al. (2009)	<ul style="list-style-type: none"> Project GREAT (Georgia Recovery-based Educational Approach to Treatment): 	Voluntary / Didactic presentations,	Design: yes; Delivery: yes	2 workshops (1x 3-h workshop &

	Initial workshop: overview of the recovery movement and the SAMHSA (2006) 'Fundamental Components of Recovery'; fostering motivation for practical skill change (collaborative goal setting; identification of SU; systemic approaches to care)	experiential exercises, role-playing, prepared discussions, SU accounts, panel discussions & question-and-answer sessions		1 x 2-h workshop delivered 1 month later)
	Second workshop: centred on shifting attitudes (collaborative relationships; allaying practitioner fears regards SU competency; shifting focus from cure to the primacy of SU personal goals; allaying concerns regarding diminished provider roles; shifting from pathology-focused care to strengths-based care)			
[9] Pollard et al. (2008)	<ul style="list-style-type: none"> • Rehabilitation Program Training: Theoretical knowledge (introduction to the 'recovery mission'; the importance of hope); understanding SU experiences; increasing knowledge of evidence-based practices; emphasising the importance of applying evidence-based practices; increasing knowledge about community services <p><u>Additional component:</u> A forum of representatives from all disciplines to maintain contact, disseminate information & provide in-service training</p>	ns / Didactic lectures, video of a lecture, SU accounts, experiential elements, group discussions & staff presentations	Design: ns; Delivery: yes	6 x 2-h sessions & 6 x 4-h community visits
[10] Repique et al. (2016)	<ul style="list-style-type: none"> • Recovery to Practice (SAMHSA, 2010): Application of recovery principles in acute care settings: patient engagement models; trauma systems theory; restraint reduction strategies; integration of peer-to-peer services in psychiatric treatment; outcomes of randomised trial of consumer-managed alternative treatment programs 	Voluntary / Group online webinar: didactic	Design: ns; Delivery: no	1-h
[11] Salgado et al. (2010)	<ul style="list-style-type: none"> • The Collaborative Recovery Training Program (Oades et al., 2005): <p>Contents: as stated above for Crowe et al. (2006)</p>	ns / ns	Design: ns; Delivery: ns	2 days
[12] Walsh et al. (2017)	<ul style="list-style-type: none"> • Advancing Recovery in Ireland (ARI) training workshop: <p>Defining the concept of recovery; exploring recovery principles and how they can be adopted into clinical practice</p>	Mandatory / Group work, individual work, conversations, SU & carer accounts, & reflective practice (individual & team perspective)	Design: yes; Delivery: yes	4-h
[13] Wilrycx et al. (2012)	<ul style="list-style-type: none"> • Recovery and recovery-oriented care: <p>Module 1 (intervention A): Focused on the basics of recovery & recovery-oriented care</p> <p>Module 2 (intervention B): Focused on the recovery-oriented attitude & competency of the professional</p>	Mandatory / ns	Design: yes; Delivery: yes	4 days (2 days per module)
[14] Wilrycx et al. (2015)	<ul style="list-style-type: none"> • Recovery and recovery-oriented care: <p>Contents: as stated above for Wilrycx et al. (2012)</p>	Mandatory / ns	Design: yes; Delivery: yes	4 days (2 days per module)
[15] Young et al. (2005)	<ul style="list-style-type: none"> • Staff Supporting Skills for Self-Help: <p>Scientific presentation on self-help & recovery; structured dialogues (focusing on barriers to self-help & recovery, & experiences that create hope); rehabilitation readiness (skills to help SU set goals & develop coping strategies); strategies for independence; professional skills supporting self-help (how to support self-help without being intrusive); detailing (continuing to meet with clinicians as needed)</p> <p><u>Additional component:</u> Technical assistance for SU to set up mutual support groups</p>	Voluntary / Didactic education, small group discussions, role-playing techniques, clinician-SU dialogues & on-going technical assistance (individual advice as needed)	Design: yes; Delivery: yes	5 group components delivered over a 1-year period & opportunities to receive individual advice as needed
[16] Zuaboni et al. (2017)	<ul style="list-style-type: none"> • Mental Health Nursing Training-Programme: <p>Personal recovery & social inclusion (session 1); basics of Motivational Interviewing, development of therapeutic relationships & coaching techniques (sessions 2 & 3); goal attainment strategies & scaling (session 4); implementation of training concepts in care process & documentation, & interdisciplinary exchange (session 5)</p>	Voluntary / ns	Design: ns; Delivery: no	5 half-day training sessions

SU: Service-Users; ns: not stated

Training Evaluation Outcomes

Of the 16 studies, eight assessed the effects of training immediately pre- and post-intervention (2, 3, 4, 6, 8, 9, 10, 11), and one had a data collection period spanning three-months pre- and post- intervention (16). The remaining seven studies utilised longitudinal designs, collecting data at three-months post-training (5), six-months post-training (1, 7, 12) or one-year post-training (13, 14, 15). Training evaluation outcomes are reported in Table 3. Studies assessed the effects of training on a range of staff, service-user and/or service-level outcomes, with four reporting positive effects (4, 7, 11, 12), ten reporting mixed effects (1, 2, 3, 5, 6, 8, 9, 13, 14, 15) and two reporting no effects (10, 16).

Table 3: Training Evaluation Outcomes

[Study Number] Authors	Evaluated Outcome	Assessment Tool	Evaluation time points	Findings
[1] Chang et al. (2013)	• Perceptions of CT-R	The CT-R Interview	Pre and 6-months post-training	(↑*) (i.e. greater familiarity)
	• Beliefs about the therapeutic milieu	Views on Therapeutic Environments (VOTE; Laker et al., 2012)	Pre and 6-months post-training	(↓*) (i.e. improvement in attitudes)
	• Attitudes	Attitudes Toward Working with People with Psychosis (McLeod et al., 2002)	Pre and 6-months post-training	(→)
	• Incidents of seclusion & restraint	Number of incidents	4-months pre and 4-months post-training	(↓) from 19 to 7
[2] Chen et al. (2014)	• Recovery knowledge	Recovery Knowledge Inventory (RKI; Bedregal et al., 2006)	Pre-training, post part 1 of training & post part 2 of training	(↑*) post part 1 of training (→) post part 2 of training
	• Group learning experience	Ratings of 18 statements about experience	Post part 2 of training	High satisfaction (4.21 out of 5)
[3] Crowe et al. (2006)	• Recovery knowledge	The collaborative recovery knowledge scale (developed for this study)	Pre and post-training	Government group: (↑*) Non-Government group: (↑*)
	• Recovery attitudes	Recovery Attitudes Questionnaire (RAQ-7; Borkin et al., 2000)	Pre and post-training	Government group: RAQ-7 first factor (↑*) RAQ-7 second factor (↑*) Non-Government group: RAQ-7 first factor (→) RAQ-7 second factor (→)
	• Recovery hopefulness	Staff Attitudes to Recovery Scale (STARS; developed for this study)	Pre and post-training	Government group: (↑*) Non-Government group: (↑*)

[4] Doughty et al. (2008)	• Recovery knowledge & attitudes	Beliefs about Recovery and WRAP questionnaire (developed by authors)	Pre and post-training	(↑*) no significant differences between scores for: • 1-day & 2-day course • SU & staff (no statistics reported)
[5] Gilburt et al. (2013)	• SU care plans	Care plan audit: change in topics covered & change in responsibility of action	Pre and 3-months post-training	CG vs. IG post-training: • IG had significantly more changes in care plan topics covered; no clear trend in topic changes • IG had significantly more changes in the attributed responsibility for actions; changes related to whether staff took sole responsibility for actions (33% CG; 25% IG) or shared responsibility with consumers (33% CG; 58% IG)
[6] Higgins et al. (2012)	• Recovery knowledge	Recovery Knowledge Questionnaire (RKQ; developed for this study)	Pre and post-training	(↑*) for 2-day training (→) for 5-day training
	• Recovery attitudes	RAQ-7 (Borkin et al., 2000)	Pre and post-training	(↑*) for 2-day training (→) for 5-day training
	• WRAP beliefs	Beliefs about Recovery and WRAP questionnaire (Doughty et al., 2008)	Pre and post-training	2-day training: Positive statements (↑*) Negative statement (↓*) 5-day training Positive statements (↑*) Negative statement (→)
[7] Meehan & Glover (2009)	• Recovery knowledge	RKI (Bedregal et al., 2006)	Pre-training, post-training and 6-months post-training	IG: (↑*) at 6-months post-training CG vs. IG at 6-month post training: IG scores increased significantly more than CG scores
[8] Peebles et al. (2009)	• Recovery knowledge	The Project GREAT Recovery Knowledge Measure (developed for this study) RKI (Bedregal et al., 2006)	IG: pre-training and post-workshop 1 CG: 2-months post-workshop 2 IG: pre-training and post-workshop 1 CG: 2-months post-workshop 2	IG: (↑*) post workshop 1 CG vs. IG: IG scores significantly higher than CG scores IG: (↑*) post workshop 1 CG vs. IG: IG scores significantly higher than CG scores
	• Recovery attitudes	Recovery Attitudinal Pre-Post Survey (Cook et al., 1995)	IG: pre-training, post-workshop 1 and post-workshop 2 CG: 2-months post-workshop 2	IG: (→) post workshop 1; (↑*) post workshop 2 CG vs. IG: IG scores significantly higher than CG scores
	• Stigma	Attribution Questionnaire-27 (AQ-27; Corrigan et al., 2004)	IG: pre-training, post-workshop 1 and post-workshop 2 CG: 2-months post-workshop 2	IG: (→) post workshop 1; (→) post workshop 2 CG vs. IG: IG scores significantly lower (i.e. less stigmatising attitudes towards SU) than CG scores
[9] Pollard et al. (2008)	• Knowledge & attitudes	Practitioners' Beliefs, Goals and Practices in Psychiatric Rehabilitation Questionnaire (PBGPPR; Casper et al., 2002)	IG: pre and post-training	IG: (→) on factor 1 (consumer-driven paradigm); (↑*) on factor 2 (staff-directed paradigm); (↑*) on factor 3 (evidenced-based practices); (→) on factor 4 (standardised service); (→) on factor 5 (recovery mission); (↑*) on total score
			CG: pre and post-training	CG vs. IG: IG score significantly higher than CG scores (→) on all four domains of RKI
[10] Repique et al. (2016)	• Recovery knowledge	RKI (Bedregal et al., 2006)	Pre-training and post-intervention phase	
	• Aggregated restraint rates	Average restraint rate: Line graph	Quarterly restraint rates over a one-year period: pre-training (Q1 and Q2), during the 3-month intervention period (Q3), and post-training (Q4)	Average restraint episodes per 1000 patient days: Q1=1.33; Q2=1.63; Q3=2.33; Q4=2.29

[11] Salgado et al. (2010)	• Recovery knowledge	RKI (Bedregal et al., 2006)	Pre and post-training	(↑*); no interaction with dispositional hope observed
	• Recovery attitudes	RAQ-7 (Borkin et al., 2000)	Pre and post-training	(↑*); no interaction with dispositional hope observed
	• Recovery hopefulness	STARS (Crowe et al., 2006)	Pre and post-training	(↑*); no interaction with dispositional hope observed
	• Provider optimism	Therapeutic Optimism Scale (TOS; Byrne et al., 2006)	Pre and post-training	(↑*); no interaction with dispositional hope observed
[12] Walsh et al. (2017)	• Recovery knowledge	RKI (Bedregal et al., 2006)	Pre and 6-months post-training	(↑*) on all four domains of RKI
	• Recovery attitudes	RAQ-16 (Borkin et al., 2000)	Pre and 6-months post-training	(↑*) on both factors of the RAQ-16
	• Confidence in using the recovery model of care	Ordinal ratings converted to mean confidence ratings	Pre and 6-months post-training	(↑*)
[13] Wilrycx et al. (2012)	• Recovery knowledge	Dutch version of the RKI (Bedregal et al., 2006)	Six measurement occasions: Pre-training baseline (Time 0); Post intervention A - delivered to half the staff sample (Time 1); Post intervention A -delivered to second half of the staff sample (Time 2); Post intervention B -delivered to half the staff sample (Time 3); Post intervention B -delivered to second half of the staff sample (Time 4); 1-year post Time 4 (Time 5)	(↑*) post intervention A (→) post intervention B The positive effect of intervention A reduced following intervention B
	• Recovery attitudes	Dutch version of the RAQ (Borkin et al., 2000)		(↑*) post intervention A (↑*) post intervention B Intervention B had a larger effect than intervention A
[14] Wilrycx et al. (2015)	• Relationships with professionals (SU perceptions)	Dutch version of the Recovery-Promoting Relationship Scale (RPRS; Russinova et al., 2006; Wilrycx et al., 2011)	Six measurement occasions: As stated above for Wilrycx et al. (2012)	(→) on subscale 'Hopefulness & empowerment' (→) on subscale 'Self-acceptance'
	• Experienced empowerment & autonomy (SU perceptions)	Dutch version of the Mental Health Recovery Measure (MHRM; van Nieuwenhuizen et al., 2013; Young & Bullock, 2003)		(→) on subscale 'Self-empowerment' (→) on subscale 'Spirituality' (↑*) on subscale 'Learning & new potentials'
[15] Young et al. (2005)	• Clinician's competencies	Competency Assessment Instrument (CAI; Chinman et al., 2003)	Pre-training and 1-year follow-up	CG vs. IG: clinicians in the IG showed significantly greater improvement in education about care, rehabilitation methods, natural supports, holistic approaches, teamwork, overall competency & recovery orientation IG & CG: (↓*) for stigma (i.e. stigma worsened)
[16] Zuaboni et al. (2017)	• SU & nurses perceptions regarding the recovery-orientation of acute psychiatric wards	The German version of the Recovery Self-Assessment scale (RSA-D; Zuaboni et al., 2015): Provider version & Patient version	Pre and post training (each data collection period lasted for 3 months)	SU ratings of RSA-D: • IG: (→) on all 6 sub-scales & total score • CG vs. IG: no significant differences between outcomes of the IG and CG
				Provider ratings of RSA-D: • IG: (→) on all 6 sub-scales & total score • CG vs. IG: no significant differences between outcomes of the IG and CG

(↑*) Statistically significant increase in scores post-training; (↓*) Statistically significant reduction in scores post-training; (→) No significant change in scores post intervention; (↓) Reduction in scores post-training but not statistically assessed; IG: Intervention Group; CG: Control Group; SU: Service-Users

Recovery-Oriented Staff Outcomes

Assessment Tools

To investigate the effects of recovery training on staff outcomes, a range of self-report questionnaires were used, five of which were developed as part of the study. Two studies (3, 11) measured staff hopefulness using the Staff Attitudes to Recovery Scale (STARS; Crowe, Deane, Oades, Caputi, & Morland, 2006), one (11) measured provider optimism with the Therapeutic Optimism Scale (TOS; Byrne, Sullivan, & Elsom, 2006), and one (15) measured staff competencies using the Competency Assessment Instrument (CAI; Chinman et al., 2003). Six studies measured recovery-consistent attitudes, one (8) using the Recovery Attitudinal Pre-Post Survey (Cook, Jonikas, & Razzano, 1995) and five (3, 6, 11, 12, 13) using versions of the Recovery Attitudes Questionnaire (RAQ; Borkin et al., 2000). To measure levels of stigma, one study (8) used the Attribution Questionnaire-27 (AQ-27; Corrigan, Watson, Warpinski, & Gracia, 2004) and another (1) included a measure of Attitudes Towards Working with People with Psychosis (McLeod, Deane, & Hogbin, 2002).

Three studies concurrently measured recovery attitudes and knowledge: two (4, 6) using the Beliefs about Recovery and Wellness Recovery Action Plan questionnaire (Doughty, Tse, Duncan & McIntyre, 2008) and one (9) the Practitioners' Beliefs, Goals and Practices in Psychiatric Rehabilitation (PBGPPR; Casper, Oursler, Schmidt, & Gill, 2002). To measure recovery knowledge, seven studies (2, 7, 8, 10, 11, 12, 13) used the Recovery Knowledge Inventory (RKI; Bedregal, O'Connell, & Davidson, 2006), one (6) used the Recovery Knowledge Questionnaire (RKQ; Higgins et al., 2012), another (3) used the Collaborative

Recovery Knowledge Scale (Crowe et al., 2006), and a further study (8) used the Project GREAT Recovery Knowledge Measure (Peebles et al., 2009).

Overview of Findings

Overall, thirteen studies evaluated the effects of recovery training on staff outcomes. One such study (11) showed positive effects on provider optimism and two (3, 11) showed positive effects on levels of staff hopefulness. Three studies (11, 12, 13) reported that staff training had positive effects on staff attitudes towards recovery. Study 3 found mixed effects, reporting significant improvements in recovery attitudes for MHPs from the government health sector, but not for those working in non-government organisations. Furthermore, study 6 reported that the recovery attitudes of MHPs, carers and service-users improved significantly after a 2-day training course, but not after an extended 5-day course. Authors acknowledged a potential ceiling effect of the RAQ-7 in relation to this finding. Study 8 also reported mixed effects: recovery attitudes of psychologists and psychiatrists improved to a statistically significant level, but only after the second phase of the training programme. However, this phase of training was specifically designed to target attitudes.

Study 15 found that when compared with a control group, clinicians who received recovery training showed significantly higher scores on a range of clinical competencies at one-year follow-up. However, stigma was found to worsen in both groups. To account for this finding, the authors acknowledged that national attention had been given to violent incidents committed by people with mental health difficulties during the study period. A further two studies (8, 1) also reported that recovery training had no effect on levels of stigma.

Using a RCT, study 9 found that in comparison to a waiting-list control group, staff who received training scored significantly higher on a measure of recovery attitudes and knowledge. Similarly, studies 4 and 6 reported significant improvements post-training on a measure of recovery attitudes and knowledge. However, these studies also included service-user participants and failed to provide differential statistics for the MHPs. Of the nine studies that employed outcome measures specific to recovery knowledge, five (3, 7, 8, 11, 12) reported significant improvements post-training, with study 8 confirming these findings across two separate outcome measures. In contrast, study 10 found that recovery-oriented training had no effect on the recovery knowledge of mental health nurses as measured by the RKI. A further two studies (2, 6) using the RKI found mixed effects, explaining these findings in terms of attrition and the potential for ceiling effects. Using an interrupted time-series design with a one-year follow-up, study 13 also demonstrated mixed effects: initial gains in recovery knowledge reduced after the second part of the training programme, which focused predominantly on attitudes.

Recovery-Oriented Service-User Outcomes

Assessment Tools

One study (14) used two self-report questionnaires to measure service-user outcomes: the Dutch version of the Recovery-Promoting Relationship Scale (RPRS; Russinova, Rogers, & Ellison, 2006; Wilrycx, Croon, van den Broek, & van Nieuwenhuizen, 2011) was used to measure service-users' perceived relationships with staff, and the Dutch version of the Mental Health Recovery Measure (MHRM; van Nieuwenhuizen, Wilrycx, Moradi, &

Brouwers, 2013; Young & Bullock, 2003) was used to measure service-users' perceived experience of empowerment and autonomy.

Overview of Findings

Study 14 found that recovery training for MHPs had no effect on service-users' perceived relationship with professionals nor their experienced sense of 'self-empowerment' or 'spirituality'; however it significantly improved their perceived experience of 'learning and new potentials'.

Recovery-Oriented Service Outcomes

Assessment Tools

In total, four studies included outcome measures relating to the recovery-orientation of services. One study (5) conducted an audit of service-user care-plans and two studies (1, 10) reported on incidents of seclusion and/or restraint by displaying these rates visually as line graphs. Additionally, two self-report questionnaires were used to measure the implementation of recovery-oriented working practices: one study (1) used the Views Of the Therapeutic Environment (VOTE; Laker et al., 2012) and another (16) used the German version of the Recovery Self-Assessment scale (RSA-D; Zuaboni, Kozel, Glavanovits, Utschakowski, & Behrens, 2015), including both provider and patient versions.

Overview of Findings

Study 5 reported the care-plans of service-users, drawn from the caseloads of staff who had received recovery-oriented training, had significantly more changes at three months post-training when compared to a control group. However, data trends did not provide conclusive evidence for the hypothesised changes: diversification of care-plan topics and collaborative responsibility for actions were not demonstrated. Reporting on incidents of seclusion and restraint, study 1 revealed a reduction by more than half (from 19 to 7) at four-months post-training. However, these findings were not subject to statistical analysis on the basis of insufficient statistical power. Study 10 reported a slight reduction in restraint rates from the time period of the intervention (Quarter 3) to the time period following the intervention (Quarter 4). However, these results are slightly misleading. Comparing restraint rates before (Quarter 1 and 2) and after the intervention (Quarter 4), they were found to increase.

Assessing the perceived implementation of recovery-oriented practice, study 1 reported that MHPs had significantly improved beliefs about the therapeutic environment at six-months post-training. Conversely, study 16 found that when compared to control groups, training had no effect on working practices (as perceived by service-users and mental health nurses). Whilst the authors suggest a number of possible explanations for this finding, it is notable that this study did not employ a follow-up evaluation.

Discussion

This study is the first review of quantitative evidence relating to recovery-oriented training programmes for MHPs. The main objectives were to determine the methodological quality of

studies, the characteristics of training programmes being implemented, and the effects of recovery-oriented training on recovery-related outcomes.

Overview of Training Effectiveness

Only 16 studies met the inclusion criteria, highlighting the dearth of quantitative intervention research on recovery training for MHPs. The heterogeneity among research designs and training interventions limited comparison of results, which alongside the methodological weaknesses of individual studies limited the ability to draw firm conclusions. Recovery-oriented staff outcomes were the most commonly reported measures of training effectiveness. Aggregating these results, there is evidence to suggest that recovery training can improve the recovery-consistent knowledge, attitudes and competencies of MHPs. Levels of stigma seem less amenable to change. A minority of studies measured the effectiveness of recovery training on service-level outcomes and only one measured service-user outcomes. The collective results of these studies were inconclusive, providing limited evidence for staff recovery training to improve clinical practice.

The results of this review suggest that benefits in recovery-oriented staff outcomes may not necessarily translate into clinical practice. There is a wealth of evidence that acknowledges the challenges of implementing practice change, and the ‘transfer of training problem’ is well established (Baldwin & Ford, 1988). A review conducted by Forsetlund et al. (2009) found that educational interventions for healthcare professionals resulted in only small improvements in professional practice and patient outcomes, concluding that educational interventions alone are unlikely to change complex behaviours. Furthermore, Gee, Bhanbhro, Cook and Killaspy (2016) acknowledged that recovery training for MHPs is unlikely to yield

long-term practice change unless other cultural and organisational changes are also addressed. Unfortunately, only two of the reviewed training programmes provided additional forms of organisational support.

Overview of Training Characteristics

Especially concerning, the vast majority of studies did not explicitly refer to theoretical frameworks underpinning the interventions, and no studies reported the use of theory to inform the evaluation. Whilst it is possible that theory was used in this way, without reporting this remains unclear. There is a recognised need to keep theory central to the process of developing and evaluating interventions (Eccles, Grimshaw, Walker, Johnston, & Pitts, 2005; Michie, Fixsen, Grimshaw, & Eccles, 2009). Theories can be used to identify constructs that are causally related to behaviour and account for change. Targeting these constructs can lead to the development of more effective interventions, and evaluations of these interventions can help develop theory further (Michie et al., 2009). There are many approaches to changing clinical practice, all of which have some value and may be useful depending on the changes needed, the target group, the clinical setting, and the specific barriers and facilitators therein (Grol, 1997). If we are to take the task of implementing recovery-oriented services seriously, then implementation interventions need to capitalise on established knowledge and guidance (e.g. French et al., 2012; Medical Research Council, 2008).

The current review also highlights the diversity of staff recovery training programmes. This finding is perhaps reflective of attempts to make training programmes specific to populations and/or service contexts, which were disparate across the identified studies. Training programmes comprised various components and studies were inconsistent in their reporting

of training characteristics, thereby limiting the ability to compare training interventions. It is however notable that the two studies to report no effects did not include service-users in the delivery of training (Repique, Vernig, Lowe, Thompson, & Yap, 2016; Zuaboni, Hahn, Wolfensberger, Schwarze, & Richter, 2017). Service-user involvement has been found to have a positive effect on staff attitudes (Cook et al., 1995) and reflective dialogue between MHPs and service-users can lead to improved quality of care (Kidd, McKenzie, & Virdee, 2014). Additionally, of the two studies to report no effects, one did not include an experiential learning component (Repique et al., 2016) and the other failed to provide this information (Zuaboni et al., 2017). Training programmes with experiential components are more successful in promoting practice change (Grol & Grimshaw, 2003; Stuart, Tondora, & Hoge, 2004). These findings point to the importance of including experiential learning and service-user involvement as part of recovery training. However, the findings of this review precluded definitive conclusions due to the large number of differing components across the training interventions. For example, the training intervention evaluated by Repique et al. (2016) also had the shortest duration and was the only intervention to rely solely on a webinar.

Overview of Methodological Quality

The variable methodological quality of reviewed studies corroborates other reviews investigating the effectiveness of staff training in mental health (e.g. Heckemann et al., 2015; Kuske et al., 2007). Only six studies included a control group, one of which employed randomisation. Most studies had questionable evaluative power and were limited by detection, performance and attrition biases. In addition, the studies that relied on convenience sampling may be subject to self-selection bias. Whilst this may have been less of an issue in

studies that involved mandatory participation, these MHPs may have been less willing to engage in the training. Staff receptiveness to change (Gee et al., 2016) and motivation to learn (Wiley, 1997) can influence the effectiveness of training; potential differences between participants further limited comparison. Evidence for the long-term effectiveness of staff recovery training is lacking, as less than half of the reviewed studies included follow-up evaluation. One of the few studies to include a follow-up period of one year reported that initial gains in recovery knowledge decreased over time (Wilrycx et al., 2012). One explanation provided was a lack of knowledge rehearsal, which is essential for the integration of new knowledge into long-term memory and the implementation of information (Awh et al., 1999; Jonides et al., 2008). The efficacy of training interventions could therefore be supported by implementation strategies such as reminders, which are commonly employed across a range of healthcare contexts (Grimshaw et al., 2004).

The range of recovery outcome measures being used to determine training effectiveness requires further consideration. All but two of the evaluated outcomes relied on self-report measures and results may therefore be subject to social desirability bias (Holtgraves, 2004). This is particularly important considering that negative views regarding recovery may be highly taboo for MHPs. In addition, the development of five new assessment tools to measure staff outcomes raises questions regarding their reliability and validity. This finding also underlines the lack of standardised assessment tools that measure recovery-oriented staff outcomes. Whilst the Recovery Knowledge Inventory (Bedregal et al., 2006) and Recovery Attitudes Questionnaire (Borkin et al., 2000) were the most commonly employed standardised measures, potential ceiling effects were acknowledged in relation to their use (Crowe et al., 2006; Higgins et al., 2012; Repique et al., 2016). Due to the greater awareness and acceptance of the recovery concept, base-line levels of recovery knowledge and attitudes

may have increased since the development of these measures (Crowe et al., 2006). No study included measures of staff behaviour or skill development and thus it was not possible to ascertain the effect of recovery training on working practices. Furthermore, the measurement of service-user and service-level outcomes were not prioritised, despite the multitude of available measures (Burgess, Pirkis, Coombs, & Rosen, 2011; Williams et al., 2012). It is also noteworthy that studies did not report consultation with service-users to inform their research design. This represents a significant limitation from a recovery orientation, as service-user collaboration is a key feature of the recovery approach.

Strengths and Limitations of the Review

Search terms were selected to target all recovery-oriented training programmes for MHPs. Although it is possible that the search strategy did not identify all relevant studies, this was mitigated by an additional manual search of reference lists. However, the exclusion of non-English papers and grey literature limited the totality of identified papers. Similarly, the exclusion of qualitative research precluded exploration of staff experiences regarding training effectiveness and implementation. Nevertheless, more empirical-based data is required to validate the recovery approach (Clasen et al., 2003; Wilrycx et al., 2012) and this review is the first to explore the quantitative evidence regarding recovery training for MHPs. However, due to the heterogeneity of study designs, the data were not suitable for a meta-analysis. The scoring system of methodological quality (QATSDD; Sirriyeh et al., 2012) accounted for the diversity of study designs and inter-rater reliability checks provided assurance of its rigorous application. Many of the studies included in this review had significant methodological weaknesses. Moreover, studies were heterogeneous in terms of their service contexts, participant groups, training interventions, evaluated outcomes and assessment tools.

Therefore, the generalisability of findings and potential conclusions are limited. Despite these limitations, this review provides an overview of the current quantitative evidence-base of recovery-oriented training for MHPs, thereby identifying important implications for clinical practice and future research.

Clinical and Service Implications

Given the pressing need to deliver recovery-oriented care, it is essential that all MHPs are equipped with appropriate knowledge, attitudes and competencies. Staff training interventions that provide group-based education on recovery principles and strategies appear to have some utility in this vein. Training programmes including experiential learning may have greater benefit; there may also be clinical value in service-user involvement, fundamental to the recovery approach. However, staff recovery training needs to be provided as part of wider organisational change. Consideration should therefore be given to reinforcing or enabling strategies that promote the transfer of recovery attitudes and knowledge into clinical practice. In measuring the effectiveness of staff recovery training, services should employ a range of staff, service-user and server-level outcome measures. This information could prove valuable in identifying future staff training and/or service priorities. Consideration should also be given to recovery values during recruitment (Farkas, Gagne, Anthony, & Chamberlin, 2005; Hope, 2004; O'Hagan, 2001; Slade, 2009a), ensuring the selection of staff who demonstrate recovery-consistent competencies. Finally, further attention needs to be given to anti-stigma initiatives that reduce stigmatising attitudes amongst MHPs.

Future Research Priorities

There is a need to improve the overall quality of research that explores the effectiveness of recovery-oriented training for MHPs. Future research should aim to include: control groups; randomisation; long-term evaluations; sample sizes that allow adequate evaluative power; and outcome measures that capture staff, service-user and service-level indicators of effectiveness. The quality of research and consistency in reporting could be encouraged through the use of established taxonomies, for example Davidson et al. (2003). Future research should also address the current limitations of recovery-oriented assessment tools for staff outcomes. This could involve operationalising recovery-oriented clinical practice, developing measures of staff competence and skill, or re-evaluating the psychometric properties of the RKI (Bedregal et al., 2006) and RAQ (Borkin et al., 2000). Additionally, research could focus on the potential utility of various staff, service-user and service-level outcome measures, providing guidance for their routine use in clinical practice and/or research. Given the cost implications of developing new training interventions, future research should ascertain the value of tailoring specific recovery training for particular professional groups and/or service contexts, as opposed to the implementation of a standardised training programme. Furthermore, it would be useful to identify core intervention components that maximise effectiveness so they can be accurately replicated. To increase our knowledge of what works and why, greater attention should be given to theory in the development and evaluation of future training. Finally, given the need for wider organisational change to occur alongside recovery training, research could focus on the role of enabling and/or reinforcing strategies in the form of organisational support or changes.

Conclusions

This review indicates that recovery-oriented training programmes have the potential to improve the recovery-consistent knowledge, attitudes and competencies of MHPs. There is however limited evidence regarding sustained change. Moreover there is limited evidence relating to service-user and service-level outcomes, suggesting that staff recovery training may have limited utility to influence clinical practice. To better implement recovery-oriented care, there is a need for training programmes to form part of wider organisational change. Rigorous research is needed on the effectiveness of staff training interventions, with systematic attention given to theoretical frameworks and the role of organisational factors. Future research should also aim to ascertain the long-term sustainability of effectiveness across a range of staff, service-user and service-level outcomes. Guidance on suitable outcome measures and anti-stigma initiatives would be advantageous. Aligning with the recovery approach, service-user involvement in all future endeavours is paramount.

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Paper 2: Empirical Research

Recovery from Psychosis in a Forensic Service: Assessing Staff and Service Users' perspectives using Q Methodology

Manuscript prepared in accordance with the *Journal of Forensic Psychology Research and Practice* guidelines (Appendix 3)

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Abstract

Recovery has become a guiding principle for mental health service delivery. However, the implementation of recovery-oriented services is hindered by conceptual multiplicity, and forensic services in particular face additional challenges. The perspectives of both those receiving and providing services are central in understanding how the recovery approach can best be supported in practice. Therefore, this study used Q methodology to explore staff and service-users' views regarding factors deemed important to recovery from psychosis in a forensic service. Ten service-users and thirteen mental health professionals completed a sixty-item Q-sort to obtain their idiosyncratic views about recovery in this context. Q analysis produced a four-factor solution (accounting for 60% of the variance), revealing four distinct perspectives. The first placed emphasis on 'personal growth and psychosocial aspects of recovery', the second on 'gaining insight and reducing recidivism', the third placed importance on 'self-focused aspects of recovery', and the final factor highlighted 'making amends and service engagement' as important to recovery. The heterogeneity of recovery beliefs indicated that multiple dimensions of recovery are important in clinical practice. The bio-medical model of care appeared most prominent, suggesting the need for greater choice in alternative treatments and improved access to alternative models of care. In order to better apply recovery values, service-users and mental health professionals require a better understanding of the various recovery dimensions, and this broad conceptualisation of recovery should be reflected in service provision.

Key words: recovery, forensic service, psychosis, service-user perspectives, staff perspectives, Q methodology

Introduction

The recovery approach has been gaining prominence in mental health policy and research, and has become a guiding principle for mental health service delivery (Department of Health [DoH], 1999; DoH, 2001; DoH, 2009; DoH, 2011; NICE, 2014; Shepherd, Boardman, & Burns, 2010; Shepherd, Boardman, & Slade, 2008; Shepherd, Boardman, Rinaldi, & Roberts, 2014). The recovery movement offers a transformational ideology for services, suggesting reforms in the way mental health is understood and managed (Farkas, 2007; Le Boutillier et al., 2011). However, critics argue that in clinical settings there has been little change beyond the renaming of ‘rehabilitation’ services, and the medical-model, based on deficit and pathology, remains dominant (Beresford, Nettle, & Perring, 2010; Glover, 2005; Lester & Gask, 2006; Perkins & Slade, 2012; Slade et al., 2014; Lakeman, 2013). Indeed, some commentators believe that mental health services are using the ‘recovery’ ideology to mask greater coercion, thereby undermining its fundamental principles (Mind, 2008; Recovery in the Bin, n.d.).

One of the biggest obstacles to implementing the recovery approach concerns a lack of shared understanding of what recovery means and how it can best be supported in practice (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; Le Boutillier et al., 2011; Le Boutillier et al., 2015; Salyers, Stull, Rollins, & Hopper, 2011). In an attempt to provide conceptual clarity, Leamy, Bird, Le Boutillier, Williams and Slade (2011) identified five key recovery processes (i.e. connectedness; hope and optimism about the future; identity; meaning in life; and empowerment) and Le Boutillier et al. (2011) identified four key domains of recovery-oriented practice (i.e. organisational commitment; supporting personally defined recovery; working relationship; and promoting citizenship). In addition, four aspects

of recovery have been identified: clinical recovery, personal recovery, function recovery, and social recovery (Lloyd, Waghorn, & Williams, 2008).

Traditionally, mental health professionals (MHPs) have been more predisposed to notions of clinical rather than personal recovery, the latter of which aligns most with the recovery movement (Anthony, 1993; Slade et al., 2014). Clinical recovery is considered in terms of symptomatology and viewed primarily as improvement in mental health outcomes (Le Boutillier et al., 2011). Although there is no universal definition of personal recovery, it is generally regarded as a unique and individual process that “involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness” (Anthony, 1993, p. 15). In keeping with notions of personal recovery, functional recovery does not require the absence of symptoms. However, functional recovery most closely aligns with the rehabilitation paradigm, placing emphasis on improving skills and functional capabilities to undertake life tasks and valued role domains (Drennan & Alred, 2012). Not mutually exclusive, social recovery refers to the social dimension of recovery, with a substantial body of research attesting to the importance of social factors (e.g. social inclusion, relationships and overcoming stigma) in enabling or impeding recovery (Boardman, Currie, Killaspy, & Mezey, 2010; Repper & Perkins, 2003; Tew et al., 2012).

In addition to the challenges posed by conceptual multiplicity, forensic services face unique difficulties when attempting to implement the recovery approach (Dorkins & Ashhead, 2011). Key features of this approach (e.g. empowerment and choice) may be restricted in forensic services due to the imperative to reduce risk and fulfil the duty of public protection (Drennan et al., 2014; Pouncey & Lukens, 2010). It has been argued however that recovery values can be expressed in a meaningful, non-tokenistic fashion, and forensic services have

begun to embrace the move towards recovery-focused care (Drennan et al., 2014; Gudjonsson, Savona, Green, & Terry, 2011; Mann, Matias, & Allen, 2014). A small but growing number of studies have explored recovery from the perspectives of people who use forensic mental health services. Reviews of these studies have identified considerable overlap with the general psychiatric literature, but crucial differences that require special attention for forensic service-users have also been acknowledged (e.g. Clarke, Lumbar, Sambrook, & Kerr, 2016; Coffey, 2006; Shepherd, Doyle, Sanders, & Shaw, 2016). Offender recovery has been proposed as an additional facet of recovery unique to forensic populations, and involves taking personal responsibility, coming to terms with the reality of one's offence, and redefining or 'discovering' a new identity (Drennan & Alred, 2012; Kaliski & De Clercq, 2012).

The lived experience perspectives of service-users are central in understanding how the recovery approach can best be supported in practice. The perspectives of MHPs are crucial because they are the ones who provide the front-line services that bridge the gap between policy rhetoric and clinical practice (Hardiman & Hodges, 2008; Le Boutillier et al., 2015). Despite the need to develop a multi-perspective evidence base (Rose, Thornicroft, & Slade, 2006), no published studies have investigated the perspectives of those receiving *and* providing forensic mental health services. Therefore, the aim of this research was to explore what factors service-users and MHPs deem important to the process of recovery from psychotic experiences in a forensic service.

Methodology

Q Methodology is an explorative technique that integrates both quantitative and qualitative approaches to enable the systematic study of subjectivity (Brown 1996). Q methodology was deemed appropriate for this study as it can bring coherence to research questions that involve complex and socially contested concepts (Rogers, 1995; Watts & Stenner, 2005). Furthermore, it has been used successfully in a number of studies within psychosis (e.g. Day, Bentall, & Warnel, 1996; Dudley, Siitarinen, James, & Dodgson, 2009; Jones, Guy, & Ormond, 2003; Wood, Price, Morrison, & Haddock, 2013).

Design

Applying Q methodology, this study used a cross-sectional design to investigate the viewpoints of MHPs and service-users regarding recovery from psychosis in forensic settings.

Participants

Q methodological studies aim to identify subjectivities that exist and are not concerned with how subjectivities are distributed across a population (Brown, Durning, & Selden, 1999). As such, participants need not be representative of a wider population, but are instead selected according to the study's aims (Chinnis, Paulson, & Davis, 2001). Purposive sampling was therefore used to ensure the sample comprised pertinent demographic groups; that is, service-users and MHPs. Within these groups, participants were recruited via a convenience sample. Q methodology does not require large participant numbers, but a ratio of one participant for every three items in the Q-set is recommended (Danielson, Webler, & Tuler, 2009). Utilising

a 60-item Q-set, 20 participants were considered sufficient for the present study, and a total of 23 participants were recruited.

Participants were recruited from a NHS medium-secure mental health forensic unit in Wales. The forensic unit comprised four male wards and one female ward, supporting a total of 61 service-users. Service-users were invited to take part in the study if they met the following inclusion criteria: (1) aged 18 or older; (2) had experienced psychotic symptoms; (3) were an inpatient on a medium-secure forensic unit; and (4) had capacity to consent to participation (agreed by their clinical team). Ten service-users were recruited, all of which were male. All service-users identified as White British and were aged between 20-54 years old ($M=36$, $SD=11.1$). In addition, 13 MHPs with qualifications in their profession were recruited from the same medium-secure forensic unit. This staff group consisted of 61.5% male participants ($n=8$) and were aged between 32-56 years old ($M=44$, $SD=8.31$). The MHPs comprised psychiatrists ($n=4$; 30.8%), nurses ($n=5$; 38.5%), psychologists ($n=3$; 23.1%) and a social worker ($n=1$; 7.7%). Additional demographic information is presented in Table 1.

Table 1: Participant Demographic Details

Service Users (N=10)		Staff members (N=13)	
Mean age [SD; range]	36 [11.1; 20-54]	Mean age [SD; range]	44 [8.31; 32-56]
Gender		Gender	
Male	10 (100%)	Male	8 (61.5%)
Ethnicity		Ethnicity	
White - British	10 (100%)	White- British	11 (84.6%)
Marital Status		Education Level	
Single	10 (100%)	No qualifications	-
Education Level		GCSC/ similar	-
No qualifications	4 (40%)	A Levels/ similar	-
GCSC/ similar	2 (20%)	Undergraduate Degree	3 (23.1%)
A Levels/ similar	2 (20%)	Postgraduate Degree	10 (76.9%)
Undergraduate Degree	2 (20%)	Job Role	
Postgraduate Degree	-	Psychiatrist	4 (30.8%)
Length of Admission		Nurse	5 (38.5%)
0-4 years	5 (50%)	Psychologist	3 (23.1%)
5-9 years	3 (30%)	Social Worker	1 (7.7%)
10- 14 years	1 (10%)	Years Qualified	
15+ years	1 (10%)	0-9 years	3 (23.1%)
Diagnosis		10-19 years	4 (30.8%)
Schizophrenia	4 (40%)	20-29 years	6 (46.2%)
Paranoid Schizophrenia	5 (50%)	Years of Forensic Experience	
Schizoffective	1 (10%)	0-9 years	3 (23.1%)
Number Prescribed		10-19 years	8 (61.5%)
Neuroleptic Medication	10 (100%)	20-29 years	2 (15.4%)

Q Methodology Procedure

Q methodology, invented by Stephenson (1953), comprises a number of stages and was completed in accordance with Armatas, Venn and Watson (2014), Brown (1996), Cross (2005), and Watts and Stenner (2005).

Development of the Q-concourse and Q-set

In Q terminology, a Q-concourse refers to an extensive collection of statements related to the research topic, which is paired down to form the Q-set (a list of statements broadly representative of the relevant opinion domain) that participants rank order during the Q-sort process (Armata et al., 2014). To develop the initial Q-concourse for this study, a number of sources were reviewed: the academic literature, recovery outcome measures, best-practice guidance and websites. In addition, six informal semi-structured interviews were conducted with MHPs working in forensic units (i.e. two psychiatrists, a psychologist, nurse specialist, staff nurse and ward manager). These interviews aimed to supplement the paucity of research exploring recovery from psychosis in forensic settings from the perspectives of MHPs. The researcher synthesised the data from the Q-concourse and identified ten important recovery domains: finding personal meaning; coping with distress; symptom management; offence related aspects; relationships with friends and family; relationships with staff; basic needs; empowerment; socio-cultural and economic factors; and aspects of service provision.

An initial Q-set of 108 potential statements representing these identified domains was then developed. Following pilot work and a review by the research team, these statements were refined and reduced to ensure that all statements were similarly phrased, overlapping statements were removed, and adequate coverage had been given to the relevant domains (Donner, 2001; Watts & Stenner, 2005). In line with the recommended Q-set size of 40-90 items (Dennis 1986), the final Q-set consisted of 60 statements. These statements were printed onto individual cards and each card was randomly assigned an identification number.

The Q-sort

Participants were asked to sort the Q-set statements according to the following instruction: ‘We are interested in recovery from psychosis in forensic settings. To what extent do you agree or disagree with the viewpoint on each card?’ To facilitate the sorting process, participants were first instructed to sort the cards into three piles (i.e. agree, disagree, or neutral) (Brown, 1980). Participants were then asked to assign these cards a ranking position on a Q-board, which comprised a 13-point scale resembling a fixed quasi-normal distribution (see Figure 1). Possible ranking values ranged from +6 for statements that were considered by the participant to be ‘most agreeable’, through zero, to -6 for statements that were considered ‘most disagreeable’ (Watts & Stenner, 2005). After all items had been ranked on the Q-board, participants were given a final opportunity to make any changes needed to ensure their responses reflected their true subjective opinion. After completion, post-sort interviews were recorded, during which participants were asked open-ended questions regarding their reasoning behind their statement ratings, whether they thought any statements were missing, and to describe their experience of the Q-sort process (Watts & Stenner, 2005).

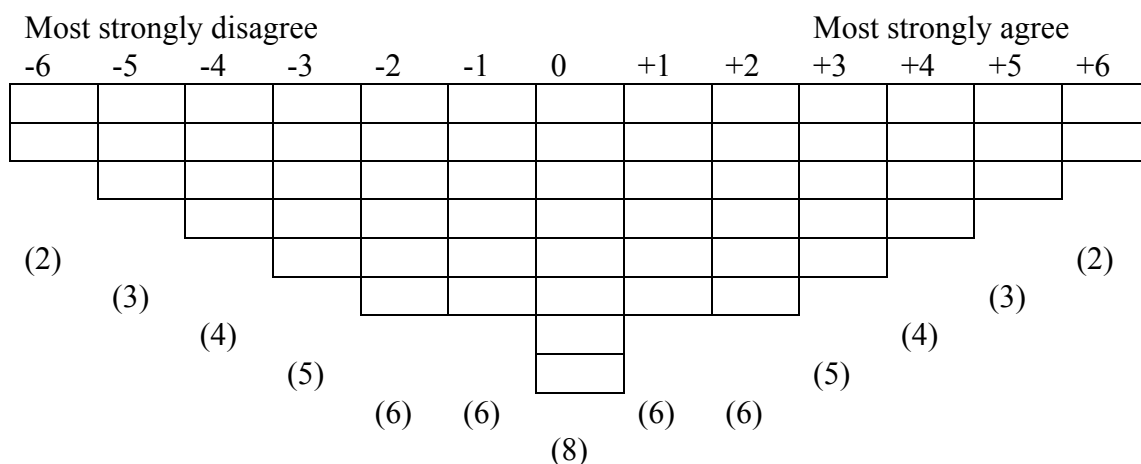


Figure 1: Q-board used during Q-sort

Q-sort Analysis Strategy

The completed Q-sorts were analysed using PQ Method 2.33 (Schmolck & Atkinson, 2012), a software package that inverts traditional factor analysis by using the participants, as opposed to items, as variables. Hence, each factor captures different statement configurations that are shared by the participants who load onto that factor (Watts & Stenner, 2005). Participants whose Q-sort loads significantly onto a single factor are considered ‘factor exemplars’. Each factor is represented by a ‘best-estimate’ Q-sort, which is based on the Q-sorts of factor exemplars. Data were subject to principal components analysis with varimax rotation to maximise the amount of variance explained by the extracted factors. To safeguard reliability, factors were only selected for interpretation if they had an eigenvalue exceeding 1.00, and had at least two factor exemplars (Watts & Stenner, 2005). Comments made by factor exemplars during the post-sort interviews were used to aid the interpretation of factors.

Ethical Approval

This study gained ethical approval from Wales NHS Research Ethics Committee and the Research and Development department of the local NHS Health Board involved.

Results

Q-method analysis resulted in a four-factor solution accounting for 60% of the variance. Please refer to the factor matrix (Table 2) for participant loadings, factor exemplars, eigenvalues and percentage of explained variance for each factor. Two participants (one

service-user and one psychiatrist) were excluded from the analysis as they had mixed loadings and failed to load significantly onto a single factor.

Table 2: Factor Matrix and Defining Q-sorts

Participant Number	Factor 1	Factor 2	Factor 3	Factor 4
1	*0.802	0.075	0.0015	-0.0393
2	*0.602	0.1161	-0.1494	0.2545
3	*0.7192	0.1853	-0.0874	0.1508
4	*0.8212	-0.0433	0.0869	-0.0098
5	-0.0097	*0.7601	0.0437	0.3864
6	0.5308	*0.6514	-0.2882	0.0184
7	0.017	-0.1514	*0.8855	0.0635
8	0.3205	0.1552	-0.1094	*0.5604
9	*0.8306	0.183	-0.046	0.1716
10	*0.7877	0.1946	0.1407	0.1141
11	0.2848	*0.6378	0.0254	0.0348
12	0.5492	0.5239	-0.0683	0.3441
13	*0.6118	0.3292	0.0366	-0.0043
14	0.1274	0.1786	0.0055	*0.7151
15	*0.6985	0.4175	0.1025	0.0855
16	0.3614	0.4522	-0.0071	0.2922
17	0.061	*0.5366	-0.0511	0.1691
18	*0.4649	0.4357	-0.0681	0.0668
19	0.4189	*0.5793	0.1541	0.0964
20	0.0171	0.069	0.1836	*0.7686
21	-0.0106	0.2898	0.1065	*0.6868
22	0.1214	*0.6315	0.1604	0.1948
23	0.0068	0.407	*0.6823	0.1407
Eigenvalue	8.1966	2.5792	1.4839	1.2883
% explained variance	25%	17%	7%	11%

Note: Factor exemplars are in bold and marked with an asterisks

The identified factors are reported below with reference to the statement rankings of the best-estimate Q-sorts (statement rankings given in parenthesis) and the supporting comments made by factor exemplars (participant number given in parenthesis).

Factor 1: Personal Growth and Psychosocial Aspects of Recovery

Accounting for 25% of the variance, nine participants exemplified this principle factor. Participants had an average age of 42 years (range 32- 56) and comprised all of the MHPs except psychiatrists (i.e. three psychologists, five nurses and one social worker). It is notable that no service-users endorsed this factor. Pre-eminent in this factor is the idea that personal growth and psychosocial aspects are important to recovery. Commensurate with the theme personal growth, participants strongly agreed with statement 7 (+6) *‘Developing a positive sense of self and self-worth is important’* and statement 43 (+5) *‘Identifying personal values and working towards positive goals is important’*. One factor exemplar (P3) commented ‘It’s [recovery] about personal growth, broadening of experiences, probably more self-realisation, self-improvement, betterment’. In addition, participants disagreed that *‘Opportunities to take risks are harmful’* (statement 45; -4), recognising the facilitative role risk taking played (one comment being ‘If you didn’t take any risks then things would be static, there would be very little room for progress or recovery’; P9).

Consistent with psychosocial aspects of recovery, participants highlighted the importance of understanding one’s difficulties in the context of one’s life, and developing idiosyncratic management strategies based on increased psychological awareness. Thus, participants disagreed with statement 1 (-4) *‘Thinking and talking about difficult past experiences is harmful’* and agreed with the following statements: *‘Understanding how negative life events have contributed to one’s difficulties is important’* (statement 3; +4); *‘Finding personal meanings in the content of psychotic experiences is important’* (statement 2; +5); *‘Finding a helpful way of relating to psychotic experiences is important’* (statement 12; +6);

‘Developing skills and confidence to manage strong emotions is important’ (statement 8; +4); and *‘Being able to recognise early signs of becoming unwell and having an action plan is important’* (statement 15; +4). A factor exemplar stated ‘Trying to help them [service-users] understand a more psychosocial and trauma informed understanding of why they have developed this illness is important... it’s about enhancing the patient’s understanding of their own needs and risks... to strive for early intervention’ (P10). In addition, participants identified relationships as an important psychosocial aspect of recovery. For example, participants agreed with statement 24 (+5) *‘Keeping contact with friends and family is important’* and statement 32 (+4) *‘Working with non-judgemental staff who make time to listen is important’*, whilst disagreed with statement 36 (-4) *‘Maintaining links with support staff after leaving the service is harmful’* (one comment being ‘...feeling more connected and less isolated is an important part of somebody’s recovery’; P9).

Participants gave further credence to psychosocial aspects of recovery by rejecting aspects associated with the traditional bio-medical model of care. Participants strongly disagreed with statement 4 (-5) *‘Understanding psychotic experiences as a biological illness is important’*, statement 51 (-5) *‘Being guided by doctor-led decisions is important’*, statement 11 (-6) *‘Being forced to take medication when displaying high levels of distress is important’*, and statement 16 (-5) *‘Having only non-medical forms of support is harmful’* (one comment being ‘The idea that psychosis is a biological condition is a myth and I don’t think that we should be pushing that on people... We over-rely on antipsychotic medication... and it’s not as efficacious as people like to believe’; P4). Participants also strongly disagreed that *‘Being offered choice about whether or not to take medication is harmful’* (statement 46; -6). However, participants recognised that genuine choice regarding medication was limited within current care provision. For example, a factor exemplar stated ‘the majority of people

coming in will be prescribed medication and expected to take it... it's a wonderful aspiration to be able to give people that choice' (P13).

Lastly, participants who loaded onto this factor disagreed with statement 5 (-4) *'Finding a religious/spiritual understanding of psychotic experiences is important'*. Comments linked to this statement included 'I don't think it's important to everybody' (P3) and 'I suppose for some people it would be important, but I'm just going on my experience of working here, it's not been one of the more important things' (P15).

Factor 2: Gaining Insight and Reducing Recidivism

Factor 2, accounting for 17% of the variance, represented the perspective of six participants with an average age of 44 years (range 28-52). Participants comprised all of the psychiatrists (n=3) and three service-users, who felt that increasing insight and reducing recidivism was important to recovery. Participants who exemplified this factor disagreed with statement 28 (-4) *'Opportunities for sexual intimacy with consenting others is important'*, statement 23 (-4) *'Finding a way to help others/give back to the community is important'*, statement 38 (-4) *'Engaging in spiritual or religious practices is important'*, and statement 2 (-4) *'Finding personal meanings in the content of psychotic experiences is important'*. Comments indicated that whilst these aspects might be important to some, they were superfluous to one's recovery. For example, participants stated 'Personal meaning, I mean it's not unimportant, but in the scheme of things it's not necessary' (P5) and 'There's no point even thinking about that [sexual intimacy], you have a bigger task in hand...' (P22).

Instead, participants placed priority on gaining insight into symptoms and risk factors, with strong agreement shown for statement 15 (+6) *‘Being able to recognise early signs of becoming unwell and having an action plan is important’* and statement 22 (+4) *‘Developing an awareness of situations that are likely to lead to offending behaviour is important’*. Participants also emphasised an association between mental illness and offending behaviour, highlighting the role of medication in staying well and reducing the risk of reoffending. As such, participants strongly agreed that *‘Taking antipsychotic medication is important’* (statement 13; +4) and *‘Taking medication in the long term to reduce levels of risk is important’* (statement 21; +6), with one comment being ‘They [service-users] won’t usually have committed their offence had they not been unwell... the key is to keep them well... key elements of keeping someone’s mental state stable are taking medication and for them to recognise when they are becoming unwell’ (P5). Participants disagreed that *‘The side effects of medication make it harmful’* (statement 14; -5) taking the view that ‘... the benefits will outweigh the negatives’ (P11). In addition, participants disagreed with statement 46 (-5) *‘Being offered choice about whether or not to take medication is harmful’*. However, in accordance with Factor 1, accompanying comments indicated that genuine choice was at times limited; for example, ‘whether or not to take medication, sometimes that’s not really an option. I think patients have a choice about *what* medication they take...’ (P5).

Moreover, participants placed additional emphasis on various factors perceived to facilitate the management of symptoms and risk. Thus, participants agreed with aspects such as, *‘Taking personal responsibility is important’* (statement 17; +5), *‘Overcoming self-harm, including substance abuse, is important’* (statement 9; +4), *‘Working alongside a team of professionals is important’* (statement 50; +5), *‘Working with staff who have clear and consistent boundaries is important’* (statement 34; +4) and *‘Taking part in talking therapy is*

important' (statement 53; +5). In addition, participants disagreed that '*Thinking and talking about difficult past experiences is harmful*' (statement 1; -6) and '*Maintaining links with support staff after leaving the service is harmful*' (statement 36; -6). In accordance with factor 1, participants also disagreed that '*Opportunities to take risks are harmful*' (statement 45; -5), recognising the importance of risk taking in promoting recovery.

Factor 3: Self-Focused Aspects of Recovery

Factor 3 accounted for 7% of the variance and comprised two service-user participants with an average age of 42 years (range 30-54). This factor emphasised the importance of self-focused aspects of recovery, with a primary theme of skills development. For example, participants agreed with statement 58 (+6) '*Developing life skills is important*' and statement 8 (+4) '*Developing skills and confidence to manage strong emotions is important*'. Participants also agreed with statement 44 (+4) '*Engaging in creative arts is important*', viewing this as a skilful way to manage difficult emotions (one comment being 'When I used to get pissed off I would write a poem and send it off'; P7). In addition, and in contrast to factor 2, participants strongly agreed with statement 23 (+5) '*Finding a way to help others/give back to the community is important*'. Associated comments indicated that voluntary work provided important opportunities to develop interpersonal skills (e.g. 'voluntary work is good character building stuff, because you are dealing with all kinds of people all the time'; P7).

A second emergent theme was the need to be self-reliant. Although participants agreed with statement 24 (+5) '*Keeping contact with friends and family is important*', comments indicated that this reflected a desire to fulfil a perceived social role, rather than the need for

social support (e.g. 'It's very important to rebuild the relationship with my children'; P7). Furthermore, participants disagreed with statement 27 (-4) '*Support for close friends/family members is important*' and statement 31 (-4) '*Developing genuine relationships with staff is important*'. While participants also disagreed with statement 36 (-6) '*Maintaining links with support staff after leaving the service is harmful*', a factor exemplar provided the clarification 'you don't want to be too dependent on staff... you have to get on with it... you have to search and look for independence' (P7).

Another emergent theme was self-exoneration (i.e. believing that people with a mental illness have diminished responsibility for their actions). Although participants agreed with statement 19 (+4) '*Coming to terms with how others view the offence is important*', they strongly disagreed with statement 22 (-6) '*Developing an awareness of situations that are likely to lead to offending behaviour is important*' and statement 17 (-5) '*Taking personal responsibility is important*'. One participant commented that 'Being mentally ill and having a mental illness, it's difficult to take personal responsibility' (P7). Participants strongly agreed with statement 4 (+5) '*Understanding psychotic experiences as a biological illness is important*', and disagreed with statement 14 (-5) '*The side effects of medication make it harmful*'. Comments [e.g. 'we have a mental illness so medication helps' (P23) and 'medication works well, but the weight gain and dribbling is terrible' (P7)] indicated that participants viewed side effects as an acceptable by-product of taking medication, which on the whole was viewed as a helpful way of managing their perceived biological illness. Perhaps surprisingly, these participants also disagreed with statement 13 (-4) '*Taking antipsychotic medication is important*', thereby raising potential questions regarding their medication compliance after leaving the service.

Further self-focused aspects of recovery concerned the importance of feeling a personal sense of safety and having opportunities for sexual intimacy. Participants agreed with statement 39 (+6) *‘Whilst restrictive, living in a secure environment promotes feelings of safety and is important’* and statement 28 (+4) *‘Opportunities for sexual intimacy with consenting others are important’*. Associated comments denoted the ability of the secure environment to meet basic needs of safety (e.g. ‘you feel safe in here’; P23), but to limit opportunities for sexual intimacy (e.g. ‘I think they [sexual experiences] are important to everyone... you are unlikely to get any in here’; P7). In keeping with factor 1 and 2 respectively, participants also disagreed that *‘Finding a religious/spiritual understanding of psychotic experiences is important’* (statement 5; -4) and *‘Engaging in spiritual or religious practices is important’* (statement 38; -5).

Factor 4: Making Amends and Service Engagement

Four participants loaded onto factor 4, which accounted for 11% of the variance. All four participants were service-users, with an average age of 35 (range 20-48). This factor placed importance on making amends and service engagement (i.e. engaging in treatment and working with staff to prevent relapse).

The theme ‘making amends’ was reflected in the participants’ agreement with statement 18 (+4) *‘Accepting the consequences of the offending behaviour is important’* and statement 23 (+6) *‘Finding a way to help others/give back to the community is important’*. Although the latter statement was also identified as important in factor 3, linking comments indicated that participants loading onto factor 4 placed more emphasis on redemption, as opposed to skills development (e.g. ‘it makes yourself a better person, helping people and giving back to the

community in a positive way'; P21). Furthermore, participants endorsed statement 27 (+5) '*Support for close friends/ family members is important*' and statement 30 (+4) '*Feeling less alone is important*', with one participant explaining that 'support for loved ones and friends is important because without them you feel like you are by yourself really, you feel alone... They [family and friends] need to know that you are not going to do anything stupid again. I wouldn't want them to go through that again' (P20).

With regards to engaging in treatment, participants strongly agreed that '*Taking antipsychotic medication is important*' (statement 13; +5) and '*Being guided by doctor-led decisions is important*' (statement 51; +4), commenting that 'The doctors know what to do. They know what's important for you' (P14). As in factor 2 and 3, participants of factor 4 disagreed with statement 14 (-4) '*The side effects of medication make it harmful*' (one comment being 'There can be side effects, but the risks are better to take medication'; P21). In addition, participants also acknowledged the benefits of engaging in psychological support. They strongly disagreed with statement 1 (-6) '*Thinking and talking about difficult past experiences is harmful*', with one participant stating that '...with psychology I have talked about my childhood and stuff. There's a lot of hidden demons there really... so being able to vent it out was good' (P14). Interestingly, these participants also disagreed with statement 10 (-5) '*Resolving difficult feelings and memories is important*', indicating that although support to explore difficult past experiences was beneficial, one's recovery was not solely reliant on resolving difficult feelings and memories.

Participants loading onto factor 4 were willing to work with staff to prevent relapse. Participants agreed that '*Feeling able to ask for help when needed is important*' (statement 49; +5) and disagreed that '*Maintaining links with support staff after leaving the service is*

harmful' (statement 36; -6). Corresponding statements included: 'it could push you to a relapse, if you can't ask for help and you are ruminating, so it's better to be able to ask for help' (P21) and 'it's good to keep in contact [with staff] in case you get illness, they can point it out' (P8). Participants also valued working with staff to develop practical strategies to reduce self-harm and substance abuse, and prevent relapse. Thus, they strongly agreed with statement 15 (+6) '*Being able to recognise early signs of becoming unwell and having an action plan is important*' and statement 9 (+4) '*Overcoming self-harm, including substance abuse, is important*'.

Participants who exemplified factor 4 placed less emphasis on self-focused aspects of recovery, disagreeing with statement 44 (-4) '*Engaging in creative arts is important*' and statement 57 (-5) '*Engaging in education that is personally meaningful is important*'. In line with the other factors, participants did not place importance on spiritual or religious aspects, disagreeing with statement 38 (-5) '*Engaging in spiritual or religious practices is important*' and statement 5 (-4) '*Finding a religious/spiritual understanding of psychotic experiences is important*' (one comment being 'I'm not really religious'; P14). Furthermore, in accordance with factor 1 and 2, participants who loaded onto factor 4 disagreed with statement 45 (-4) '*Opportunities to take risks are harmful*'.

Additional Feedback

Participant feedback regarding the Q-sort process was resoundingly positive. In particular, service-users commented that it had helped them to reflect on their own recovery process and to identify important aspects to their recovery. For example, 'It's interesting, I enjoyed it to be honest... it's made me realise how far I've come' (P11) and 'This is quite helpful actually,

very useful... it's made me realise all the things that are important... it's put things into perspective' (P22). The MHPs reported that the process had enabled them to reflect on their personal values and professional practice. For example, 'it's quite interesting isn't it, because it's kind of a reflection of my values so it gets you thinking about what are my personal values' (P4), and 'it's a good exercise actually, it's good insight for us as well, to see how we have been focusing in our work' (P19).

Discussion

This study used Q methodology to explore the perspectives of people providing *and* receiving support in a medium-secure forensic mental health service. The aim of the study was to identify important factors in the process of recovery from psychotic experiences in a forensic service. Q-analysis produced a four-factor solution, revealing four distinct perspectives. The first placed emphasis on 'personal growth and psychosocial aspects of recovery', the second on 'gaining insight and reducing recidivism'; the third placed importance on 'self-focused aspects of recovery', and the final factor highlighted 'making amends and service engagement' as important.

The findings support previous literature regarding the heterogeneity of recovery beliefs and idiosyncratic nature of recovery (e.g. Leamy et al., 2011; Pitt, Kilbride, Nothard, Welford, & Morrison, 2007; Wood et al., 2013). It was interesting to note that factor one (personal growth and psychosocial aspects of recovery), most closely affiliating with notions of personal recovery, was not endorsed by service-users or psychiatrists. Instead, this factor encompassed all of the other MHPs. In line with previous research, these MHPs believed that

making sense of past experiences in personally meaningful ways is key to recovery (Ferrito, Vetere, Adshead, & Moore, 2012; Laithwaite & Gumley, 2007; Thornhill, Clare, & May, 2010). This aligns with the idea that the construction of a coherent narrative plays a significant role in developing a functional sense of self, thus promoting recovery (Davidson & Strauss, 1992; Crossley, 2000). However, this viewpoint stands in contrast to factor 2 (gaining insight and reducing recidivism), which placed importance on medication and the management of symptoms and risk. Participants in this group (comprising all of the psychiatrists and three service-users) privileged notions of clinical recovery, viewing personal meaning as unnecessary. Drennan and Alred (2012) acknowledged that in forensic mental health services, there is a tendency to treat the apparent symptoms of mental illness and to presume this simultaneously addresses the risk for reoffending. This assertion seemed to ring true for the participants endorsing factor 2, who attributed offending behaviour to mental illness and placed importance on the long term use of medication to reduce risk.

The third factor (self-focused aspects of recovery) identified a group of service-users who prioritised factors linked to functional recovery, placing importance on skills development and independence. Self-focused recovery was also identified by Wood et al. (2013), who explored service-users' perceptions of recovery from psychosis in the general mental health population. The authors described a group of service-users who did not value external support and placed sole emphasis on internal factors, suggesting that negative service experiences could be accountable. Whilst this remains a valid explanation for the emphasis on self-reliance in this study, another possible explanation draws on attachment theory (Bowlby, 1979). Forensic service-users have usually suffered some form of childhood abuse, neglect or exploitation (Coid, 1992), which can lead to the development of insecure attachment patterns of interpersonal behaviour (Adshead, 2002). These service-users may

therefore find it difficult to develop trusting relationships with staff, may adopt a dismissive stance towards relationships, and are less likely to seek help in times of crisis (Mann et al., 2014). Attachment theory provides a useful framework within clinical practice, as it can promote positive interpersonal relationships and help staff understand problematic behaviours (Adshead, 2002; Berry & Drake, 2010; Mann et al., 2014; Renn, 2002; Rich, 2006).

In contrast to factor 3, service-user participants loading onto factor 4 (making amends and service engagement) valued staff support and felt able to ask for help when needed. This finding resonates with a key theme in the recovery literature emphasising the importance of recovery-promoting relationships, including partnership working with MHPs (Mann et al., 2014; Slade, 2009). Although keen to work with staff, these participants placed importance on doctor-led decisions and thus appeared to assume a slightly more passive role than one would expect of a true partnership. A priority for these participants concerned a dimension of offender recovery, that is, accepting the consequences of having offended and attempting to make amends. Radzik (2009) acknowledged the desire to redress wrongdoing or make amends is indicative of a hope for redemption. This emphasis therefore has significance not only for recovery, of which hope is the cornerstone, but also for reducing the risk of reoffending. Research suggests that offenders who have managed to desist from crime have often tried to find meaning in their life by turning negative experiences into a redemptive narrative (Ferrito et al., 2012; Maruna, 2001).

To a greater or lesser degree, all identified viewpoints emphasised important aspects of social recovery (e.g. interpersonal relationships and/or social inclusion). But in contrast to the recovery literature within general mental health populations (e.g. Mowbray et al., 2005; Warner, 2009), participants did not give primacy to the need for meaningful education or

employment, which are arguably important means of gaining social capital. This discrepancy may represent differing priorities for forensic service-users, who remain detained and therefore more concerned with the conditions in the forensic service. The theme of safety did not emerge from the general mental health recovery framework proposed by Leamy et al. (2011), however this is considered significant to the process of recovery in forensic settings (Shepherd et al., 2016). Indeed, participants loading onto factor 3 highlighted the role of the secure environment in promoting feelings of safety, thereby facilitating their recovery. Another aspect of relevance to forensic services concerns risk management. Risk taking is fundamental to human growth and learning, and the perception of offending risk must be delicately balanced against the need for appropriate opportunities to recover (Langan, 2008). It is encouraging that the majority of participants (i.e. those loading on factor 1, 2 and 4) adopted this view. Participants who emphasised ‘self-focused aspects of recovery’ (factor 3) may have been more risk-averse as they lacked belief in the value and availability of support from others. Future research would be needed to substantiate this claim.

Clinical and Service Implications

The process of recovery will often involve a combination of elements with different priorities at different stages, thus the division of recovery into categories is inevitably artificial (Drennan & Alred, 2012). However, it is important that service-users and MHPs have a good understanding of the various dimensions of recovery (Lloyd et al., 2008). Identifying the priorities of service-users, within this broader conceptualisation of recovery, could enable services to better apply recovery values through the provision of individually tailored, client-centred care. For example, those who prioritise dimensions of offender recovery could benefit from restorative approaches (Cook, Drennan, & Callanan, 2015) or therapy groups

that incorporate the topic of redemption (Ferrito et al., 2012). They may also benefit from participative responsibilities within the service (e.g. mentoring or co-facilitating peer groups) or assistance in finding a suitable voluntary role. Service-users who place emphasis on functional recovery may need support to operationalise rehabilitation goals and opportunities to develop their skills. However, those prioritising clinical recovery may want to focus on symptom management before moving on to other aspects of their care.

Orienting mental health services towards recovery will involve system transformation (Leamy et al., 2011; Shepherd et al., 2010). The findings of this study verify claims that the bio-medical model remains dominant in clinical practice. All identified factors that comprised service-user participants (i.e. factor 2, 3 and 4) highlighted bio-medical aspects as being important to recovery. This was in stark contrast to the viewpoint expressed in factor 1, which privileged psychosocial aspects associated with personal recovery. It has been suggested that the medical model might be more attractive to forensic service-users, as it in some way mitigates their responsibility for past transgressions (Mezey, Kavuma, Turton, Demetriou, & Wright, 2010). Whilst not relevant to all service-users, the theme 'self-exoneration' identified within factor 3 appears to support this hypothesis. However, it is also possible that service-users lack knowledge of the breadth of the recovery concept and the opportunities it presents. This points to the need to ensure that MHPs feel equipped to educate service-users regarding the various dimensions of recovery, thereby providing greater choice in terms of preferred conceptualisations and treatment priorities. It has been suggested that forensic service-users are more accustomed to being told about treatment, rather than having treatment decisions negotiated and being offered choice (Mezey et al., 2010). Although all MHPs in this study recognised the need to offer choice, they admitted that with regards to medication choice was limited. All service-user participants were prescribed

neuroleptic medication at the time of this study. Therefore, in line with previous research (e.g. Lewis 2012; Mancini, Hardiman, & Lawson, 2005; Pitt et al., 2007), this study suggests the need for greater choice in alternative treatments and improved access to alternative models of care.

Strengths, Limitations and Future Research

Q methodology has been recommended as the methodology of choice when exploring attitudes and subjective opinion (Cross, 2005). However, a number of concerns have been raised regarding its implementation. For example, the provision of a pre-designed Q-set containing a finite number of statements can place limits on the participant's responses. There is also risk of bias at the interpretation stage as the researcher may be influenced by their own position (Rogers, 1995). However, this study attempted to address these concerns by conducting post Q-sort interviews, during which participants were encouraged to share their views about the research topic and to highlight aspects they considered to be missing. These participant comments were used during the interpretation phase to add clarity and depth to the findings. In addition, the use of Q methodology creates the potential for participant bias, as participants may respond in ways thought to be acceptable to the researcher rather than reflecting their true opinion. This issue is particularly pertinent when taking into account the detained status of the service-user participants. Considering psychiatrists often hold the most power in teams in relation to controlling leave and discharge, it is possible that service-users may have endorsed the medical model in the hope that this would lead to beneficial outcomes. In an attempt to address this issue, all participants were made aware that their engagement in the research would have no impact on their care/employment, and the anonymity of the process was made clear.

A further limitation of this study concerns the small sample size and the sample demographic, which may reduce the generalisability of the findings. Participants were recruited from one NHS medium-secure forensic mental health service in Wales and contextual issues therefore need to be taken into account. In addition, all service-user participants identified as White British. The ethnicity of the sample may account for the finding that religious or spiritual aspects were deemed unimportant to the process of recovery. Individuals of black and minority ethnic origin have been found to place greater emphasis on spirituality (Leamy et al., 2011), thus future research including people from diverse ethnic and cultural backgrounds is warranted. Moreover, all service-user participants were males who had experienced psychotic phenomena. Further study would therefore be needed to explore the relevance of these findings to female service-users and those who experience other forms of mental health difficulties.

Participants in this study found the Q-sort process a positive experience. The Q-sort process has been found to encourage collaborative working (Jones et al., 2003) and could be considered a therapeutic tool in its own right (Wood et al., 2013). Therefore, there is potential for the Q-sort process to be used within clinical practice as an assessment tool, which could be applied over time to identify the changing recovery priorities of service-users. In addition, the Q-sort process could facilitate dialogue between MHPs and service users, providing opportunities for education regarding recovery concepts and support to find their own way of understanding their difficulties. Evaluative studies would be needed to assess the impact of using the Q-sort process in this context; for example, assessing the impact on levels of service satisfaction. Furthermore, researchers should continue to develop a repertoire of evidence-based interventions that map onto the various dimensions of recovery. This would

ensure that service providers are in a position to offer service-users greater choice regarding their recovery plan.

Conclusions

Service-users and MHPs have varying views regarding factors deemed important to recovery from psychosis in a forensic service. Thus, multiple dimensions of recovery are important within clinical practice. Service-users and MHPs require a better understanding of the various recovery dimensions, and this broad conceptualisation of recovery should be reflected in service provision. To ensure conceptual clarity, services should expand their use of language to reflect the various recovery dimensions. Service-users were less inclined to endorse notions of personal recovery, which align most closely with the recovery movement, and their viewpoints highlighted the prominence of the bio-medical model of care. In order to better apply recovery values, this study suggests the need for greater choice in alternative treatments and improved access to alternative models of care.

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Paper 3: Critical Reflection

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Introduction

In this paper I critically reflect on my research process, which culminated in a systematic review and empirical study. First I provide a rationale for the overall focus of the thesis. I then consider the systematic review and empirical paper in turn, reflecting on the process of formulating my research questions and conducting the research. I further evaluate the key findings and implications of each study with reference to the wider contexts of research, policy and practice. The strengths and limitations of the thesis as a whole are then explored, and implications for future practice and research discussed. Finally I attend to the dissemination of the research, envisaging possible avenues for impact.

Deciding on a Research Topic

Why Recovery?

Truth be told, my review of the literature on recovery was fraught with tensions. As an aspiring clinical psychologist, and having used the term recovery in my clinical practice, I was surprised to learn the conceptual multiplicity surrounding the concept, and the multi-layered and contrasting assumptions entwined in these different notions. Though they are not mutually exclusive, I identified the following contradictions in the recovery literature: recovery as a process versus recovery as an outcome; scientific versus consumer models of recovery (Bellack, 2006); recovery ‘from’ versus recovery ‘in’ (Davidson, Schmutte, Dinzeo, & Andres-Hyman, 2008); service-based recovery versus user-based recovery (Schrack & Slade, 2007); clinical recovery versus social recovery (Secker, Membrey, Grove, &

Seebohm, 2002); and clinical recovery versus personal recovery (Slade, Amering, & Oades, 2008). I initially found these apparent inconsistencies to be overwhelming and became concerned that my research might inadvertently align with ideas antithetical to my professional values.

In an attempt to gain better understanding, I found it helpful to consider the recovery movement as an historical development, and was especially intrigued to learn about the integral role of research. In the 1980s a series of long-term outcome studies demonstrated that the course of illness was variable both across and within individuals, and many people who met strict diagnostic criteria had very good outcomes, often without maintenance medication (Bellack, 2006). At the same time, service-users/survivors began publishing personal narratives of their recovery from serious mental illness (Andresen, Oades, & Caputi, 2003). A common theme to emerge from these accounts was an emphasis on understanding recovery as something other than the absence of illness and functional impairment (Slade et al., 2008). Their experience was testimony to the resiliency that allows for growth and transformation after the onset of disability, which was overlooked by mental health systems enmeshed in a deficiency orientation (Onken, Craig, Ridgway, Ralph, & Cook, 2007). The concept of recovery challenged the traditional perspective regarding the course of illness and the associated assumptions concerning the potential to live a productive and satisfying life (Bellack, 2006). The recovery movement therefore offers a transformational ideology for services and calls for reforms in the way mental illness is understood and managed (Farkas, 2007; Le Boutillier et al., 2011). With this understanding in mind, I was better able to make sense of the discrepancies in the literature, which were seemingly representative of two distinct paradigmatic approaches.

The imperative for mental health services to be recovery-oriented is now a central theme in national and international policy (Department of Health [DoH], 2011; Le Boutillier et al., 2011; National Institute for Mental Health in England [NIMHE], 2005; World Health Organisation [WHO], 2013). There are concerns, however, that recovery may become the latest fad in the line of social policies informing yet not dramatically changing service provision (Bedregal, O'Connell, & Davidson, 2006; Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; Davidson, O'Connell, Tondora, Staeheli, & Evans, 2005). Bedregal et al. (2006) acknowledged that due to the rapid proliferation of the recovery concept, alongside the varied recovery-oriented definitions and approaches, practitioners and researchers are at risk of losing the opportunity to move psychiatric practice in an entirely new direction. Thus, my initial concerns regarding conceptual complexity became one of the key motivating factors for my research. I felt inspired by the core values of the recovery movement and was keen to contribute to the literature in an attempt to advance its cause.

Consideration of Language

The language used to describe psychological phenomena is never neutral. Of course it is imbued with meaning but also with values, power relations and ideological undercurrents. It is no surprise, then, that there has been much debate over the best terminology when referring to those who access mental health services. The discourses we choose, or inadvertently invoke, contribute to power dynamics, and terms like 'client', 'consumer', 'customer', 'service-user' and 'expert' by experience have all been found wanting (McLaughlin, 2009). To ensure my use of language aligned with the recovery approach and my professional values, I was especially cognisant of this issue. I initially chose the term consumer as this appeared most prominent within the recovery literature and seemed to convey a sense of

empowerment and liberation. However over time I became more aware of concerns that recovery was being ‘hijacked’ and used as a ‘cover’ for service reduction and reduced welfare support (Mind, 2008; Slade, Adams, & O'Hagan, 2012). Morrow (2013) queried whether recovery is a progressive paradigm or a neo-liberal smokescreen. Considering that “neo-liberals tell us we are individual *consumers* and [we should] not rely on the state, but stand on our own two feet” (Beresford, 2015, p. 19), I started to associate the term consumer with marketisation and disempowerment. After much deliberation, I therefore decided to use the term service-users. Although I recognise this term may still be unsatisfactory, it is the most commonly used in the United Kingdom (McLaughlin, 2009), and frequently used by academics and clinicians alike.

I am aware that the legitimacy of psychiatric diagnostic categories and mental ‘illness’ is an increasingly contested issue (e.g. Bentall, 2004; Johnstone, 2008; Moncrieff, 2008; Rosenberg, 2006). However this issue is yet to be resolved. Diagnostic criteria are therefore used throughout this thesis and proved useful for recruitment purposes and the collation of relevant literature. Nonetheless, the use of diagnostic categories does not imply a predetermined biological understanding of service-users’ distress.

Study 1: Systematic Review

Formulating the Research Question

Conducting initial scoping searches of the literature, I realised that much scholarship in this area was focused on qualitative experiences and conceptualisations of recovery. I also

quickly discovered that a systematic review and narrative synthesis relating to personal recovery in mental illness had already been conducted (i.e. Leamy, Bird, Le Boutillier, Williams, & Slade, 2011). Whilst I recognised that a significant period of time had passed since its publication, the authors of this review advised that further research seeking conceptual clarity may not have high scientific pay-off, and future research efforts were best spent addressing service-level questions. Holding in mind that forensic settings can present unique challenges to the recovery agenda (Dorkins & Adshead, 2011), I turned my attention towards recovery within these settings. Two recently published systematic reviews of the qualitative literature were identified, one providing a meta-synthesis (Shepherd, Doyle, Sanders, & Shaw, 2016) and the other a narrative synthesis (Clarke, Lumbard, Sambrook, & Kerr, 2016). Widening my search parameters, I identified additional systematic reviews concerning attachment and psychosis (Gumley, Taylor, Schwannauer, & MacBeth, 2013), measures of personal recovery (Shanks et al., 2013) and measures of the recovery-orientation of mental health services (Williams et al., 2012). Given the apparent abundance of research, I began to wonder why the provision of recovery-oriented services was not commonplace. In a moment of clarity, I remembered the need for service-level research as proposed by Leamy et al. (2011) and my thoughts turned towards implementation. Here I discovered a growing body of evidence focusing on recovery-oriented training programmes for mental health professionals (MHPs). A rapid realist review focused on the factors contributing to lasting change in practice following such training (Gee, Bhanbhro, Cook, & Killaspy, 2016); however there appeared to be no review of the characteristics and effectiveness of the various recovery training programmes being implemented. I hoped to address this gap in the literature.

Aim

My aim was to systematically review the quantitative literature relating to recovery-oriented training programmes for MHPs. The main objective was threefold: to determine the methodological quality of studies, to identify the characteristics of training programmes being implemented, and to explore the effects of recovery-oriented training on recovery-related outcomes.

Search and Screening Strategy

I was keen to ensure that my search terms were specific to my research question, yet broad enough to identify all relevant studies. I sought advice from my academic supervisor and a university librarian, who helped me refine my terms and feel reassured in my strategy. To ensure appropriate coverage, I entered my search terms into six bibliographic databases: two relating to health (CINAHL; MEDLINE), two relating to social sciences (ASSIA; PsycINFO), and two relating to multidisciplinary content (Scopus; Web of Science). Considering recovery as a relatively recent concept in mental health, I deemed it appropriate to limit the date on database searches (i.e. from 1988 onwards). The use of a software package (Mendeley reference manager) proved useful in collating the identified studies and also facilitated the screening process. I relied on the PRISMA guidance (Moher, Liberati, Tetzlaff, Altman, & Prisma Group, 2009) to ensure my search and screening strategy was systematic and my reporting of this process was transparent. To further ensure a thorough approach, I conducted a manual search of reference lists to identify additional papers of relevance.

To meet the inclusion criteria, studies needed to describe and evaluate a discrete recovery-oriented training programme that was delivered to MHPs. I chose not to disqualify studies according to professional roles and service contexts. Although I recognised the merit in conducting more specific research (e.g. focusing on inpatient settings and/or interventions that target key professional groups), I aimed to review the broad range of training programmes being implemented and the breadth of the review was ultimately felt to be a strength. I excluded non-English-language papers and grey literature and thus needed to consider the potential for language and publication bias. Studies that report positive findings are more likely to be published in English-language and peer-reviewed journals than those reporting null findings (Cherry & Dickson, 2017). However, my limited linguistic ability and desire to include high quality papers guided these criteria. Whilst the majority of identified studies were quantitative, I was initially unsure as to whether to also include qualitative data. In total the search strategy identified four qualitative and four mixed-methods studies, but on closer review it became apparent that these papers used a range of qualitative methodologies (e.g. semi-structured interviews or focus groups) of varying scientific quality. In an attempt to ensure clarity and rigour in the reporting of the results, I decided to include the mixed-methods studies but only focus on the quantitative data. Much of the recovery evidence is of a narrative nature and more empirical-based data is needed to validate the recovery approach (Clasen, Meyer, Brun, Mase, & Cauley, 2003; Wilrycx, Croon, van den Broek, & van Nieuwenhuizen, 2012).

Quality Assessment and Data Synthesis

The search and screening process identified 16 studies with various research designs. I therefore decided to use the Quality Assessment Tool for Studies with Diverse Designs

(QATSDD), which has demonstrated good reliability and validity (Sirriyeh, Lawton, Gardner, & Armitage, 2012). This assessment tool comprises 14 criteria that apply to quantitative studies, each scored on a 4-point scale. The developers of the QATSDD argue that a scaled response can provide a more accurate quality assessment than dichotomous scoring, but this can also limit the degree to which inter-rater reliability is likely to be established (Sirriyeh et al., 2012). Recognising the process of scoring papers would require some degree of methodological judgment and expertise, I became conscious of my relative inexperience as a researcher. To ensure rigor, I invited a second reviewer to adopt the same process and critically appraise a random sample of four papers (25%), where I was reassured to find an inter-rater reliability of 71%. This provided me with some much-needed confidence in my own research skills. Whilst it would have been beneficial for all papers to be independently rated by a second reviewer, the minimum standard requiring 10% of studies to be ‘double-assessed’ (National Institute for Health and Clinical Excellence [NICE], 2012) was exceeded.

Having obtained numerical values for the quality of studies, I was left feeling unsure about how best to approach the interpretation of these scores. Whilst the QATSDD provides guidance regarding the scoring of individual criteria (Appendix 4), it does not provide guidance regarding cut-off values to indicate which studies qualify as robust. Given this lack of clarity and the small number of studies identified, I decided to use the quality ratings to aid interpretation of the results rather than to exclude studies. In tabulating the quality scores (Appendix 2) I was able to identify patterns of strengths and weaknesses across the relevant criteria. Holding in mind the recovery approach, I felt encouraged that ‘evidence of user involvement in design’ was considered an indication of study quality. However it was disappointing to discover that studies consistently received low scores on this criteria. On the

whole, this process provided me with a structured approach to critically appraise the individual and collective quality of studies, thereby enhancing the quality of the review.

Designing suitable data extraction tables took a few attempts. I initially felt overwhelmed by the amount of data available and eventually decided on three separate tables. In hindsight, it may have been beneficial to include a table of participant characteristics to highlight the lack of psychiatrists receiving recovery training. Considering psychiatrists often hold the most power within teams, this finding could have added depth to the research. I was conscious, though, of the word limit imposed by the target journal and chose data tables that corresponded with the three main objectives of the review. On reflection, this enabled me to remain focused on the relevant data and facilitated my reporting of the results. Due to the diversity of study designs, assumptions of homogeneity were not satisfied and meta-analysis was deemed inappropriate. Instead I conducted a narrative synthesis of the data and found it helpful to refer to published guidance (i.e. Popay et al., 2006). Upon completion, I used the Critical Appraisal Skills Programme (CASP; 2018) systematic review checklist as a final quality check (Appendix 5). Whilst I was satisfied with the overall quality, I was also aware that the credibility of the review is largely dependent on the quality of included studies. This initially caused me some concern as the quality assessment process had identified a number of methodological weaknesses and potential sources of bias. Nevertheless, the reporting of these limitations provided important information on the current evidence-base, thereby revealing future research priorities.

Further Exploration of Key Findings and Implications

Table 1 provides an overview of the key findings and implications of the systematic review. Key themes will now be further appraised with reference to the wider contexts of research, policy and practice.

Table 1: Overview of Key Findings and Implications for Study 1

Study 1: Recovery-Oriented Training Programmes for Mental Health Professionals: A Narrative Literature Review	
Key Findings	Key Implications
<ul style="list-style-type: none"> ● Heterogeneity among studies and methodological weakness limited the ability to draw firm conclusions. ● Training programmes that included experiential learning and service-user involvement may be advantageous. ● Most recovery training programmes and evaluations lacked a theoretical framework. ● Training effectiveness was most commonly measured via self-report recovery-oriented staff outcomes. ● Recovery training has the potential to improve the recovery-consistent knowledge, attitudes and competencies of MHPs, however stigma was less amenable to change. ● Limited evidence for staff recovery training to improve service-user and service-level outcomes. 	<ul style="list-style-type: none"> ● Staff recovery training needs to be provided as part of wider organisational change to enable the implementation of recovery values in clinical practice. ● Consideration should to be given to recovery values at the recruitment level. ● Systematic attention needs to be given to theoretical frameworks and the role of organisational factors (e.g. reinforcing or enabling strategies) in the design and evaluation of recovery training. ● Training effectiveness needs to be measured using a range of outcome measures. ● Future research is needed to: improve the overall quality of evidence; address limitations of recovery-oriented staff outcome measures; provide guidance for routine use of suitable staff, service-user and server-level outcome measures; ascertain benefits of specific recovery training for professional groups and/or service contexts; develop and evaluate theory driven training interventions.

The Need for Recovery Competent Staff

Given the pressing need to deliver recovery-oriented practice, it was encouraging to find that recovery training programmes appear effective in improving recovery-consistent knowledge, attitudes and competencies of MHPs. Recovery is a profoundly social process (Jacobson &

Greenley, 2001) and there is strong evidence that service-users are significantly affected by interpersonal interactions, including those with healthcare professionals (Tarrier & Barrowclough, 2003). Lakeman (2010) reported that the most valued professional competencies supportive of recovery-focused practice include: listening to and respecting the service-user's view; conveying a belief that recovery is possible; and recognising, respecting and promoting the service-user's resources and capacity for recovery. Barrowclough et al. (2001) further acknowledged that service-users can accurately perceive staff thoughts and feelings towards them, and negative staff attitudes can thus have a detrimental impact on the therapeutic environment and process of recovery. The need to ensure all MHPs are henceforth equipped with appropriate knowledge, attitudes and competencies to enact recovery values is paramount. The findings of the review suggest that group-based education on recovery principles and strategies have some utility in this vein, thereby making a case for the provision of staff recovery training within mental health services. In line with published guidance (Farkas, Gagne, Anthony, & Chamberlin, 2005; Hope, 2004; O'Hagan, 2001; Slade, 2009), the need to consider recovery-values during staff recruitment was also acknowledged.

The Role of Theory

Perhaps the most significant finding of the review concerns the limited ability of staff recovery training to influence clinical practice. This finding corroborates the 'transfer of training problem' (Baldwin & Ford, 1988). One explanation concerns the lack of theory and inappropriate methods used to design interventions (Davies, Walker, & Grimshaw, 2010; French et al., 2012; Van Bokhoven, Kok, & Van Der Weijden, 2003). Theoretical perspectives are valuable when attempting to implement effective change in clinical practice

because they can help to identify potential barriers to change and strategies to overcome them (Grol & Grimshaw, 2003). An overview of theories that underpin different approaches to implementing guidelines and changing clinical practice is presented in Table 2 (Grol, 1997). Notwithstanding published guidance (e.g. French et al., 2012; Medical Research Council, 2008), the vast majority of reviewed studies did not report the use of theory to inform the design or evaluation of training interventions.

Table 2: Approaches to Changing Clinical Practice (Grol, 1997)

Approach	Theories	Focus	Interventions, strategy
Focus on internal processes			
Educational	Adult learning theories	Intrinsic motivation of professionals	<ul style="list-style-type: none"> • Bottom up, local consensus development • Small group interactive learning • Problem based learning
Epidemiological	Cognitive theories	Rational information seeking and decision making	<ul style="list-style-type: none"> • Evidence based guideline development • Disseminating research findings through courses, mailing, journals
Marketing	Health promotion, innovation and social marketing theories	Attractive product adapted to needs of target audience	<ul style="list-style-type: none"> • Needs assessment, adapting change proposals to local needs • Stepwise approach • Various channels for dissemination (mass media and personal)
Focus on external influences			
Behavioural	Learning theory	Controlling performance by external stimuli	<ul style="list-style-type: none"> • Audit and feedback • Reminder systems, monitoring • Economic incentives, sanctions
Social interaction	Social learning and innovation theories, social influence/power theories	Social influence of significant peers/role models	<ul style="list-style-type: none"> • Peer review in local networks • Outreach visits, individual instruction • Opinion leaders • Influencing key people in social networks • Patient mediated interventions
Organisational	Management theories, system theories	Creating structural and organisational conditions to improve care	<ul style="list-style-type: none"> • Re-engineering care process • Total quality management/continuous quality improvement approaches • Team building • Enhancing leadership • Changing structures, tasks
Coercive	Economic, power, and learning theories	Control and pressure, external motivation	<ul style="list-style-type: none"> • Regulations, laws • Budgeting, contracting • Licensing, accreditation • Complaints/legal procedures

Although the reviewed training programmes were found to differ across studies, all included a group-based educational component providing information on strategies to inform recovery-oriented practice, thereby aligning with an educational approach. All training programmes also provided information regarding the concepts of the recovery agenda, which could be viewed as an epidemiological approach. A marketing approach places emphasis on

the importance of a clear and attractive message, adapted to the target audience (Grol & Grimshaw, 2003). Opportunities to hear service-users' personal stories of recovery could have promoted the importance of recovery-oriented care. Thus the inclusion of service-users in the delivery of training programmes could be considered a marketing approach, potentially explaining the finding that service-user involvement may have additional benefits for staff recovery outcomes. The majority of training programmes focused exclusively on internal processes, with only two focusing on external influences (i.e. Pollard, Gelbard, Levy, & Gelkopf, 2008; Young et al., 2005). Creating more recovery-focused services is not an 'add on' to existing ways of doing things, rather it requires a fundamental change in philosophy, culture and practice (Shepherd, Boardman, & Slade, 2008; Slade et al., 2008; Perkins & Morgan, 2017). That is to say, the successful implementation of recovery-oriented care will likely require various strategies targeting both internal processes and external influences. In line with this claim, the review recommended that systematic attention be given to theoretical frameworks and the role of organisational factors (e.g. enabling or reinforcing strategies) in the future design and evaluation of recovery training.

The Need for a Whole-System Approach

MHPs have identified conflicting system priorities as being the most frequent barriers to implementing recovery-oriented practice (Gilburt, Slade, Bird, Oduola, & Craig, 2013; Le Boutillier et al., 2014; Le Boutillier et al., 2015b). Recovery has been "made to fit a health infrastructure where its meaning is shaped by a traditional focus on hierarchy, clinical tasks, professional language, medicalization and psychiatric power" (Le Boutillier et al., 2015b, p. 433). It has been argued that if recovery-oriented principles are to have transformative impact on mental health services, then fundamental changes are needed at the source of our mental

health workforce: academic departments and institutions (Mabe, Ahmed, Duncan, Fenley, & Buckley, 2014). Only one of the reviewed studies focused specifically on training psychiatrists and psychologists within an academic institution (Peebles et al., 2009). Considering the power that psychiatrists hold within teams, I was surprised that this was also the only study to specifically target psychiatrists. Given the need for whole-system change and the unique role that psychiatrists play in moving the recovery agenda forward, future research could focus on recovery training initiatives in academic institutions, and on those that are tailored specifically to the needs of psychiatrists.

The provision of recovery-oriented practice sits in contradistinction to the backdrop of commissioning priorities and performance targets (Le Boutillier et al., 2015a; Le Boutillier et al., 2015b). It has been argued that services have operationalised recovery in terms of improved clinical outcome scores, reduced hospital admissions, discharge and a return to work (Slade et al., 2014; Le Boutillier et al., 2015a; Le Boutillier et al., 2015b). Further consideration therefore needs to be given to the role of recovery-oriented outcome measures in promoting system change. The findings of the review suggested the need for guidance on suitable recovery-oriented measures that can be implemented of as part of routine quality measurement. Although such guidance exists for Australian mental health services (Burgess, Pirkis, Coombs, & Rosen, 2011), guidance broadly applicable to a range of evaluative strategies (e.g. service user, staff and service level outcomes) and healthcare contexts would be beneficial. Moreover, consistency in the use of outcome measures across clinical and research domains could enable the direct comparison of research findings, and promote the on-going refinement of recovery-oriented practice. This information could be salient in determining the recovery-orientation of services, also acting as a guide for commissioning purposes.

The Need to Reduce Stigma

Best practice guidance published by the Department of Health (2007) states the need to “ensure that all efforts are made to present non-stigmatising and positive views of people who experience mental health problems” (p. 27). Reducing social stigma can help to reduce internalised stigma, which can restrict the ability of service-users to define a self apart from their diagnosis (Jacobson & Greenley, 2001). Although only a minority of the reviewed studies included measures of stigma, it is concerning that recovery training was found to be ineffective in reducing levels of stigma among MHPs. One explanation is that none of the reviewed training programmes included information pertaining to psychosocial conceptualisations of mental illness. Biogenetic causal attributions of mental illness are linked to stigmatising attitudes towards service-users and an increased desire for social distance (Dietrich et al., 2004; Rüsch, Angermeyer, & Corrigan, 2005). Conversely, psychosocial causal attributions are associated with less stigmatising beliefs and less desire for social distance (Lincoln, Arens, Berger, & Rief, 2008; Walker & Read, 2002). Furthermore, MHPs with a more biological (as opposed to psychosocial) orientation are less likely to predict that services would improve by involving service-users in service planning, or by their employment (Kent & Read, 1998). Thus, promoting psychosocial explanations for psychiatric symptoms among MHPs could lead to reduced stigma and a greater desire to collaborate with service-users, a key feature of the recovery approach. However, the process of recovery is not confined to mental health services and there is also a need to reduce stigmatising attitudes within wider society. Anti-stigma campaigns promoting a medical view of mental illness (i.e. mental illness is an illness like any other) have been largely unsuccessful (Read & Law, 1999; Walker & Read, 2002) and this approach should therefore

be reappraised (Lincoln et al., 2008). Future research regarding anti-stigma initiatives that aim to modify causal beliefs would therefore be of significant interest to the recovery agenda.

Study 2: Empirical Research

Formulating the Research Question

During the initial stages of formulating my research question, I organised a meeting with my two clinical supervisors - both clinical psychologists working in a forensic mental health service in South Wales. I was keen to discuss the practicalities of the research, such as participant recruitment and supervision arrangements, but also intrigued to learn more about recovery within a forensic context. In its broadest sense, the recovery paradigm aims to promote choice while opposing coercive forms of treatment (Pouncey & Lukens, 2010; Simpson & Penney, 2011). Due to the need for forensic services to protect the public and manage risk, I was concerned that the recovery approach may be less applicable in these settings. Through discussions with my supervisors, I became aware of my dominant discourse concerning risk and culpability, and felt ashamed that this had momentarily clouded my humanistic ethos. Forensic service-users have often had traumatic and terrifying childhood experiences, including extremes of abandonment, cruelty and humiliation (Adshead, 2002; Renn, 2002). According to attachment theory (Bowlby, 1979), these experiences can lead to insecure attachments, which in turn reduce the capacity for self-regulation, hindering the ability to mentalise and communicate psychological needs in adaptive, non-violent ways (Fonagy & Adshead, 2012; Mann, Matias, & Allen, 2014). Moreover, forensic service-users are typically highly socially disadvantaged and often have

little experience of living autonomously, having been in some sort of ‘care’ all their lives (Dorkins & Adshead, 2011). Holding this wider picture in mind, it was clear to me that the recovery approach could entail real value for this demographic.

After an extensive review of the literature, I was pleased to identify some ‘gaps’. Research into recovery in forensic settings does not tend to focus on recovery from psychosis, and research concerning recovery from psychosis does not tend to focus on forensic service-users. In addition, there is lack of research exploring the views of MHPs working in forensic settings. MHPs play a central role in the provision of recovery-oriented care and there is a need to develop a multi-perspective evidence base (Rose, Thornicroft, & Slade, 2006). I therefore decided to explore recovery from psychosis within a forensic setting from the perspectives of those receiving *and* providing care. My supervisors agreed that this would not only address a gap in the literature, but also have clinical relevance.

Aim

To explore the factors that service-users and healthcare professionals deem important to recovery from psychosis within a forensic service.

Ethical Approval

The requirement to obtain full NHS ethical approval was a daunting prospect. Luckily, the trainees in the year above hosted a support session to explain the process and offer advice. This information proved useful in the process of obtaining university sponsorship (Appendix 6) and applying for Research and Development approval from both the NHS and Local Health Board (LHB). Whilst I found the process of completing the required paperwork time

consuming, and at times confusing, it afforded me a more comprehensive understanding of my research and the ethical quandaries it presented. See Appendix 7 for the research protocol.

As part of the NHS application, I was required to consider a range of ethical, legal and managerial issues. Drawing on the Caldicott Principles (DoH, 2013), Data Protection Act 1998 (2005) and Guidance on Conduct and Ethics for Students (Health and Care Professionals Council, 2016), I felt assured that my research met the necessary standards of professional practice. Maintaining participant anonymity seemed particularly important given that the participants were either receiving or providing support from within the same service setting. Moreover, due to the detainee status of the forensic service-users, it was essential they knew their involvement in the research would not impact their care, and that all information would be kept confidential with the exception of issues relating to risk. In making this information explicit, I hoped to reduce the potential for social desirability bias (Holtgraves, 2004). I was aware that the service-user participants may have varying reading abilities and was keen to ensure that the recruitment process was inclusive and not experienced as threatening. I therefore also compiled accessible versions of the participant information sheet (see Appendix 8 for all participant information sheets) and consent form (see Appendix 9 for all consent forms), and accounted for extra time to explain this information. These forms proved useful during participant recruitment.

It also felt pertinent to consider issues relating to risk. A number of measures were taken to ensure the safety of the participants and myself. For example, I was inducted into the service and adhered to its safety and security procedures. In addition, I had a management plan in place should a disclosure of risk be made, and participants were recruited according to the

inclusion and exclusion criteria. Following these criteria, service-user participants were only included if their clinical team agreed their involvement would be suitable; they were excluded if experiencing acute distress. Considering all possible risk scenarios provoked some anxiety around conducting the research and, although I was glad to have all possibilities covered, I couldn't help but think that this process reflected the risk averse culture in which we live. This reflection felt significant at the time, especially considering the tension between recovery values that promote autonomy and the need for forensic services to manage risk.

Although slightly nerve wracking, meeting with the Research Ethics Committee afforded me the opportunity to verbalise the justification for my research and to defend my decision-making. I felt proud to receive subsequent confirmation of ethical approval (Appendix 10) and was grateful for all the support I had received along the way. I felt it was important to ensure that the trainees in the year below also benefited from a support session, which I was more than happy to facilitate.

Rationale for Using Q Methodology

I initially thought that Interpretative Phenomenological Analysis (IPA) would be best suited to the research as it aims to provide detailed examinations of personal lived experience (Smith, Flowers, & Larkin, 2009). However, the more I learnt about Q methodology (Stephenson, 1953) the more I came to appreciate its relevance and value. Seeing recovery as a process that is unique to individuals, it felt important to employ a methodology that values subjectivity. Q Methodology is an explorative technique integrating quantitative and qualitative approaches to enable the systematic study of subjectivity (Brown, 1996). It typically adopts a multi-participant format to explore highly complex and socially contested

subject matters (Rogers, 1995; Watts & Stenner, 2005). Given the controversial nature of recovery, Q methodology seemed well suited to the aims of the research. Furthermore, Q methodology has been used in a number of research studies concerning psychosis and has received positive feedback from both researchers and participants (e.g. Day, Bentall, & Warnel, 1996; Dudley, Siitarinen, James, & Dodgson, 2009; Wood, Price, Morrison, & Haddock, 2013). The process of engaging in Q methodology has been found to promote collaborative working and is less threatening than direct questions (Jones, Guy, & Ormond, 2003). This provided me with further justification for the use of Q methodology, given that people with a diagnosis of psychosis may have difficulties engaging with or trusting new people (Morrison, Renton, Dunn, Williams, & Bentall, 2004).

Recruitment

Adhering to the research proposal approved by the NHS and LHB Research and Development departments, participants were recruited from a medium secure forensic mental health service in South Wales; the process was led by one of my clinical supervisors. I planned to conduct the interviews within the forensic service and was hopeful that this would aid participant recruitment. I felt encouraged that Q methodology does not require large participant numbers and typically employs small sample sizes of between 20-40 people (Cairns, 2012). In line with recommendations (Danielson, Webler, & Tuler, 2009), 20 participants was considered sufficient for this research. Participants do not need to be representative of a wider population, but are instead selected according to the study's aims (Chinnis, Paulson, & Davis, 2001). As such, MHPs and service-users were purposively selected. Whilst participants were recruited via a convenience sample within these groups, it felt important to promote a sense of equality by ensuring that equivalent numbers of service-

users and MHPs were recruited. Of a total 23 participants, 10 were service-users and 13 were MHPs from a range of professional backgrounds (i.e. psychologists, psychiatrists, nurses and a social worker). With the aim of capturing a diversity of opinions, I felt slightly disappointed that due to service pressures only one social worker and no occupational therapists were recruited. In addition, the forensic unit comprised more male wards than female wards (four male and one female) and unfortunately no female service-users met the inclusion criteria. All service-user participants identified as White British males. I recognised that the participant demographics, small sample size and single location of recruitment would limit the generalisability of the research findings. However, as stated in the empirical paper, Q studies aim to identify viewpoints that exist and are not concerned with how viewpoints are distributed across a population (Brown, Durning, & Selden, 1999). I was immensely grateful for all the participants who were willing to give up their time and take part in the research. Furthermore, I was very appreciative of my supervisor's support and smooth organisation of this process.

Development of the Q-concourse and Q-set

Q methodology comprises a number of stages and I found it helpful to refer to the guidance produced by Armatas, Venn and Watson (2014), Brown (1996), Cross (2005), and Watts and Stenner (2005). The first phase involved creating the Q-concourse and Q-set. As explained in the empirical paper, the Q-concourse refers to an extensive collection of statements related to the research topic, which is pared down to form the Q-set (a list of statements that each make a different assertion about the topic) that participants rank order during the Q-sort (Armatas et al., 2014). Given the Q-set needs to be 'broadly representative of the opinion domain' (Watts & Stenner, 2005, p. 75), I reviewed a diverse range of sources to develop the initial Q-

concourse. Due to the conceptual multiplicity underpinning recovery, I initially found this process overwhelming and decided that I needed to adopt a more systematic approach. I started to collate relevant statements from the research literature regarding service-users' experiences of recovery from psychosis (e.g. Andresen et al., 2003; Pitt, Kilbride, Nothard, Welford, & Morrison, 2007; Thornhill, Clare, & May, 2004) with forensic service-users' experiences of recovery (e.g. Barnao, Ward, & Casey, 2015; Clarke et al., 2016; Ferrito, Vetere, Adshead, & Moore, 2012; Laithwaite & Gumley, 2007; Mezey, Kavuma, Turton, Demetriou, & Wright, 2010; Shepherd et al., 2016). Next I reviewed recovery-oriented outcome measures (as identified in: Shanks et al., 2013; Burgess et al., 2011), best-practice guidance (e.g. Drennan et al., 2014; Cook, 2014; Le Boutillier et al., 2011; Slade, 2009) and relevant websites (e.g. National Elf Service, 2017; Recovery in the Bin, n.d.). To account for the lack of literature exploring the perspectives of MHPs working in forensic settings, I conducted six informal semi-structured interviews (Appendix 11) with a range of MHPs (i.e. two psychiatrists, a psychologist, nurse specialist, staff nurse and ward manager). It was interesting to hear the different perspectives and I began to wonder whether service-users were conscious of the differing opinions within teams and how they made sense of this. I also became more acutely aware of my own positioning and was keen to ensure this did not influence my final Q-set.

Synthesising the data from the Q-concourse and developing my initial Q-set was a lengthy and evolving process. I found it helpful to group statements according to emerging themes, which resulted in the identification of ten important recovery domains (i.e. finding a personal meaning; coping with distress; symptom management; offence related aspects; relationships with friends and family; relationships with staff; basic needs; empowerment; socio-cultural and economic factors; and aspects of service provision). I was mindful that the Q-set could

impose limits on the participants' responses, therefore my initial Q-set contained 287 statements. I subsequently managed to reduce this to 108 statements by removing statements with overlapping content. To ensure that all statements were easily understandable and adequate coverage had been given to the relevant domains, I engaged in a process of piloting and conducted preliminary Q-sorts with two MHPs. My supervisors also reviewed the suitability of these statements. Responding to feedback I further reduced and refined the Q-set to 60 statements (Appendix 12), thereby ensuring the Q-sort process was not experienced as daunting and all statement cards were distinct from one another.

The Q-sort and Analysis

Following the Q-sort procedure outlined in the empirical paper, all 23 participants managed to sort the statement cards onto the forced distribution Q-board. It is interesting to recall that some of the MHPs questioned the use of a forced distribution, yet none of the service-users did – perhaps reflecting an inherent power imbalance. Of those who did question this, they were reassured by the opportunity to explain the reasoning for their choices during the post-sort interview, which was audio recorded. In fact, these post-sort interviews proved valuable for a number of reasons. Asking participants whether they thought any statements were missing provided reassurance that the Q-set was indeed representative of the opinion domain. In addition, it was reassuring to hear that the Q-sort process was considered a positive experience, with potential clinical benefits. Furthermore, participant explanations for their statement rankings added depth and clarity to their viewpoints, consequently aiding the analysis and reducing the risk of interpretation bias.

I chose to use PQ Method 2.33 (Schmolck & Atkinson, 2012) to conduct a factor analysis of the participants' statement configurations. I relied on Youtube tutorials produced by Sue-Z Q (2014) to guide me through this process: from downloading the software package to interpreting the resulting factor arrays (i.e. the summarising Q-sort produced to represent each factor). I decided to employ factor analysis with varimax rotation in an attempt to maximise the amount of explained variance. To ensure reliability, I only selected factors for interpretation if they had two or more factor exemplars (i.e. participants whose Q-sorts loaded significantly onto a single factor) and an eigenvalue exceeding 1.00 (Watts & Stenner, 2005). This resulted in a four-factor solution accounting for 60% of the variance, indicating four distinct perspectives. Meeting with my academic supervisor, experienced in the use of Q methodology, provided me with assurances that I was justified in my decisions and had completed the analysis correctly.

During the write-up of the results, I began the interpretation phase by combining the quantitative output of the factor analysis (i.e. the four factor arrays of statements) with the qualitative data obtained during the post-sort interviews. In this way, each factor array began to convey meaning, enabling the identification of shared and contested viewpoints. To facilitate this process, I compiled tables that summarised the statements defining each factor (Appendix 13). Selecting the supporting comments made by the factor exemplars required some diplomacy. I planned to disseminate the research findings within the forensic service and although it was important to highlight the differing opinions among participants, I did not want this difference to be experienced as divisive. I therefore avoided selecting comments that were highly critical of other disciplines within the team. I was surprised at how much I enjoyed the process of integrating the quantitative and qualitative data, and was impressed by the sense of coherence this methodology encouraged.

Further Exploration of Key Findings and Implications

Table 3 provides an overview of the key findings and implications of the empirical paper. Key themes will now be further appraised with reference to the wider contexts of research, policy and practice.

Table 3: Overview of Key Findings and Implications for Study 2

Study 2: Recovery from Psychosis in a Forensic Service: Assessing Staff and Service Users' perspectives using Q Methodology	
Key Findings	Key Implications
<ul style="list-style-type: none">• Four distinct perspectives identified: (1) <i>Personal growth and psychosocial aspects of recovery</i>, (2) <i>Gaining insight and reducing recidivism</i>, (3) <i>Self-focused aspects of recovery</i>, and (4) <i>Making amends & service engagement</i>.• No psychiatrists or service-user participants endorsed factor 1, which aligned most closely with 'personal recovery'.• The bio-medical model of care appeared most prominent in clinical practice.• The Q-sort process was considered a positive experience.	<ul style="list-style-type: none">• Multiple dimensions of recovery are important within clinical practice and a broad conceptualisation of recovery should be reflected in service provision.• Services should expand their use of language to reflect the various recovery dimensions.• There is need for greater choice in alternative treatments and improved access to alternative models of care.• Further research is required to explore the relevance of the findings to other demographic groups and service contexts.• Future research should explore the utility of the Q-sort process as a therapeutic tool.

Clinical Recovery vs. Personal Recovery

In accordance with the recovery literature (e.g. Leamy et al., 2011; Pitt et al., 2007; Wood et al., 2013), the findings of this study highlighted the heterogeneity of recovery beliefs amongst individuals. However, the discrepancy between the participants who loaded onto the emerging factors was of particular interest and warrants further consideration. There appeared to be a clear divide within the staff group of participants, with all psychiatrists giving priority to factor 2 (*Gaining insight and reducing recidivism*) and all other MHPs

emphasising the importance of factor 1 (*Personal growth and psychosocial aspects of recovery*). This difference in opinion seemed to reflect the disparity between notions of clinical recovery (i.e. symptomatic remission; Lieberman et al., 2008) and personal recovery (i.e. personal growth, hope and autonomy; Meehan, King, Beavis, & Robinson, 2008). As explained in the empirical paper, personal recovery aligns most closely with the recovery paradigm, whilst clinical recovery aligns with the traditional bio-medical model of care. In light of these contrasting conceptualisations of recovery, there is a further need to acknowledge the diverse ways in which mental illness is conceptualised.

Biological vs. Psychosocial Conceptualisations of Mental Illness

Mental illness is a contentious issue (Gold, 2011). The traditional bio-medical approach draws on the broken brain metaphor (Lieberman et al., 2008) and emphasises interventions based on biology and pharmacology (Kidd, Kenny, & McKinstry, 2014). It is perhaps unsurprising that the participants practising as psychiatrists placed importance on aspects of clinical recovery when considering their professional training. As Moncrieff (2007) laments, “the institution of psychiatry is built on two assumptions: that mental distress and deviant behaviour arise from biological abnormalities, and that biological interventions can resolve them... Unfortunately the evidence suggests that the story is not that simple” (p. 296). When individual understandings of causality are overemphasised, the broader cultural landscape of social, economic and political contributors is neglected (Hayes & Hannold, 2007; Kidd et al., 2014). Whilst the recovery approach does not “conceptually preclude or practically exclude psychiatry” (Pouncey & Lukens, 2010, p. 95), it advocates a more holistic approach than the traditional medical model (Clarke et al., 2016), and suggests the need for reform in the understanding and management of mental illness (Farkas, 2007; Le Boutillier et al., 2011).

Going one-step further, the Division of Clinical Psychology (2013) has explicitly criticised the current system of psychiatric diagnosis and acknowledged the need for a paradigm shift towards a conceptual system based on something other than a ‘disease model’. Offering an alternative to the bio-medical model, psychosocial models place emphasis on the role of social environments (e.g. early childhood environment, family atmosphere, critical life events and socio-economic factors) in contributing to and influencing mental health problems (Rössler, 2001). Moreover, multiple psychosocial factors (e.g. low socioeconomic status, high psychosocial stress, child abuse, poor parenting and domestic violence) have been linked to violent behaviour (Kashani, Jones, Bumby, & Thomas, 1999; Liu, 2011). Whilst it is generally accepted that there is often an interaction between biological and psychosocial factors - as encompassed in the biopsychosocial model (Engel, 1978) - the weighting given to these factors remains controversial and up for debate.

Predominance of the Bio-Medical Model

Growing criticism of traditional mental health services has arisen from the prevailing view among service-users and advocates that the bio-medical model impinges on civil rights, while fostering dependency and disability (Mabe et al., 2014). However, considering psychiatry continues to be the dominant profession in mental health services (Beresford, 2015), I was not surprised by the finding that the bio-medical model of care appeared most prominent in clinical practice. I also anticipated that different professional groups would hold different beliefs, but was surprised that no service-users endorsed the importance of ‘personal growth and psychosocial aspects of recovery’. A number of potential explanations for this finding were explored: service-users may have lacked knowledge of the various conceptualisations of recovery; they may have drawn on their own experiences of care that prioritised medication

compliance; or the medical model may have been preferred as it in some way mitigates responsibility for the offence (Mezey et al., 2010). All of these possibilities have important clinical implications and require further thought.

Broadening the Conceptualisation of Recovery in Clinical Practice

It is highly likely that the service-user participants lacked knowledge regarding the various conceptualisations of recovery. Drennan and Alred (2012) acknowledged that the degree of common language between the psychiatric rehabilitation model and recovery has led to difficulties in conveying the differences between these two paradigms. Furthermore, there is a lack of shared understanding regarding what recovery means in practice (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006), the empirical paper drawing attention to the heterogeneity of views among participants. This finding suggests that multiple dimensions of recovery are important to clinical practice. It is therefore essential that a broad conceptualisation of recovery be reflected in service provision. In addition to offering a range of interventions that reflect the various recovery dimensions, services should also refine their use of language to ensure conceptual clarity. Increasing precision and consistency in the use of the recovery lexicon could facilitate a better understanding of the recovery approach and the opportunities it presents. To align with the recovery values of choice and self-determination, MHPs need to support service-users to find their own way of understanding their experience of mental health difficulties (Barker & Buchanan-Barker, 2011). MHPs will therefore require the appropriate knowledge and skills to provide service-users with education regarding the various conceptualisations of recovery and mental illness. Kidd et al. (2014) recognised the need for processes where service-users and MHPs are brought together to engage in dialogue that draws on different knowledge bases. Whilst the findings of the

empirical paper suggest that the Q-sort process could serve this function, the need for further research to substantiate this claim was acknowledged.

Questioning the Use of Medication to Manage Risk

Another important clinical consideration concerns the finding that all service-users were prescribed neuroleptic medication and lacked choice regarding medication compliance. It is therefore possible that the lack of emphasis placed on ‘personal growth and psychosocial aspects of recovery’ (and the emphasis placed on bio-medical aspects of care) could be a reflection of service users’ recovery experiences within the forensic service. This study is not the first to suggest the need for greater choice in alternative treatments and improved access to alternative models of care (e.g. Lewis 2012; Mancini, Hardiman, & Lawson, 2005; Pitt et al., 2007). But this raises important questions in a forensic milieu where the need to manage risk is salient. Within forensic services, the medical model serves to reduce the anxiety of MHPs by offering simplification and a sense of certainty (Mann et al., 2014; Moore, 1995). There is a “powerful tendency in forensic mental health services to treat the apparent symptoms of mental illness and to presume that this simultaneously addresses the potential for future offending” (Drennan & Alred, 2012, p. 17). Elbogen & Johnson (2009), however, found that severe mental illness did not independently predict future violent behaviour, and understanding the link between violent acts and mental illness requires consideration of its association with other risk factors (e.g. substance abuse, environmental stressors and a history of violence). The long-term use of neuroleptic medication to manage risk (as endorsed by factor 2 in the empirical paper) therefore seems questionable. In addition, there are important ethical considerations when taking into account the often debilitating side-effects of medication. Whilst it is beyond the scope of this critique to provide a comprehensive review

of risk management strategies, it is worth noting the Good Lives Model (Ward, 2002; Ward & Maruna, 2007). This model has proved useful in motivating forensic service-users to work towards “better, safer and more socially responsible lives” (Barker, 2012, p. 36), and it has the potential to be a more empowering way of understanding the roots of offending behaviour (Barker, 2012).

The Role of Causal Beliefs

Finally, there is a further need to consider the implicit message when enforcing medication compliance. It is possible that this could contribute to the biogenic narrative of mental illness (e.g. brain damage, brain disease and/or genetic inheritance), thereby influencing service-users locus of control. Biological causal attributions of mental illness have been found to correlate positively with an external locus of control, in which individuals adopt a passive role of minimal responsibility (Kent & Read, 1998). The theme ‘self-exoneration’ identified in the empirical paper (i.e. factor 3) appeared to support the notion that the medical model can mitigate forensic service-user’s sense of responsibility for the committed offence (Mezey et al., 2010). Whilst this could potentially benefit some forensic service-users, it could also have a negative effect on their process of recovery. Key aspects of offender recovery include taking personal responsibility, coming to terms with the reality of one’s offence, and the need to redefine or ‘discover’ a new identity (Drennan & Alred, 2012; Kaliski & De Clercq, 2012). Moreover, a more external locus of control is significantly related to fewer periods of recovery in both psychosis and depression (Harrow, Hansford, & Astrachan-Fletcher, 2009). And thus, the way service-users conceptualise the aetiology of mental health problems has important implications. Promoting psychosocial causal beliefs could engender a greater internal locus of control, and future research should therefore aim to gain better

understanding of the relationships between causal beliefs, loci of control, risk management and recovery.

The Thesis as a Whole

Strengths and Limitations

The aim of the thesis was to advance the recovery agenda by making a valuable contribution to the literature base. The main strength of the thesis therefore lies in the respective focus of each paper, as the specific topics of enquiry were chosen to address identified gaps within the recovery literature. However, due to the differences between the topics, the findings of the empirical paper did not directly build upon the findings of the systematic review. Collectively, the thesis included the perspectives of service-users and MHPs within a forensic context (empirical paper), and established the current quantitative evidence regarding recovery-oriented training interventions for MHPs (systematic review). I was initially concerned that the disparity between the studies would limit the overall conclusions of the thesis, however I now feel that this added breadth to the overall findings.

Appraising the methodological strength of the thesis as a whole requires consideration of the methodologies employed by the individual studies. A number of strengths and limitations were acknowledged and discussed within the individual papers, and in this critique. In summary, the data from the systematic review violated assumptions of homogeneity and thus a narrative synthesis was deemed most appropriate. Whilst this methodology proved insufficient in establishing firm conclusions, it enabled the identification of general trends

within the data. Although the decision to focus exclusively on quantitative data was justified at the outset, on reflection the inclusion of qualitative data could have added more depth to the findings. The review took account of the diverse study designs by using an appropriate quality appraisal tool (i.e. QATSDD; Sirriyeh et al., 2012), and the review was deemed to be of sufficient quality in its own right (CASP, 2018). Although the overall credibility of the review was limited by the methodological weaknesses of reviewed studies, the acknowledgement of these limitations highlighted future research priorities.

The empirical paper employed Q methodology, which proved useful in exploring the perspectives of both service-users and MHPs. The systematic development and piloting of the Q-set resulted in 60 statement cards, which were deemed to encapsulate the broad opinion domain regarding recovery. The Q-analysis used varimax rotation to maximise the amount of explained variance, and factor interpretation was completed in line with published guidance to ensure reliability. This resulted in a four-factor solution accounting for 60% of the variance. Factor interpretation was further supplemented by the participants' comments made during the post-sort interviews, thereby adding clarity to the findings and reducing interpretation bias. Participants gave positive feedback regarding the Q-sort process and potential clinical benefits were acknowledged. Overall, I feel that Q methodology was the correct choice for the empirical paper. It enabled subjective input to be converted into objective structures (Watts & Stenner, 2005) and the results appeared robust and valid. However, as with any methodology some limitations need consideration. Q methodology is not concerned with ascertaining the prevalence of viewpoints within a population, and a number of factors limited the generalisability of the findings. Furthermore, the results may have been influenced by social desirability bias, however assurances regarding anonymity attempted to mitigate this.

Despite methodological limitations, both papers were considered sufficiently robust to submit for publication. I view the prospective publication of these papers to be a strength, as the wider dissemination of the findings has potential to influence future endeavours of clinicians and academics. However, the word limits imposed by the target journals restricted the scope of the research studies. A strength of the thesis as a whole therefore lies in the extended discussion of the research findings within this critique, which it is important to note was also limited by word restrictions. The implementation of recovery-oriented services is a complex issue that has important ideological implications for the whole community. The debate around recovery should therefore not be confined to the clinical service environment, but must extend into the broader community (Meehan et al., 2008). This is particularly pertinent when considering the critique that recovery has been co-opted for economic and political reasons that sit at odds with the recovery philosophy of human rights and socio-economic equality (Recovery in the Bin, n.d.). The thesis as a whole does not do justice to the myriad social, political, economic and legal factors that impinge on recovery. These limitations notwithstanding, all papers within the thesis report pragmatic conclusions that can be used to inform clinical practice, service development and future research, thus advancing the recovery agenda.

Clinical and Service Implications

To ensure the provision of recovery-oriented practice, all staff members need to be recovery competent. Services should therefore focus on recovery-competencies at the recruitment level and provide staff with in-house recovery-oriented training. Whilst group-based education on recovery principles and strategies seem useful in promoting recovery knowledge, attitudes and competencies, these interventions have less utility in reducing levels of stigma towards

service-users. Services therefore need to invest in additional anti-stigma initiatives for MHPs or ensure this issue has been considered and reflected within the recovery training programmes provided. Taking the thesis as a whole, there is a pressing need to promote psychosocial understandings of mental health difficulties because psychosocial causal attributions have the potential to reduce stigma within mental health services and the wider community. In addition, promoting psychosocial orientations amongst MHPs could encourage a greater desire to collaborate with service-users in the design and delivery of services. Furthermore, psychosocial causal beliefs among service-users could engender a greater internal locus of control with potential benefits for their recovery and risk management. Service-users need to be offered improved access to alternative models of care and require support to find their own way of understanding their experience of mental health difficulties (Barker & Buchanan-Barker, 2011). To support such choice, training programmes need to provide MHPs with the necessary knowledge and skills to educate service-users about the different conceptualisations of recovery and mental illness.

The structured dominance of the medical model should not be denied (Beresford, 2015) and staff recovery training in isolation may have limited ability to influence clinical practice. As such, services should provide recovery training alongside other forms of organisational support, taking account of theory and evidence in the selection of strategies. To monitor progress and inform system change, services need to routinely measure recovery-oriented outcomes across various levels (e.g. service-user, staff, service). To advance the recovery agenda there is also need for conceptual clarity and it is therefore imperative that a broad recovery lexicon be applied within clinical practice. The following notions appear useful: clinical recovery, personal recovery, functional recovery, social recovery and offender recovery. Finally, whilst providers of forensic services face the additional challenge of

ensuring public protection, the use of medication to manage risk seems to be predicated on misconceptions regarding the link between mental illness and violence. The implication is that services must give careful consideration to issues of efficacy and ethics when prescribing medication in secure settings.

Future Research Priorities

To inform the choice of recovery training interventions used within services, future research is needed to ascertain the benefits of recovery training programmes that target different professional groups and/or service contexts. Given the need for whole-system change and the power that psychiatrists hold within teams, research on the efficacy of recovery training initiatives that target psychiatrists and/or take place within academic institutions would be of particular value. Such research would need to draw on established theories (e.g. Grol, 1997) and frameworks (e.g. French et al., 2012; Medical Research Council, 2008) to inform both the design and evaluation of the training interventions. There is also a need for future research to provide guidance on suitable recovery-oriented measures for routine use in clinical practice and research. Consistent use of recovery measures could facilitate the comparison between research studies, promote the on-going refinement of recovery-oriented practice, and inform the commissioning of recovery-oriented services. Furthermore, there is a need for clinical processes where service-users and MHPs are brought together to exchange dialogue that draws on different knowledge bases (Kidd et al., 2014). The Q-sort process shows promise as a collaborative clinical tool to engage MHPs and service-users in conversations about the various notions of recovery and mental illness. Future research should therefore evaluate the clinical value of the Q-sort process used in this way. To better implement recovery-oriented practice, there is an imperative for greater choice in alternative

treatments. Thus, future research also needs to establish a range of evidence-based psychosocial interventions that map onto the various dimensions of recovery. To advance the implementation of psychosocial interventions within clinical practice, there is a further need for future research to advance our understanding of the relationships between causal beliefs, loci of control, risk management and recovery. Finally, to better align with the recovery agenda all future research endeavours should prioritise inclusion and/or consultation with service-users.

Conclusions

A number of key policy documents recognise the need to provide recovery-oriented mental health services (DoH, 2011; NIMHE, 2005; WHO, 2013). However, the implementation of recovery-oriented practice remains sporadic and there is a risk that we could lose the opportunity to dramatically change service provision (Bedregal et al., 2006). In an attempt to advance the recovery agenda, the thesis addressed gaps within the literature and provided pragmatic recommendations for clinical practice, service development and future research. However, implementing recovery-oriented care is a complex issue and the scope of the thesis is not all encompassing. If we are to move from policy statements to the implementation of recovery principles, there is arguably much more debate required, with particular attention to the broader social, political and economic landscape.

Dissemination

I plan to publish the systematic review and empirical paper. I am hopeful that their respective findings will be useful in advancing recovery-oriented practice and research. In selecting the target journals, I carefully considered their relevance, readership and impact. For the systematic review, I chose the Psychiatric Rehabilitation Journal (see Appendix 1 for author guidelines), a peer-reviewed journal with an impact factor of 1.037. A number of the reviewed studies were published in this journal and I therefore felt assured of its relevance.

To ensure the empirical paper was seen by clinicians and academics working in the field of forensics, I considered the three main peer-reviewed journals specialising in this area: Journal of Forensic Practice (impact factor: 0.47); Journal of Forensic Psychiatry and Psychology (impact factor: 1); Journal of Forensic Psychology Research and Practice (impact factor: 0.609). I decided on the latter (see Appendix 2 for author guidelines). Although this journal does not have the highest impact factor, it has a less restrictive word limit. Aforementioned, Q methodology is a quanti-qualitative approach and the use of participant comments to elaborate on the results of the factor analysis was considered a strength. Word count permitting, I was able to keep these comments within the results which added depth and clarity to the findings.

In addition to publication, I plan to disseminate the findings of the empirical paper within the service in which the research was conducted. I have been invited to present at a team meeting, which will be attended by the staff members who took part in the research. My clinical supervisor has also agreed to ask the service-user participants if they would like the opportunity to meet with me to discuss the research findings. I hope this offer is accepted, as I would be very interested to hear their thoughts.

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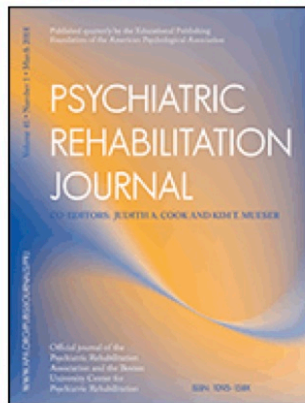
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APPENDICES

Appendix 1: Psychiatric Rehabilitation Journal Author Guidelines

Psychiatric Rehabilitation Journal®



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Manuscript Preparation

Prepare manuscripts according to the [Publication Manual of the American Psychological Association \(6th edition\)](#). Manuscripts should be copyedited for bias-free language (see Chapter 3 of the *Publication Manual*)

Follow US Psychiatric Rehabilitation Association (USPRA) Language Guidelines. These guidelines are based on the fundamental values of the psychiatric rehabilitation field: respecting the worth and dignity of all persons and groups, as well as honoring and advocating for individual rights and interests, and opposing discrimination in services and in society.

Review APA's [Checklist for Manuscript Submission](#) before submitting your article. Use 12-point Times New Roman font with consistent headings and subheadings and omit underlining. All references should be included in the reference list in APA format. Use of Endnotes is not permitted.

Abstract and Keywords

All research manuscripts should include a structured abstract containing a maximum of 250 words. Abstracts that are incomplete or do not conform to the following structure will be returned to the authors for revision.

- **Objective:** the primary purpose of the article should be clearly stated.
- **Methods:** this section must state the sample size and nature of subjects, data sources, study design, how dependent variables were measured and the specific analytic techniques (statistical tests, qualitative analysis strategy) that were used.
- **Results:** primary findings should be stated clearly and concisely, describing statistical results as appropriate.
- **Conclusions and Implications for Practice:** implications of the findings for the field of psychiatric rehabilitation, mental health, or recovery should be clearly stated and future directions may be described.

All theoretical manuscripts should include a structured abstract with the following required sections:

- **Objective:** the primary purpose of the article should be clearly stated.
- **Method:** this section should describe the methodology used and type of analysis conducted.
- **Findings:** primary findings should be stated clearly and concisely.
- **Conclusions and Implications for Practice:** implications of the findings for the field of psychiatric rehabilitation, mental health, or recovery should be clearly stated and future directions may be described.

Abstracts for brief reports should not exceed 150 words.

Please supply up to five keywords or brief phrases after the abstract.

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Psychiatric Rehabilitation Journal will now publish Impact and Implications Statements in addition to regular abstracts. This feature allows authors to provide an outline of the practice or policy implications of the research discussed in the paper, thereby offering a clear understanding of how the presented research can be applied.

At the start of each paper the authors should provide 2–3 sentences, with the header "Impact", that states what the current paper adds to the literature and one to two practice or policy implications the findings. This is not a statement of the conclusions, rather a thoughtful series of statements highlighting the novel contribution of the work and translation of the findings for practice or policy. This section should be no more than 200 words.

Please refer to [Guidance for Translational Abstracts, Public Significance Statements, and Social Media Messages](#) to help you write your statement.

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Manuscript Length Articles should not exceed 5,000 words; Brief Reports should not exceed 1,500 words, and Letters to the Editor should not exceed 300 words. Word counts are exclusive of tables, figures, and references. All revisions must adhere to these word limits. Authors must include the word count (exclusive of tables, figures, and references) on the title page of their manuscripts. Authors must review and use the [Guidelines for Nonhandicapping Language in APA Journals](#).

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Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the [APA Style website](#). Below are additional instructions regarding the preparation of display equations, computer code, and tables.

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- **Authored Book:**
Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach*. Cambridge, MA: MIT Press.
- **Chapter in an Edited Book:**
Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

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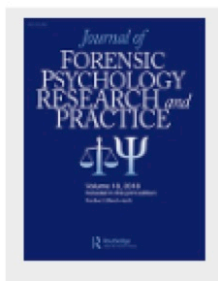
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Appendix 2: Quality Scores of Reviewed Studies

Quality Assessment: Individual Study Scores																	Total score (out of 42)
	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10	Q11	Q12	Q13	Q14	Q15	Q16	
Chang et al. (2013)	2	3	2	0	1	3	3	3	2	1		3	2		0	2	27
Chen et al. (2014)	3	2	3	0	1	2	1	2	2	1		2	0		0	1	20
Crowe et al. (2006)	1	2	2	0	2	2	2	1	2	2		3	1		0	2	22
Doughty et al. (2008)	1	3	2	0	1	3	0	2	2	2		2	2		0	1	21
Gilburt et al. (2013)	1	3	3	0	2	2	1	2	0	2		2	1		0	2	21
Higgins et al. (2012)	1	2	2	0	2	1	2	1	1	2		3	2		0	2	21
Meehan and Glover (2009)	1	1	1	0	1	1	3	2	3	3		2	1		0	1	20
Peebles et al. (2009)	1	2	3	0	2	2	3	3	3	2		3	1		0	2	27
Pollard et al. (2008)	1	3	2	0	2	2	1	1	0	2		3	1		0	1	19
Repique et al. (2016)	1	3	3	0	2	3	3	2	3	2		2	1		0	2	27
Salgado et al. (2010)	1	3	3	1	2	2	3	2	3	2		3	2		0	2	29
Walsh et al. (2017)	1	3	2	0	3	3	3	2	3	2		3	2		1	2	30
Wilrycx et al. (2012)	1	3	3	0	2	3	2	2	3	2		3	2		0	2	28
Wilrycx et al. (2015)	1	3	3	1	2	3	3	3	3	2		3	2		0	2	31
Young et al. (2005)	1	2	2	0	2	1	2	2	1	3		3	3		0	2	24
Zuaboni et al. (2017)	1	3	3	1	2	1	3	2	1	3		3	2		0	3	28

Appendix 3: Journal of Forensic Psychology Research and Practice Author Guidelines



Journal of Forensic Psychology Research and Practice

Instructions for authors

Thank you for choosing to submit your paper to us. These instructions will ensure we have everything required so your paper can move through peer review, production and publication smoothly. Please take the time to read and follow them as closely as possible, as doing so will ensure your paper matches the journal's requirements. For general guidance on the publication process at Taylor & Francis please visit our [Author Services website](#).

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About the journal

Journal of Forensic Psychology Research and Practice is an international, peer-reviewed journal publishing high-quality, original research. Please see the journal's Aims & Scope for information about its focus and peer-review policy.

Peer review

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Preparing your paper

Submission types

Journal of Forensic Psychology Research and Practice accepts the following types of submissions: Case studies and articles dealing with treatment and assessment in police, court, and/or correctional settings. Research submissions exploring individual, family, adult, and juvenile populations are

encouraged. Sections of the journal include Articles, Commentary, Practice Update, Case Report, and Ethics, Psychology and Public Policy. The *Journal* does not accept books for review. Suggested length of the article is 20 to 30 pages, double spaced.

Formatting and templates

Papers may be submitted in any standard file format, including Word and LaTeX. Figures should be saved separately from the text. The main document should be double-spaced, with one-inch margins on all sides, and all pages should be numbered consecutively. Text should appear in 12-point Times New Roman or other common 12-point font. Include an abstract including: name, address, telephone number, and e-mail address.

Case Report Guidelines

Protection of Human Subjects and Animals in Research . Manuscripts that describe research with human subjects or animals must explicitly state that the research was conducted in accord with relevant legal and ethical standards. Authors must state the name of the committee (e.g., IRB) that approved and monitored the study. For research with human subjects, authors must include statements indicating that there was a complete discussion of the study with potential participants; that written informed consent was obtained after this discussion (or if a waiver of consent was obtained, an explanation of this); and that the study was conducted in accordance with the Declaration of Helsinki. For research conducted with animals, authors must indicate that institutional and national guidelines for the care and use of animals were followed.

Confidentiality . Participants and patients have a right to privacy that should not be violated without informed consent. Identifying information, including names, initials, or hospital numbers, should not be published in written descriptions, photographs, or pedigrees unless the information is essential for scientific purposes and the patient (or parent or guardian) gives written informed consent for publication. Nonessential identifying details should be omitted. Informed consent should be obtained if there is any doubt that anonymity can be maintained. If identifying characteristics are altered to protect anonymity, such as in genetic pedigrees, authors should provide assurance, and editors should so note that such alterations do not distort scientific meaning.

Style guidelines. Submissions to *Journal of Forensic Psychology Practice* should follow the style guidelines described in the *APA Publication Manual* (6th ed.). *Merriam-Webster's Collegiate Dictionary* (11th ed.) should be consulted for spelling.

References. References should be cited parenthetically in the text by author surname(s) and year, in accordance with APA Publication Manual guidelines:

<i>1 author</i>	(Smith, 2010)
<i>2 authors</i>	(Smith & Jones, 2010)
<i>3 to 5 authors</i>	(Smith, Jones, & Smythe, 2010) first mention; (Smith et al., 2010) thereafter
<i>6 or more authors</i>	(Smith et al., 2010)

When available, page numbers should be included in citations of direct quotations (e.g., (Smith, 2010, p. 25)).

References should be listed in a separate section at the end of the main text. All references in the list should be ordered alphabetically by the first author's surname. Examples of common reference types appear below.

Journal article

Taylor, J., & Ogilvie, B. C. (1994). A conceptual model of adaptation to retirement among athletes: A meta-analysis. *Journal of Applied Sport Psychology*, 6(1), 1–20. doi:10.1080/10413209408406462

Book

Duke, J. A. (2001). *Handbook of phytochemical constituents of GRAS herbs and other economic plants*. Boca Raton, FL: CRC Press.

Edited book chapter

Gordon, S. (1995). Career transitions in competitive sport. In T. Morris & J. Summers (Eds.), *Sport psychology: Theory, applications and issues* (pp. 474–493). Milton, Australia: Wiley.

Online/Website

United States Census Bureau. (2014). *American housing survey: 2013 detailed tables*. Retrieved from <http://www.census.gov/newsroom/press-releases/2014/cb14-tps78.html>

Dissertation/Thesis

Allison, N. (1981). *Bacterial degradation of halogenated aliphatic acids* (Doctoral dissertation). Trent Polytechnic, Nottingham, UK.

Conference presentation

Alfermann, D., & Gross, A. (1997, January). *Coping with career termination: It all depends on freedom of choice*. Paper presented at the 9th Annual World Congress on Sport Psychology, Netanya, Israel.

Paper/Report

Grigg, W., Moran, R., & Kuang, M. (2010). *National Indian education study* (NCES 2010-462). Washington DC: National Center for Education Statistics.

Checklist: what to include

1. **Author details.** Please include all authors' full names, affiliations, postal addresses, and email addresses on the cover page. Where appropriate, please also include [ORCiDs](#) and social media handles (Facebook, Twitter or LinkedIn). One author will need to be identified as the corresponding author, with their email address normally displayed in the published article. Authors' affiliations are the affiliations where the research was conducted. If any of the named co-authors moves affiliation during the peer-review process, the new affiliation can be given as a footnote. Please note that authorship may not be changed after acceptance. Also, no changes to affiliation can be made after your paper is accepted. Read more on authorship [here](#).
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3. **Keywords.** Keywords are the terms that are most important to the article and should be terms readers may use to search. Authors should provide 3 to 5 keywords. Please read our page about [making your article more discoverable](#) for recommendations on title choice and search engine optimization.
4. **Funding details.** Please supply all details required by your funding and grant-awarding bodies as follows:

For single agency grants

This work was supported by the <Funding Agency> under Grant <number xxxx>.

For multiple agency grants

This work was supported by the <Funding Agency #1> under Grant <number xxxx>; <Funding Agency #2> under Grant <number xxxx>; and <Funding Agency #3> under Grant <number xxxx>.
5. **Disclosure statement.** With a disclosure statement you acknowledge any financial interest or benefit that has arisen from the direct applications of your research. Further guidance, please see our page on [what is a conflict of interest and how to disclose it](#).

6. **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file, or anything else which supports (and is pertinent to) your paper. Supplemental material must be submitted for review upon paper submission. Additional text sections are normally not considered supplemental material. We publish supplemental material online via Figshare.

7. **Figures.** Figures should be high quality (600 dpi for black & white art and 300 dpi for color). Figures should be saved as TIFF, PostScript or EPS files. Figures embedded in your text may not be able to be used in final production.

8. **Tables.** Please supply editable table files. We recommend including simple tables at the end of your manuscript, or submitting a separate file with tables.

9. **Equations.** If you are submitting your manuscript as a Word document, please ensure that equations are editable. Please see our page on [mathematical symbols and equations](#) for more information.

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Appendix 4: QATSDD (Sirriyeh et al., 2012) Scoring Guidance

Table 1 Quality assessment tool and scoring guidance notes				
Criteria	0 = Not at all	1 = Very slightly	2 = Moderately	3 = Complete
Explicit theoretical framework	No mention at all.	Reference to broad theoretical basis.	Reference to a specific theoretical basis.	Explicit statement of theoretical framework and/or constructs applied to the research.
Statement of aims/objectives in main body of report	No mention at all.	General reference to aim/objective at some point in the report including abstract.	Reference to broad aims/objectives in main body of report.	Explicit statement of aims/objectives in main body of report.
Clear description of research setting	No mention at all.	General description of research area and background, e.g. 'in primary care'.	General description of research problem in the target population, e.g. 'among GPs in primary care'.	Specific description of the research problem and target population in the context of the study, e.g. 'nurses and doctors from GP practices in the east midlands'.
Evidence of sample size considered in terms of analysis	No mention at all.	Basic explanation for choice of sample size. Evidence that size of the sample has been considered in study design.	Evidence of consideration of sample size in terms of saturation/information redundancy or to fit generic analytical requirements.	Explicit statement of data being gathered until information redundancy/saturation was reached or to fit exact calculations for analytical requirements.
Representative sample of target group of a reasonable size	No statement of target group.	Sample is limited but represents some of the target group or representative but very small.	Sample is somewhat diverse but not entirely representative, e.g. inclusive of all age groups, experience but only one workplace. Requires discussion of target population to determine what sample is required to be representative.	Sample includes individuals to represent a cross section of the target population, considering factors such as experience, age and workplace.
Description of procedure for data collection	No mention at all.	Very basic and brief outline of data collection procedure, e.g. 'using a questionnaire distributed to staff'.	States each stage of data collection procedure but with limited detail, or states some stages in details but omits others.	Detailed description of each stage of the data collection procedure, including when, where and how data were gathered.
Rationale for choice of data collection tool(s)	No mention at all.	Very limited explanation for choice of data collection tool(s).	Basic explanation of rationale for choice of data collection tool(s), e.g. based on use in a prior similar study.	Detailed explanation of rationale for choice of data collection tool(s), e.g. relevance to the study aims and assessments of tool quality either statistically, e.g. for reliability & validity, or relevant qualitative assessment.
Detailed recruitment data	No mention at all.	Minimal recruitment data, e.g. no. of questionnaire sent and no. returned.	Some recruitment information but not complete account of the recruitment process, e.g. recruitment figures but no information on strategy used.	Complete data regarding no. approached, no. recruited, attrition data where relevant, method of recruitment.
Statistical assessment of reliability and validity of measurement tool(s)	No mention at all.	Reliability and validity of measurement tool(s) discussed, but not statistically assessed.	Some attempt to assess reliability and validity of measurement tool(s) but insufficient, e.g. attempt to establish test-retest reliability is unsuccessful but no action is taken.	Suitable and thorough statistical assessment of reliability and validity of measurement tool(s) with reference to the quality of evidence as a result of the measures used.
(Qualitative only) Fit between stated research question and method of data collection	No research question stated.	Method of data collection can only address some aspects of the research question.	Method of data collection can address the research question but there is a more suitable alternative that could have been used or used in addition.	Method of data collection selected is the most suitable approach to attempt answer the research question
(Quantitative) Fit between stated research question and format and content of data collection tool e.g. interview schedule	No research question stated.	Structure and/or content only suitable to address the research question in some aspects or superficially.	Structure & content allows for data to be gathered broadly addressing the stated research question(s) but could benefit from greater detail.	Structure & content allows for detailed data to be gathered around all relevant issues required to address the stated research question(s).
(Qualitative) Fit between research question and method of analysis	No mention at all.	Method of analysis can only address the research question basically or broadly.	Method of analysis can address the research question but there is a more suitable alternative that could have been used or used in addition to offer greater detail.	Method of analysis selected is the most suitable approach to attempt answer the research question in detail, e.g. for qualitative IPA preferable for experiences vs. content analysis to elicit frequency of occurrence of events, etc.
Good justification for analytical method selected	No mention at all.	Basic explanation for choice of analytical method	Fairly detailed explanation of choice of analytical method.	Detailed explanation for choice of analytical method based on nature of research question(s).
Assessment of reliability of analytical process (Qualitative only)	No mention at all.	More than one researcher involved in the analytical process but no further reliability assessment.	Limited attempt to assess reliability, e.g. reliance on one method.	Use of a range of methods to assess reliability, e.g. triangulation, multiple researchers, varying research backgrounds.
Evidence of user involvement in design	No mention at all.	Use of pilot study but no involvement in planning stages of study design.	Pilot study with feedback from users informing changes to the design.	Explicit consultation with steering group or statement or formal consultation with users in planning of study design.
Strengths and limitations critically discussed	No mention at all.	Very limited mention of strengths and limitations with omissions of many key issues.	Discussion of some of the key strengths and weaknesses of the study but not complete.	Discussion of strengths and limitations of all aspects of study including design, measures, procedure, sample & analysis.

Appendix 5: CASP Systematic Review Checklist



Section A: Are the results of the review valid?

1. Did the review address a clearly focused question?

Yes	<input checked="" type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: An issue can be 'focused' in terms of

- the population studied
- the intervention given
- the outcome considered

Comments: Three main objectives clearly stated.

2. Did the authors look for the right type of papers?

Yes	<input checked="" type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: 'The best sort of studies' would

- address the review's question
- have an appropriate study design (usually RCTs for papers evaluating interventions)

Comments: Focus on quantitative literature justified.

Is it worth continuing?

3. Do you think all the important, relevant studies were included?

Yes	<input checked="" type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Look for

- which bibliographic databases were used
- follow up from reference lists
- personal contact with experts
- unpublished as well as published studies
- non-English language studies

Comments: Manual search of reference lists ensured a thorough search.

4. Did the review's authors do enough to assess quality of the included studies?

Yes	<input checked="" type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: The authors need to consider the rigour of the studies they have identified. Lack of rigour may affect the studies' results ("All that glitters is not gold" Merchant of Venice – Act II Scene 7)

Comments: The QATSDD was used.

5. If the results of the review have been combined, was it reasonable to do so?

Yes	<input checked="" type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider whether

- results were similar from study to study
- results of all the included studies are clearly displayed
- results of different studies are similar
- reasons for any variations in results are discussed

Comments: Combined using narrative synthesis.

Section B: What are the results?

6. What are the overall results of the review?

HINT: Consider

- If you are clear about the review's 'bottom line' results
- what these are (numerically if appropriate)
- how were the results expressed (NNT, odds ratio etc.)

Comments: Training programmes were diverse and the methodological quality of studies was variable. Training programmes appear effective in improving staff recovery-oriented outcomes. Limited evidence for training programmes to improve service-user / service-level outcomes.

7. How precise are the results?

HINT: Look at the confidence intervals, if given

Comments: N/A due to narrative synthesis methodology.

Section C: Will the results help locally?

8. Can the results be applied to the local population?

Yes	<input checked="" type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider whether

- the patients covered by the review could be sufficiently different to your population to cause concern
- your local setting is likely to differ much from that of the review

Comments: Local population defined as mental health professionals.

9. Were all important outcomes considered?

Yes	<input checked="" type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider whether

- there is other information you would like to have seen

Comments:

10. Are the benefits worth the harms and costs?

Yes	<input checked="" type="checkbox"/>
Can't Tell	<input type="checkbox"/>
No	<input type="checkbox"/>

HINT: Consider

- even if this is not addressed by the review, what do you think?

Comments:

Appendix 6: Cardiff University Sponsorship Confirmation Letter



Research and Innovation Services
Gwasanaethau Ymchwil ac Arloesi
Acting Director, Cyfarwyddwr Dros Dro Dr David G Bembo

Cardiff University
McKenzie House, 7th Floor
30-36 Newport Road
Cardiff CF24 0DE
Wales UK
Tel +44(0)29 2087 5834
Fax +44(0)29 2087 4189

06.06.2017

Dr Dougal Hare,
South Wales Doctoral Programme in Clinical Psychology,
Cardiff University,
11th Floor Tower Building,
70 Park Place,
Cardiff,
CF10 3AT

Prifysgol Caerdydd
Tŷ McKenzie, 7^{fed} Llawr
30-36 Heol Casnewydd
Caerdydd CF24 0DE
Cymru, Y Deyrnas Unedig
Ffôn +44(0)29 2087 5834
Ffacs +44(0)29 2087 4189

Dear Dr Hare,

Recovery from psychosis in forensic settings: assessing staff and service user's views using Q methodology

I understand that you are acting as Chief Investigator for the above DClinPsy project to be conducted by Kim Jackson-Blott.

I confirm that Cardiff University agrees/agrees in principle to act as Sponsor for the above project, as required by the Research Governance Framework for Health and Social Care.

Scientific Review

I can also confirm that Scientific Review has been obtained from DClinPsy supervisors.

Insurance

The necessary insurance provisions will be in place prior to the project commencement. Cardiff University is insured with UMAL. Copies of the insurance certificate are attached to this letter.

Approvals

On completion of your IRAS form (required for NHS REC and NHS R&D/HRA approvals), you will be required to obtain signature from the Sponsor ('Declaration by the Sponsor Representative').

Please then submit the project to the following bodies for approval:

- NHS Research Ethics Committee;
- Health & Care Research Wales Permissions Coordinating Unit (formerly known as NISCHR PCU) - to arrange host organisation R&D approval for Welsh NHS sites.

Once Research and Innovation Services has received evidence of the above approvals, the University is considered to have accepted Sponsorship and your project may commence.

Roles and Responsibilities

As Chief Investigator you have signed a Declaration with the Sponsor to confirm that you will adhere to the standard responsibilities as set out by the Research Governance Framework for Health and Social Care. In accordance with the University's Research Integrity & Governance Code of Practice, the Chief Investigator is also responsible for ensuring that each research team member is qualified and experienced to fulfill their delegated roles including ensuring adequate supervision, support and training.

If your study is adopted onto Health & Care Research Wales Clinical Research Portfolio you are required to upload recruitment data onto the portfolio database.



Registered Charity, no. 1136855
Elusen Gofrestredig, rhif 1136855

Contracts

No research specific tasks delegated to NHS Host Organisation staff (staff acting as participants) – no contract required.

May I take this opportunity to remind you that, as Chief Investigator, you are required to:

- ensure you are familiar with your responsibilities under the Research Governance Framework for Health and Social Care;
- undertake the study in accordance with Cardiff University's Research Integrity & Governance Code of Practice (available on the Cardiff University Staff and Student Intranet) and the principles of Good Clinical Practice;
- ensure the research complies with the Data Protection Act 1998;
- where the study involves human tissue, ensure the research complies with the Human Tissue Act and the Cardiff University Code of Practice for Research involving Human Tissue (available on the Cardiff University Staff and Student Intranet);
- inform Research and Innovation Services of any amendments to the protocol or study design, including changes to start /end dates;
- co-operate with any audit, monitoring visit or inspection of the project files or any requests from Research and Innovation Services for further information.

You should quote the following unique reference number in any correspondence relating to Sponsorship for the above project:

SPON1604-17

This reference number should be quoted on all documentation associated with this project.

Yours sincerely



Dr K J Pittard Davies
Head of Research Governance and Contracts
Direct line: +44 (0) 29208 79274
Email: resgov@cardiff.ac.uk

Cc Kim Jackson-Blott

Appendix 7: Research Protocol



NHS
WALES
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CYMRU

School of Psychology
Ysgol Seicoleg

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De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol



Cardiff University
Tower Building
70 Park Place
Cardiff CF10 3AT
Wales UK
www.psych.cf.ac.uk
Prifysgol Caerdydd
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RESEARCH PROTOCOL

Recovery from psychosis in forensic settings: assessing staff and service user's views using Q methodology

By: Kim Jackson-Blott

Supervisors: Bronwen Davies, Sara Morgan and Dougal Hare

METHODOLOGY

This study will use Q Methodology, which is an explorative technique integrating both quantitative and qualitative approaches to enable the systematic study of subjectivity (Brown 1996). Q methodology was deemed appropriate for this study as it assesses patterns across participants rather than across items, and can thus identify shared or contrasting narratives or understandings about an area of interest – in this case, recovery from psychosis in forensic settings. Q methodology comprises a number of stages (Brown, 1980; Watts & Stenner, 2012) and will consist of two phases of participant engagement.

Stage 1: Developing a Q-Concourse

The initial stage of the research process is to define the topic of interest and gather existing views held about it; in Q terminology, this is called the Q-concourse. This study will use two main sources of information to develop the Q-Concourse (i.e. existing literature and interviews). Relevant literature on recovery (i.e. journals, recovery scales/measures and practice guidelines) will be examined and prominent themes will be extracted. Healthcare professionals will be interviewed (Phase one of participant engagement) and asked to discuss these themes in an open-ended style (e.g. 'what are your thoughts and views about...?'). The aim of is to gain a wide range of viewpoints regarding recovery from psychosis in forensic settings.

Stage 2: Developing A Q-Set

Utilising the data from the Q-concourse, the researchers will produce a list of statements representing all the varying viewpoints about the topic of interest, which is termed the Q-Set. In line with recommendations (Dennis 1986; Kerlinger, 1986), a Q-set of 40-90 items will be developed. These statements will then be printed onto individual cards and the cards will be randomly assigned a number.

Stage 3: The Q-Sort interview

The second phase of participant involvement will require the recruited participants (healthcare professionals and service users) to sort the statements cards in the Q-Set in terms of perceived importance/level of agreement (i.e. engage in a process called the Q-Sort). The Q-sort is a self-directed process during which the participant ranks/sorts the cards into a Q-sort grid of “most important” and “least important” to recovery. Once completed, respondents will be asked to explain their reasoning for each item choice made and to reflect on their experience of the Q-sort process. These commentaries will be recorded and transcribed and used as supplementary data during the interpretation stage.

Stage 4: Factor Analysis

The individual Q-sorts completed by participants will then be subjected to factor analysis. The resulting factors will identify clusters/groups of participants who ranked statements in similar ways, suggesting the existence of a shared view among a group of people.

Stage 5: Interpret The Resulting Factors

Using the participants commentaries obtained during the Q-sort interviews, the emerging factors will be interpreted to understand the views of the overall group, as well as any similarities and differences in viewpoints within the group (Van Exel & de Graaf, 2005).

PARTICIPANT RECRUITMENT:

Service Users:

██████████ (onsite Clinical Psychologist and Clinical Supervisor) and/or the professional staff members working in ██████████ (Medium Secure forensic setting) and/or ██████████ (Low secure forensic setting) will identify service users who meet the inclusion criteria of this study. Professionals who are familiar to these individuals will provide them with a participant information sheet ('Participant Information: Service User' or 'Participant Information: Service User - Accessible'). This will include all relevant information about the study and an expression of interest reply slip. If slips are returned and indicate an interest in taking part in the study, the researcher will organise a convenient time to meet with potential participants at an appropriate location within ██████████ or ██████████.

Inclusion criteria

- Males and females aged 18 years of age or older
- Currently an inpatient in a forensic unit (low/medium secure) within [REDACTED]
- Has a history/diagnosis of psychosis/psychotic symptoms
- Has capacity to consent to participation as agreed by their clinical team
- Participant's clinical team agree to their involvement
- Sufficiently fluent in English to be able to complete an interview for approximately 45minutes

Exclusion criteria

- Anyone experiencing acute distress and/or psychotic symptoms, and is therefore unable to provide informed consent
- Anyone who does not have the level of cognitive ability and communication skills to enable them to provide informed consent

Staff Members:

[REDACTED] (onsite Clinical Psychologist and Clinical Supervisor) [REDACTED] [REDACTED] (Clinical Psychologist and Clinical Supervisor) will identify potential staff members who meet the inclusion criteria of this study. These individuals will be provided with a participant information sheet ('Participant Information: Staff- Phase 1' / 'Participant Information: Staff- Phase 2') for the appropriate stage of the research process. If reply slips are returned and indicate an interest in taking part in the study, the researcher will organise a convenient time to conduct a telephone interview or to meet with potential participants at an appropriate location within [REDACTED].

Inclusion criteria

- Older than 18 years of age
- Qualified in their profession (e.g. Psychologists, Psychiatrists and Nurses)
- Currently working in a forensic unit (low/medium secure) within [REDACTED]
- Sufficiently fluent in English to be able to complete an interview for approximately 45minutes



Exclusion criteria

- None

Consent:

Prior to engagement in the interviews, the researcher will meet with prospective participants to ensure that they meet the inclusion criteria, are aware of what their participation would involve, and to obtain informed consent for their involvement ('Consent Form: Service User'; 'Consent Form: Service User - Accessible'; 'Consent Form: Staff - Phase 1'; 'Consent Form: Staff - Phase 2').

Appendix 8: Participant Information Sheets

 	<p>School of Psychology Ysgol Seicoleg</p> <p>South Wales Doctoral Programme in Clinical Psychology <i>De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol</i></p>	<p>Cardiff University Tower Building 70 Park Place Cardiff CF10 3AT Wales UK www.psych.cf.ac.uk Prifysgol Caerdydd Adellad y Tŵr 70 Plas y Parc Caerdydd CF10 3AT Cymru Y Deyrnas Unedig</p>
<h3>PARTICIPANT INFORMATION SHEET (STAFF- PHASE 1)</h3> <h4>Recovery from psychosis in forensic settings: assessing staff and service user's views using Q methodology</h4> <p>By Kim Jackson-Blott, Bronwen Davies, Sara Morgan and Dougal Hare</p> <p>We would like to invite you to take part in this project. It is a research study by a Trainee Clinical Psychology student at Cardiff University, who is interested in recovery from psychosis in forensic settings. The term psychosis is used here to describe an experience of hearing voices, having hallucinations or holding beliefs that others find unusual. Before you decide whether to take part, we would like to explain the project and what this would involve.</p> <h4>Outline of the project</h4> <p>Phase 1 For the first phase of this research, I am interested in finding out what healthcare professionals think about recovery from psychosis in forensic settings. You have been invited to take part because you have experience of working in a forensic setting, and with individuals who have experienced psychotic phenomena. We hope to interview up to 15 healthcare professionals for this phase of the project. The resulting information will help to shape the second phase of the research, which will involve a card sort exercise to elicit individual's viewpoints.</p> <p>Phase 2 Following phase 1, a number of statements about recovery from psychosis in forensic settings will be placed on information cards. I would be very interested in knowing more about your thoughts, and I would like to interview you whilst you sort and rate these cards. This will help us identify what you think is important and what is not. I will also interview service users about their views. In total, I hope that approximately 20 people will take part in the card sort interview. It is hoped that this study will lead to an increased understanding of how people view recovery from psychosis in forensic settings, and the factors that that are considered important to this process.</p>		

What will happen?

If you decided that you would like to participate in phase 1 and/or phase 2 of the research, I would be happy to meet with you at a convenient time and location to conduct the interview. I would be happy to conduct the interview for phase 1 over the telephone if this would be more convenient for you. Telephone interviews are not an option for phase 2 of this research as this phase involves a card sort exercise. Before the interview begins, you will have the opportunity to ask any questions you may have, and to give your consent to participate. I anticipate that this process and the interview will take approximately 60 minutes in total. During this time you will be welcomed to take a break if needed, and to say as much or as little as you feel comfortable. You could also end the interview at any time and withdraw from the project without having to give a reason. Withdrawal will not lead to any adverse consequences.

Deciding to take part

It is entirely up to you whether you decide to take part in this research. There will be no negative repercussions should you choose not to take part. If you decide that you would like to take part in the research, please fill in the reply slip below and hand it back to Sara Morgan (Clinical Psychologist), who will return it to me. Please feel free to ask Sara any questions you may have regarding this project and/or your participation.

Will my taking part remain confidential?

All of the information you provide will be kept confidential. The only time I cannot guarantee confidentiality is if I believe you are at risk of harm to yourself or to someone else. In these instances I will have to break confidentiality. However I will, where possible, talk to you about this first if I did need to break confidentiality.

The interview will be audio recorded. The audio recordings will be kept as password protected documents accessible only by the researcher. The recordings will be transcribed and any personal information that could identify you will be removed. Once transcribed, the recordings will be deleted. All data would be stored securely while the study is written up. Furthermore, your consent form will be kept in a locked filing cabinet at the researcher's university base. Some direct quotations may be included in the final report, but you would not be identifiable as the speaker. The anonymised transcripts will be kept in a locked filing cabinet at the researcher's university base for 15 years after the study is complete.

What will happen to the results of the research study?

When we have finished the study, we can send you a summary of our findings if you would like. The results of the research will be submitted as part of a Doctorate in Clinical Psychology. It is also intended that the research be published. No participants will be identified in any way as part of this process.

Who is funding and monitoring the research?

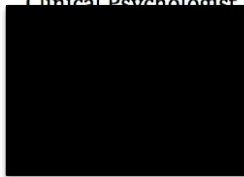
The research is funded by Cardiff University as required by the Research Governance Framework for Health and Social Care. However, no individual will receive any payment for his or her participation in the study. The project has been approved by a NHS Research Ethics Committee. It will also regularly be monitored by my supervisors to ensure that quality, standards and safety are maintained.

Experiencing Distress:

If you were to experience any distress as a result of participating in this project, please inform a member of the research team (details below) and we will do our best to provide you with appropriate support.

Project Lead: Kim Jackson-Blott
Trainee Clinical Psychologist
Cardiff University
11th Floor, School of Psychology
Tower Building
70 Park Place
Cardiff
CF10 3AT.
Telephone: (02920) 870582

Clinical Supervisor: Dr Sara Morgan
Clinical Psychologist



Academic Supervisor: Dr Dougal Hare
Research Director
Cardiff University
11th Floor, School of Psychology
Tower Building
Cardiff
CF10 3AT
(02920) 874007

What if I have concerns about this research?

If you have any concerns or complaints about this project, please direct these in the first instance to:

- Reg Morris (Honorary Professor and Director of the Doctoral Programme in Clinical Psychology). Address: 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT. Telephone: 02920 870582

You can also contact the Community Health Council:

- Address: Abertawe Bro Morgannwg University Health Board, First floor, Cimla Hospital, Neath, SA11 3SE. Telephone: 01639 683490. Email: office.abm@waleschc.org.uk

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION

Kind Regards,

Kim Jackson-Blott

Please keep the above information for your own records.

REPLY SLIP (Staff)

Name:

.....

Please tick

	Phase 1	Phase 2	Both phases
I am interested in taking part in this research	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am not interested in taking part in this research	<input type="checkbox"/>		

Telephone/ Email:

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PARTICIPANT INFORMATION SHEET (STAFF – PHASE 2)

Recovery from psychosis in forensic settings: assessing staff and service user's views using Q methodology

By Kim Jackson-Blott, Bronwen Davies, Sara Morgan and Dougal Hare

We would like to invite you to take part in this project. It is a research study by a Trainee Clinical Psychology student at Cardiff University, who is interested in recovery from psychosis in forensic settings. The term psychosis is used here to describe an experience of hearing voices, having hallucinations or holding beliefs that others find unusual. Before you decide whether to take part, we would like to explain the project and what this would involve.

Outline of the project

Following the information-gathering phase of this research (phase 1), a number of statements about recovery from psychosis in forensic settings have been placed on information cards. I would be very interested in knowing more about your thoughts, and I would like to interview you whilst you sort and rate these cards. This will help us identify what you think is important and what is not. You have been invited to take part in this research because you have experience of working in forensic settings, and with individuals who have experienced psychotic phenomena. I will also interview service users about their views. In total, I hope that approximately 20 people will take part in the card sort interview. It is hoped that this study will lead to an increased understanding of how people view recovery from psychosis in forensic settings, and the factors that are considered important to this process.

What will happen?

If you decided that you would like to take part, I would be happy to meet with you at a convenient time and location to conduct the card sort exercise. Before the card-sort begins, you will have the opportunity to ask any questions you may have, and asked to sign a consent form. I anticipate that this process and the card sort exercise will take approximately 60 minutes in total. During this time you will be welcome to take a break if needed, and to say as much or as little as you feel comfortable. You could also end the card sort at any time and withdraw from

the project without having to give a reason. Withdrawal will not lead to any negative consequences.

Deciding to take part

It is entirely up to you whether you decide to take part in this research. There will be no negative repercussions should you choose not to take part. If you decide that you would like to take part in the research, please fill in the reply slip below and hand it back to Sara Morgan (Clinical Psychologist), who will return it to me. Please feel free to ask Sara any questions you may have regarding this project and/or your participation.

Will my taking part remain confidential?

All of the information you provide will be kept confidential. The only time I cannot guarantee confidentiality is if I believe you are at risk of harm to yourself or to someone else. In these instances I will have to break confidentiality. However I will, where possible, talk to you about this first if I did need to break confidentiality.

The card sort interview will be audio recorded. The audio recordings will be kept as password protected documents accessible only by the researcher. The recordings will be transcribed and any personal information that could identify you will be removed. Once transcribed, the recordings will be deleted. All data would be stored securely while the study is written up. Furthermore, your consent form will be kept in a locked filing cabinet at the researcher's university base. Some direct quotations may be included in the final report, but you would not be identifiable as the speaker. The anonymised transcripts will be kept in a locked filing cabinet at the researcher's university base for 15 years after the study is complete.

What will happen to the results of the research study?

When we have finished the study, we can send you a summary of our findings if you would like. The results of the research will be submitted as part of a Doctorate in Clinical Psychology. It is also intended that the research be published. No participants will be identified in any way as part of this process.

Who is funding and monitoring the research?

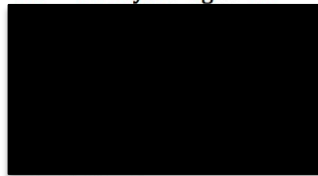
The research is funded by Cardiff University as required by the Research Governance Framework for Health and Social Care. However, no individual will receive any payment for his or her participation in the study. The project has been approved by a NHS Research Ethics Committee. It will also regularly be monitored by my supervisors to ensure that quality, standards and safety are maintained.

Experiencing Distress

Previous studies have found that people often enjoy the card sort exercise and it can help them gain a clearer understanding of their views. However, if you were to experience any distress as a result of participating in this project, please inform a member of the research team (details below) and we will do our best to provide you with appropriate support.

Project Lead: Kim Jackson-Blott
Trainee Clinical Psychologist
Cardiff University
11th Floor, School of Psychology
Tower Building
70 Park Place
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CF10 3AT.
(02920) 870582

Clinical Supervisor: Dr Bronwen Davies
Clinical Psychologist



Clinical Supervisor: Dr Sara Morgan
Clinical Psychologist



Academic Supervisor: Dr Dougal Hare
Research Director
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THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION

Kind Regards,

Kim Jackson-Blott
Trainee Clinical Psychologist (Project Lead)

Please keep the above information for your own records.

REPLY SLIP (Staff -Phase 2)

Name:

.....

Please tick

I am interested in taking part in this research	
I am not interested in taking part in this research	

Telephone/ Email:

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PARTICIPANT INFORMATION SHEET – Service User

Recovery from psychosis in forensic settings: assessing staff and service user's views using Q methodology

By Kim Jackson-Blott, Bronwen Davies, Sara Morgan and Dougal Hare

We would like to invite you to take part in this project. It is a research study by a Trainee Clinical Psychology student at Cardiff University, who is interested in recovery from psychosis in forensic settings. The term psychosis is used here to describe an experience of hearing voices, hallucinations or holding beliefs that others find unusual. The study does not have any impact on the care and support you are receiving or will receive in the future. Before you decide whether to take part, we would like to explain the project and what this would involve.

If you would prefer for someone to read this information sheet with you, please feel free to ask. In this case, Sara Morgan (research project Clinical Supervisor) will be happy to meet with you and to answer any questions you may have.

Outline of the project

I would be very interested in finding out about your thoughts on recovery from psychosis in a forensic service. To do this, I would like to interview you whilst you sort and rate some information cards. This will help us identify what you think is important and what is not. You have been invited to take part in this research because you have experienced an episode of psychosis and have experience of receiving care from a forensic service. I will also interview healthcare professionals about their views. In total, I hope to speak to approximately 20 people. It is hoped that this study will lead to an increased understanding of how people view recovery from psychosis in forensic settings, and the factors that that are considered important to this process.

What will happen?

If you decided that you would like to take part, I would be happy to meet with you at a convenient time in a private place on your ward to conduct the card sort interview. Before the card-sort begins, you will have the opportunity to ask any questions, and will be asked to sign a consent form. I anticipate that this process

and the card sort interview will take approximately 60 minutes in total. During this time you will be welcome to take a break if needed, and to say as much or as little as you feel comfortable. You could also end the card sort at any time and withdraw from the project without having to give a reason. Withdrawal will not lead to any negative consequences to the care that you receive or will receive in the future.

Deciding to take part

It is entirely up to you whether you decide to take part in this research. There will be no negative repercussions should you choose not to take part. If you decide that you would like to take part in the research, please fill in the reply slip below and hand it back to the staff member that gave you this information.

Will my taking part remain confidential?

All of the information you provide will be kept confidential. The only time I cannot guarantee confidentiality is if I believe you are at risk of harm to yourself or to someone else. In these instances I will have to break confidentiality. However I will, where possible, talk to you about this first if I did need to break confidentiality.

The card sort interview will be audio recorded. The audio recordings will be kept as password protected documents accessible only by the researcher. The recordings will be transcribed and any personal information that could identify you will be removed. Once transcribed, the recordings will be deleted. All data would be stored securely while the study is written up. Furthermore, your consent form will be kept in a locked filing cabinet at the researcher's university base. Some direct quotations may be included in the final report, but you would not be identifiable as the speaker. The anonymised transcripts will be kept in a locked filing cabinet at the researcher's university base for 15 years after the study is complete.

What will happen to the results of the research study?

When we have finished the study, we can send you a summary of our findings if you would like. The results of the research will be submitted as part of a Doctorate in Clinical Psychology. It is also intended that the research be published. No participants will be identified in any way as part of this process.

Who is funding and monitoring the research?

The research is funded by Cardiff University as required by the Research Governance Framework for Health and Social Care. However, no individual will receive any payment for his or her participation in the study. The project has been approved by a NHS Research Ethics Committee. It will also regularly be monitored by my supervisors to ensure that quality, standards and safety are maintained.

Experiencing Distress

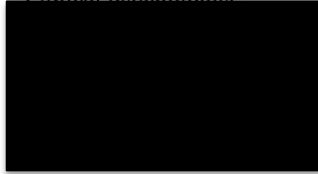
Previous studies have found that people often enjoy the card sort exercise and it can help them gain a clearer understanding of their views. However, if you were to experience any distress as a result of participating in this project, please inform a member of the research team (details below) and we will do our best to provide you with appropriate support.

Project Lead: Kim Jackson-Blott
Trainee Clinical Psychologist
Cardiff University
11th Floor, School of Psychology
Tower Building
70 Park Place
Cardiff
CF10 3AT.
(02920) 870582

Clinical Supervisor: Dr Bronwen Davies
Clinical Psychologist



Clinical Supervisor: Dr Sara Morgan
Clinical Psychologist



Academic Supervisor: Dr Dougal Hare
Research Director
Cardiff University
11th Floor, School of Psychology
Tower Building
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CF10 3AT
(02920) 874007

What if I have concerns about this research?

If you have any concerns or complaints about this project, please direct these in the first instance to:

- Prof Reg Morris (Honorary Professor and Director of the Doctoral Programme in Clinical Psychology). Address: 11th Floor, School of Psychology, Tower Building, 70 Park Place, Cardiff, CF10 3AT. Telephone: 02920 870582

You can also contact the Community Health Council:

- Address: Abertawe Bro Morgannwg University Health Board, First floor, Cimla Hospital, Neath, SA11 3SE. Telephone: 01639 683490. Email: office.abm@waleschc.org.uk

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION

Kind Regards,

Kim Jackson-Blott
Trainee Clinical Psychologist (Project Lead)

Please keep the above information for your own records and return the reply slip below to the member of staff that gave you this information.

REPLY SLIP (Service user)

Name:

.....

Please tick

I am interested in taking part in this research	
I am not interested in taking part in this research	



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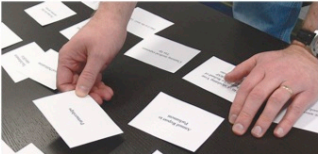




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PARTICIPANT INFORMATION SHEET- Service User



Recovery from psychosis in forensic settings: assessing staff and service user's views using Q methodology

By Kim Jackson-Blott, Bronwen Davies, Sara Morgan and Dougal Hare

	<p>Hi, my name is Kim Jackson-Blott. I am a Trainee Clinical Psychologist.</p>
	<p>I am doing research to find out what people think about recovery from psychosis in forensic settings, and what is important to this process. You have been asked because you have experienced an episode of psychosis and have experience of receiving care from a forensic service.</p>
	<p>Before you decide whether to take part, we would like to explain the project and what this would involve.</p>

	<p>It is entirely up to you whether you decide to take part in this research. You would be free to withdraw from the study at any time, without having to give a reason. The care you receive now or in the future will not be affected if you choose not to take part or withdraw from the study.</p>
	<p>If you decide to take part, I would like to interview you whilst you sort and rate some information cards about recovery. I hope to interview you and about 5 other service users to help me with this research.</p>
	<p>I will also be interviewing healthcare professionals who have worked in forensic services.</p>
	<p>The interviews will be done in a private place on your ward.</p>
	<p>It will take approximately 60 minutes to answer any questions you may have, gain your consent to take part in the study and to complete the interview. You can have a break or stop at any time.</p>
	<p>The interview would be recorded on a Dictaphone to ensure I remember all your important points.</p>
	<p>When I have written down what you said during your interview I will delete the recording. The written interview will then be stored in a locked drawer and will not have your name on it.</p>

	<p>All of the information you provide will be kept confidential. Any personal information that could identify you would be removed. This means that no one will know it is you whose information it is except us.</p>
	<p>The only time I would not be able to keep what you say private is if you say that you or someone else has/will come to harm.</p> <p>I will need to tell someone else if this were to happen. However, I will try to tell you first if I needed to tell someone else.</p>
	<p>We cannot promise that the study will help you, but by participating in the study, you may find that you learn more about your views on recovery. The information we get from this study will hopefully lead to better understanding of how to support people in their recovery from psychosis in forensic services.</p>
	<p>You will not receive any payment for your involvement in the project.</p>
	<p>I care about your safety and wellbeing. Therefore, if you were to become at all distressed during the interview, I could stop the interview and arrange for a staff member to provide you with some support.</p>
	<p>When we have finished the study, we can send you a summary of our findings if you would like. Please let the researcher know if you would like this.</p>

	<p>This research will be submitted as part of a Doctorate in Clinical Psychology. It is also hoped that this research will be published. You would not be identified in any submission/publication.</p>
	<p>All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your safety, rights, wellbeing and dignity. This study has been reviewed and agreed by them.</p>
	<p>If you have a concern about any aspect of this study, you could ask to speak to the researchers (details below) who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the NHS Complaints Procedure. Details can be obtained from [REDACTED]</p>
	<p>If you are happy to take part in this research project, please complete the reply slip below and return it to the staff member who gave you this form.</p>
<div data-bbox="309 1375 459 1554">  <p>Kim Jackson-Blott</p> </div> <div data-bbox="512 1366 649 1554">  <p>Dr Sara Morgan</p> </div>	<p>Please contact Kim Jackson-Blott (Cardiff University - 02920 870582) or Sara Morgan ([REDACTED]) if you have any questions, or ask a staff member to help you contact us.</p>



**Thank
You!!!**

**Thank you very much for taking the time to
read this information leaflet. Please keep it for
your own records.**

REPLY SLIP (Service User)

Name:

Please tick

	I am interested in taking part in this research	
	I am not interested in taking part in this research	

Appendix 9: Consent Forms



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CONSENT FORM (STAFF - PHASE 1)

Recovery from psychosis in forensic settings: assessing staff and service user's views using Q methodology

By Kim Jackson-Blott, Bronwen Davies, Sara Morgan and Dougal Hare

Participant Identification Number:.....

Please initial each of the following statements if you agree:

	Please initial
1. I confirm that I have read and understood the information sheet for the above named study	
2. I have been given the opportunity to ask any questions, and have had any questions answered to my satisfaction	
3. I understand that my participation is voluntary and that I am free to withdraw from participating in the study at any time, without having to give a reason, and without my employment and legal rights being affected.	
4. I understand that all the information I disclose will be kept confidential unless the researcher is worried about my or someone else's safety.	
5. I consent to the interview being recorded and transcribed. I understand that the audio recordings will be destroyed once they have been transcribed, but the anonymised transcriptions will be kept securely for a period of 15 years.	
6. I am happy that all the information I disclose will be kept anonymised, with the possible use of anonymised word for word quotation in the research report.	
7. I understand that the final report will be submitted for publication.	
8. I agree to take part in the above study	

Name of Participant (PLEASE PRINT)	Date	Signature
Name of Researcher (PLEASE PRINT)	Date	Signature



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CONSENT FORM (STAFF - PHASE 2)

Recovery from psychosis in forensic settings: assessing staff and service user's views using Q methodology

By Kim Jackson-Blott, Bronwen Davies, Sara Morgan and Dougal Hare

Participant Identification Number:.....

Please initial each of the following statements if you agree:

	Please initial
1. I confirm that I have read and understood the information sheet for the above named study	
2. I have been given the opportunity to ask any questions, and have had any questions answered to my satisfaction	
3. I understand that my participation is voluntary and that I am free to withdraw from participating in the study at any time, without having to give a reason, and without my employment and legal rights being affected.	
4. I understand that all the information I disclose will be kept confidential unless the researcher is worried about my or someone else's safety.	
5. I understand that participation will involve my card sort interview being audio-recorded. I understand that the audio recordings will be destroyed once they have been transcribed, but the anonymised transcriptions will be kept securely for a period of 15 years.	
6. I am happy that all the information I disclose will be kept anonymised, with the possible use of anonymised word for word quotation in the research report.	
7. I understand that the final report will be submitted for publication.	
8. I agree to take part in the above study	

Name of Participant (PLEASE PRINT)	Date	Signature
Name of Researcher (PLEASE PRINT)	Date	Signature



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CONSENT FORM (Service user)

Recovery from psychosis in forensic settings: assessing staff and service user's views using Q methodology

By Kim Jackson-Blott, Bronwen Davies, Sara Morgan and Dougal Hare

Participant Identification Number:.....

Please initial each of the following statements if you agree:

	Please initial
1. I confirm that I have read and understood the information sheet (service user version) for the above named study	
2. I have been given the opportunity to ask any questions, and have had any questions answered to my satisfaction	
3. I understand that my participation is voluntary and that I am free to withdraw from participating in the study at any time, without having to give a reason, and without my healthcare and legal rights being affected.	
4. I understand that all the information I disclose will be kept confidential unless the researcher is worried about my or someone else's safety.	
5. I understand that participation will involve my card sort interview being audio-recorded. I understand that the audio recordings will be destroyed once they have been transcribed, but the anonymised transcriptions will be kept securely for a period of 15 years.	
6. I am happy that all the information I disclose will be kept anonymised, with the possible use of anonymised word for word quotation in the research report.	
7. I understand that the final report will be submitted for publication.	
8. I agree to take part in the above study	

Name of Participant (PLEASE PRINT)	Date	Signature
Name of Researcher (PLEASE PRINT)	Date	Signature



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School of Psychology
Ysgol Seicoleg

South Wales Doctoral Programme in Clinical Psychology
De Cymru Rhaglen Doethuriaeth mewn Seicoleg Glinigol



Cardiff University
Tower Building
70 Park Place
Cardiff CF10 3AT
Wales UK
www.psych.cf.ac.uk
Prifysgol Caerdydd
Adelaid y Tŵr
70 Plas y Parc
Caerdydd CF10 3AT
Cymru Y Deyrnas Unedig









CONSENT FORM (Service user - Accessible)



Recovery from psychosis in forensic settings: assessing staff and service user's views using Q methodology

By Kim Jackson-Blott, Bronwen Davies, Sara Morgan and Dougal Hare

Participant Identification Number:.....

Please initial each of the following statements:

		Yes 	No 
	Have you read (or had read to you) the participant information sheet and understand what this research study will involve?	[]	[]
	Have you asked all the questions you want, and had them answered to your satisfaction?	[]	[]
	Do you understand that your participation is voluntary and you are free to withdraw from the study at any time, without having to give a reason, and without your healthcare being affected?	[]	[]
	Do you understand that all the information you provide will be kept confidential unless the researcher is worried about your or someone else's safety?	[]	[]
	Do you understand that the card sort interview will be recorded, the recording will be deleted once it is written up (without your name on it), and this anonymised information will be kept securely for 15 years?	[]	[]
	Do you understand that the things you say and do will be kept anonymous, and this anonymised information will be written up in the research report?	[]	[]

	Do you understand that the final report will be submitted for publication?	[]	[]
	Do you agree to take part in the above study?	[]	[]

Name of Participant (PLEASE PRINT)	Date	Signature
Name of Researcher (PLEASE PRINT)	Date	Signature

Appendix 10: NHS Research and Development Ethical Approval Letters



Gwasanaeth Moseg Ymchwil
Research Ethics Service



Wales Research Ethics Committee 2
Castlebridge 4
15-19 Cowbridge Road East
Cardiff
CF11 9AB

Telephone: 029 2078 5738
E-mail: sandra.raybould@wales.nhs.uk
Website: www.hra.nhs.uk

16 July 2017

Miss Kim Jackson-Blott
Trainee Clinical Psychologist
Cardiff & Vale NHS Foundation Trust
South Wales Doctoral Programme in Clinical Psychology
Cardiff University,
11th Floor Tower Building
70 Park Place,
Cardiff, CF10 3AT

Dear Miss Jackson-Blott,

Study title: Recovery from psychosis in forensic settings: assessing staff and service user's views using Q methodology

REC reference: 17/WA/0229
Protocol number: SPON1604-17
IRAS project ID: 222323

The Research Ethics Committee reviewed the above application at the meeting held on 12 July 2017. The Committee wishes to thank you and Dr Bronwen Davies for attending to discuss the application.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact hra.studyregistration@nhs.net outlining the reasons for your request. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise).

Guidance on applying for HRA Approval (England)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations.

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

The Committee made the following recommendation:

The layout of the Participant Information Sheet might need to be revised, so that tearing-off the reply slip does not remove the contact details on the reverse.

This is a suggestion only and not a condition of ethical approval.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Summary of discussion at the meeting

Ethical issues raised by the Committee in private discussion, together with responses given by you and Dr Davies when invited into the meeting

Recruitment arrangements and access to health information, and fair participant selection

The Committee discussed the recruitment method, the fairness of the inclusion and exclusion criteria, and whether any incentives or payments are made.

The Committee was satisfied that the selection of participants has taken into account the patients' clinical care, participants will be recruited fairly and sufficient details are provided in the protocol regarding the inclusion and exclusion criteria.

The Committee requested a clarification in relation to the methodology: why is more staff than patients being interviewed and why staff does not take part in the second part of the study. You clarified that this is a particular of the Q Methodology. The first phase is get statement cards representing a broad range of views; there is ample information from published literature about what service users feel is important; this information can be drawn upon rather than asking service users to contribute. The second phase involves a card sorting exercise and both staff and service users will be asked to take part - as this part of the study will generate the data to be analysed.

The Committee queried whether patients with a range of conditions will be recruited into the study to ensure a representative group.

You clarified that the inclusion criteria is a current or past diagnosis of psychosis.

The Q methodology is not concerned with representativeness or generalisability, but rather with ascertaining the range of statements illustrating what the priorities are.

The Academic Supervisor added that this is a cohort of convenience, not representativeness.

Favourable risk benefit ratio; anticipated benefit/risks for research participants

The Committee queried whether justifying 90 statement cards in 45 minutes might be a burden on participants.

You clarified that it is not possible to state definitively how many statement cards will be generated in the first phase of the study, there may be between 45 to 90 items. Participants will not be asked to justify the choice for each card, only for those statements with which they most agree or most disagree.

Care and protection of research participants; respect for potential and enrolled participants' welfare and dignity; data protection and confidentiality

The Committee discussed the respect for potential and enrolled research participants' welfare and dignity and the arrangements made to protect privacy through confidentiality.

A further query was raised in relation to how the team will identify patients who want to receive a copy of the study summary and how will this be sent.

You clarified that participants will be asked after the interview whether they would like to have a summary of the study findings; if they confirm, arrangements will be made with staff in the unit to ensure that the participant receives a summary of the study.

Dr Davies added that it is standard practice to develop posters with study findings - which are then on display in the unit, so patients can see the results of studies in which they have been involved.

The Committee noted that access to patient information and ability to break code rests solely with the Chief Investigator, and queried the code-break process in your absence, should risks arise. You explained that the participant ID is documented on the Consent Forms; these are stored securely at the University site; it is not envisaged that an emergency code break would be necessary, if there are risk issues identified they will be dealt with on the spot; the student will liaise with the clinical supervisor to discuss any such occurrences.

Informed consent process and the adequacy and completeness of participant information

The Committee discussed the provision of information to research participants about the purpose of the research, its procedures and potential risks and benefits, and whether it included all procedures as described in the protocol.

The Committee acknowledged that written informed consent will be taken as part of a process - with participants having adequate time to consider the information, and opportunity to ask questions.

The Committee queried whether there is a coercion to take part - as the participants are patients who have been detained under the criminal part of the Mental Health Act, any privileges earned depend on hospital staff.

Dr Davies clarified that this had not been their experience. A number of studies have been run in recent years and it was always clear that this is a choice to take part; patients have felt at liberty to opt-out of a studies in which they did not want to be involved. The Participant Information Sheet and the consent process clarifies that the standard of care will not be affected by a decision to take part, nor by the option to not take part or withdraw from the study.

The Committee agreed that the procedures described in the protocol had been adequately addressed in the Information Sheet but asked whether it would be possible to give examples of the possible content of the statement cards in the Participant Information Sheet, so that participants would know what to expect.

You clarified that interviews with the health care professionals will generate a range of areas or themes, from which statements will be refined and statement cards will be developed.

The Academic Supervisor added that the Q methodology has been used before in the unit so patients are familiar with the type of short /simple statements which appear on statement cards. Patients who have taken part in previous studies stated that it was a positive process which increased their self-confidence.

The Committee commended you on producing an easy-read version of the Participant Information Sheet, but queried whether it is envisaged that some participants will have learning difficulties, as this is not mentioned in the application form, and if this is the case there might be a concern in relation to their capacity to consent.

Dr Davies clarified that some patients have a low IQ or might have borderline/mild learning difficulties. The research team wanted to make the information accessible and a pictorial version guides people more easily through the information about what the study entails.

All potential participants have capacity (under the provisions of the Mental Capacity Act)

You added that the clinical team will confirm capacity for each patient who would like to take part in the study.

It was noted that it is intended to use direct quotations from interviews and the Committee queried whether this would be identifying patients.

You confirmed that these would not be attributable to individual patients and other identifiable statements made in relation to healthcare professionals or peers will be anonymised.

The Committee noted that the layout of the Participant Information Sheet might need to be revised, as tearing-off the reply slip also removed the contact details on the reverse. Grammatical and semantic constructs might also benefit from revision (the word 'hope to' is used too often)

Other ethical issues were raised and resolved in preliminary discussion before your attendance at the meeting.

No ethical issues were raised in relation to:

- Social or scientific value; scientific design and conduct of the study
- Suitability of the applicant and supporting staff
- Independent review
- Suitability of supporting information
- Other general comments
- Suitability of the summary of the research

Please contact the REC Manager if you feel that the above summary is not an accurate reflection of the discussion at the meeting.

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper [Covering Letter]		23 June 2017
Evidence of Sponsor insurance or indemnity [Cardiff University Insurance]	1	18 July 2016
IRAS Checklist XML [Checklist_26062017]		26 June 2017
Letter from sponsor [Sponsor acceptance letter]		06 June 2017
Participant consent form [Consent Form- Staff- Phase 1]	1	09 June 2017
Participant consent form [Consent Form- Staff- Phase 2]	1	09 June 2017
Participant consent form [Consent Form- Service user]	1	09 June 2017
Participant consent form [Consent Form- Service user- Accessible]	1	09 June 2017
Participant information sheet [Participant Information- Staff]	1	09 June 2017
Participant information sheet [Participant Information- Staff- Phase 2]	1	09 June 2017
Participant information sheet [Participant Information- Service user]	1	09 June 2017
Participant information sheet [Participant Information- Service user- Accessible]	1	09 June 2017
REC Application Form [REC_Form_23062017]		23 June 2017
Research protocol or project proposal [Research Proposal]	1	06 June 2017
Summary CV for Chief Investigator (CI) [CV- Kim Jackson-Blott]	1	17 May 2017
Summary CV for student [CV- Kim Jackson-Blott]	1	17 May 2017
Summary CV for supervisor (student research) [CV- Dr Dougal Hare]	1	26 June 2017
Summary, synopsis or diagram (flowchart) of protocol in non technical language [Research Protocol]	1	06 June 2017

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

No declarations of interest were made in relation to this application.

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

17/WA/0229

Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely



Dr Iolo Doull
Chair

E-mail: sandra.raybould@wales.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments

"After ethical review – guidance for researchers"

*Copy to: Sponsor: Mrs Helen Falconer, Cardiff University
R&D Lead: Ms Samantha Rees, ABMU Health Board*

Wales REC 2

Attendance at Committee meeting on 12 July 2017

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>
Professor A Bayer	Professor of Geriatric Medicine	No
Mr Haydn Cullen-Jones	Lay Member	Yes
Dr I Doull	Consultant Respiratory Paediatrician - Chair	Yes
Dr N A Drage	Consultant Dental Radiologist	No
Dr C Fraser	Lay Member - Vice Chair	Yes
Dr N Goyal	Consultant Radiologist	No
Dr W J Kell	Consultant Haematologist	No
Mrs S J Kotecha	Research Fellow	Yes
Dr D Maldonado-Perez	Lay Member	Yes
Mr M McGreevy	Lay Member	No
Mr J Owen	Lay Member - Alternate Vice Chair	Yes
Dr R Price-Davies	Pharmacist	No
Miss K Sidhu	Lay Member	No
Dr D Tatovic	Consultant Diabetes & Endocrinology	Yes

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs Sandra Raybould	REC Assistant Administrator
Dr Rossela Roberts	Research Ethics Service Manager



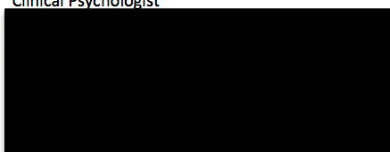
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University Health Board

R&D
RESEARCH & DEVELOPMENT
Abertawe Bro Morgannwg University Health Board

Dyddiad/Date: 11th September 2017

Dr Sara Morgan
Clinical Psychologist



ABMU Health Board Research & Development
Swansea University
Floor 1, Institute of Life Science 2
Singleton Park
Swansea
SA2 8PP
☎ 01792 530888
✉ abm.rd@wales.nhs.uk

Dear Dr Morgan,

Re: Recovery from psychosis in forensic settings
IRAS Ref: 222323
Sponsor: Cardiff University

Thank you for submitting the above named research proposal to ABMU Health Board for NHS R&D permission. The attached listed documents were reviewed.

Health Board R&D Governance checks have been completed and passed. Please accept this letter as confirmation of local NHS R&D Health Board permission.

As part of Research Governance, you are required to:

1. Adhere to the protocol approved and inform the R&D office and the relevant Research Ethics Committee of any changes to the study, including the end date, for review/approval and record update.
2. For Health Board Sponsored studies, notify the R&D office of serious adverse events immediately upon knowledge, in accordance with local Standard Operating Procedure on Pharmacovigilance and as outlined in your Study Initiation meeting.
3. For Externally Sponsored studies, the Health Board should only be notified of SAEs or Suspected Unexpected Serious Adverse Reaction (SUSAR) arising in local ABMU Patients.
4. Complete any interim and final reports requested by the R&D office. If sponsored by ABMU Health Board, you will be asked to complete a 6 monthly progress report for submission to the Joint Scientific Review Committee along with your final report at study completion.
5. Ensure that your research complies with any relevant regulatory requirements and legislation relating to: Clinical Trials, Data Protection Act 1998, Health & Safety, Caldicott Guidelines, the use of Human Tissue for research purposes, Mental Capacity and ICH Good Clinical Practice (GCP). The R&D team can advise you on applicable regulatory and statutory requirements relevant to your study.
6. Comply with Data Protection requirements, notably no personal or patient identifiable data should leave the Health Board unless explicit consent from the individual or patient has been taken and documented. Unless consent is present, all study related documents must be either fully or linked anonymised. *Identifiable patient data includes name, address, full postcode, date of birth, NHS number and local patient identifiable codes as well as photographs, videos, audio tapes or other images of patients. Personal identifiable information includes the member of staff's name, address, full post code, date of birth, NI*

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number and staff number as well as photographs etc' – ABMU Data Protection & Confidentiality Policy, Version 2.1 September 2013.

7. Ensure that all training courses requested by the Sponsor are completed by all relevant members of the research team before any research activity is carried out. All research staff undertaking clinical trials of an investigational medicinal product (CTIMPs) must be GCP trained, and should continue to update their GCP training every 2 years. Copies of GCP certificates should be filed in the Trial Site File, with a copy forwarded to the R&D Department.
8. Ensure the research is undertaken in compliance with all Health Board R&D Standard Operating Procedures (SOPs). The latest versions of all SOPs can be obtained by contacting the R&D Department or from the R&D Intranet pages
9. If the study is sponsored by ABMU Health Board you must notify the R&D Office of your intention to open the study in other sites.
10. For ABMU Health Board Sponsored studies, sign a Conditions of Sponsorship Agreement & attend a Study Initiation meeting as organised by the R&D Department.

Clinical Research Portfolio Studies

If your study has been adopted onto the Clinical Research Portfolio (CRP), it will be a condition of our permission that the Chief Investigator site uploads local recruitment data onto the portfolio database.

For more information on the process of uploading recruitment data please look at the following link:

<http://www.healthandcareresearch.gov.wales/uploading-recruitment-data/>

Uploading of recruitment data will enable Health and Care Research Wales to monitor research activity within Health Boards, resulting in NHS R&D allocations to be driven by activity.

For more information and advice on the Health and Care Research Wales Portfolio please email:

portfolio@wales.nhs.uk

Amendments to the Study

Any changes made to the study after the issue of this letter will be treated as an amendment.

Amendments can be 'substantial' or 'non-substantial'. It is the duty of the Sponsor to classify the amendment and notify all relevant regulatory bodies accordingly, this duty may be delegated to the Chief Investigator or other authorised individual.

For a substantial amendment, the Sponsor or delegated individual will be required to submit a Notice of Substantial Amendment form to the REC, the lead permission co-ordinating function for the study and the MHRA (if applicable). For all ABMU sponsored studies substantial amendments must first be submitted to the Joint Study Review Committee (JSRC) for approval prior to submitting to REC and Health and Care Research Wales Permissions (Research-permissions@wales.nhs.uk).

For non-substantial amendments, the Sponsor or delegated individual are required to submit the amendment details to the lead permission co-ordinating function for the study. They will then pass the amendment details onto all relevant nations, for Wales this would be Health and Care Research Wales who will notify ABMU R&D Department for review.

Details of how to classify your amendment as substantial or non-substantial are available from Health Research Authority - <http://www.hra.nhs.uk/research-community/during-your-research-project/amendments/>

Indemnity Arrangements

The Sponsor indemnifies and holds harmless ABM University Health Board, its employees and agents for any harm caused by negligence on behalf of the Sponsor, including any harm caused to participants by the administration of the investigational product. However, please note that the Sponsor will not

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indemnify ABM University Health Board for any harm caused by negligence on behalf of the research team or other individual or agent. Researchers employed by ABM University Health Board, including those holding Honorary Contract status are indemnified against actions for negligent harm via standard arrangements with Welsh Risk Pool (WRP).

Please discuss any planned use of in-house work instructions/sops with the Sponsor company during Initiation to ensure localised documents correctly summarise the protocol requirements and this is agreed to, in writing, by the Sponsor Company.

ABM University Health Board reserves the right to suspend approval of any research study where deviation from appropriate RG & GCP standards is uncovered.

May I take this opportunity to wish you well in undertaking the research. We will write to you in the future to request updates on the progress of the research and look forward to receiving outcomes of the study.

Yours sincerely,

E. Brinkley

PP

Professor J Stephens
Deputy Assistant Medical Director (R&D)
ABMU Health Board

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Re: Recovery from psychosis in forensic settings
IRAS Ref: 222323
Sponsor: Cardiff University

SSI Documents Received

Document:	Subtitle:	Version:
Site-Specific Information Form (signed/authorised pdf or hard copy)		07 Aug 2017
Site-Specific Information form checklist		
R&D Application checklist		
R&D Form (Parts A-D) (signed/authorised pdf or hard copy)		20 Jun 2017

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Re: Recovery from psychosis in forensic settings

IRAS Ref: 222323

Sponsor: Cardiff University

R&D Application Documents Received

Document:	Subtitle:	Version:
Other (please specify)	Hazel Powell CD approval	
Evidence of insurance or indemnity (non-NHS sponsors only)	Employers, Public and products liability, Expiry 31 Jul 2017	18 Jul 2016
Research participant consent form	Service user	v1, 09 Jun 2017
Research participant consent form	Service user- Accessible	v1, 09 Jun 2017
Research participant consent form	Staff- Phase 1	v1, 09 Jun 2017
Research participant consent form	Staff- Phase 2	v1, 09 Jun 2017
Summary CV for Academic Supervisor	B Davies	26 Jun 2017
Summary CV for Academic Supervisor	D Hare	26 Jun 2017
Summary CV for Principal Investigator (PI)	S Morgan	08 May 2017
Summary CV for Chief Investigator (CI)	K Jackson-Blott	17 May 2017
GCP Certificates	S Morgan	12 Jul 2013
GCP Certificates	K Jackson-Blott	08 Aug 2016
Research participant information sheet (PIS)	Service user	v1, 09 Jun 2017
Research participant information sheet (PIS)	Service User- Accessible	v1, 09 Jun 2017
Research participant information sheet (PIS)	Staff phase 1	v1, 09 Jun 2017
Research participant information sheet (PIS)	Participant Information- Staff Phase 2 (Version1- 09.06.17)	v1, 09 Jun 2017
REC favourable opinion letter and all correspondence	Favourable opinion	16 Jul 2017
Research protocol		v1, 06 Jun 2017
Written final confirmation from the organisation(s) acting as sponsor	Cardiff University sponsorship letter	06 Jun 2017

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☎ Direct line/Rhif llinell union: 01792 530888

✉ abm.rd@wales.nhs.uk
Research & Development Department
ABM University Health Board
Singleton Hospital
Swansea

25 August 2017

Miss Kim Jackson-Blott
Trainee Clinical Psychologist
South Wales Doctoral Programme in Clinical Psychology
Cardiff University
11th Floor, Tower Building
70 Park Place
CARDIFF
CF10 3AT

Dear Miss Jackson-Blott

Letter of access for research – NHS to NHS

RE: Recovery from psychosis in forensic settings
IRAS REF: 222323

This letter should be presented to each participating organisation before you commence your research at that site, Abertawe Bro Morgannwg University Health Board.

In accepting this letter, each participating organisation confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on 25 August 2017 and ends on 30 June 2018 unless terminated earlier in accordance with the clauses below.

As an existing NHS employee you do not require an additional honorary research contract with the participating organisation(s). The organisation(s) is/are satisfied that the research activities that you will undertake in the organisation(s) are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Your employer has confirmed in writing to this organisation that the necessary pre-engagement checks are in place in accordance with the role you plan to carry out in the organisation(s). Evidence of checks should be available on request to Abertawe Bro Morgannwg University Health Board.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this organisation. ***Please note that you cannot***

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start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project.

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While undertaking research through Abertawe Bro Morgannwg University Health Board, you will remain accountable to your employer Cardiff and Vale University Health Board but you are required to follow the reasonable instructions of the named Local Collaborator, Dr Sara Morgan, Clinical Psychologist, [redacted] ABMU HB or those given on her behalf in relation to the terms of the research.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by [Insert organisation] or this organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with Abertawe Bro Morgannwg University Health Board policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with Abertawe Bro Morgannwg University Health Board in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on Abertawe Bro Morgannwg University Health Board premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each participating [Insert organisation] prior to commencing your research role at each site.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

The organisation(s) will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach

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Pencadlys ABM / ABM Headquarters, 1 Talbot Gateway, Port Talbot, SA12 7BR. Ffon / Tel: (01639) 683344
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of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the organisation(s) accept no responsibility for damage to or loss of personal property.

This letter may be revoked and your right to attend the organisation(s) terminated at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the organisation(s) or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the organisation that employs you through its normal procedures. You must also inform the nominated manager in each participating organisation..

Yours sincerely



Samantha Rees
R&D Administrator
ABMU Health Board

Appendix 11: Semi-Structure Interview Schedule (Phase 1)

SEMI-STRUCTURED INTERVIEW – PHASE 1

What helps the process of recovery from psychosis in a forensic service?

1. What's your role within the service?
 - How do you support patients in their recovery from psychosis?
2. When I talk about recovery from psychosis in forensic services, are there any thoughts/views/experiences that come to mind that you would be happy to share?
 - Thinking of recovery as an outcome, what would the outcome be / how would we know someone was recovering?
 - Thinking of recovery as a process/personal journey, what do you think changes over time?

Intra-psychological

3. Are there any patient characteristics/attitudes that are important to the process of recovery?
Anything that helps/hinders?
4. What do you think helps patients to rebuild a positive sense of identity?

Interpersonal

5. Do you think relationships are important to recovery?
 - Why? / How? / With whom?
6. What type of support is available to help patient's with their relationships?
7. What kind of staff qualities/attitudes help to develop positive relationships with patients?

Institutional Setting

8. Thinking specifically about the forensic setting and service procedures...
 - Is there anything that could hinder recovery? What? How?
 - Is there anything that could help promote recovery? What? How?
9. Are there ways of working within forensic services that can help empower patients?
 - Examples

Societal

10. What opportunities are available to encourage social inclusion?
 - Does anything act as a barrier to social inclusion?
11. Drawing on your experience, what life skills do patients need to develop in order to re-engage with the community?
12. Any final thoughts about factors that promote recover from psychosis in forensic services?

Appendix 12: Final Q-Set

FINAL Q-SET COMPRISING 60 STATEMENTS:

10 domains with 4-7 statements in each

Finding Personal Meaning

1. Thinking and talking about difficult past experiences is harmful
2. Finding personal meanings in the content of psychotic experiences is important
3. Understanding how negative life events have contributed to one's difficulties is important
4. Understanding psychotic experiences as a biological illness is important
5. Finding a religious/spiritual understanding of psychotic experiences is important
6. Recognising the potential for positive change and personal growth is important
7. Developing a positive sense of self and self-worth is important

Coping with Distress

8. Developing skills and confidence to manage strong emotions is important
9. Overcoming self-harm, including substance abuse, is important
10. Resolving difficult feelings and memories is important
11. Being forced to take medication when displaying high levels of distress is important
12. Finding a helpful way of relating to psychotic experiences is important

Symptom Management

13. Taking antipsychotic medication is important
14. The side effects of medication make it harmful
15. Being able to recognise early signs of becoming unwell and having an action plan is important
16. Having *only* non-medical forms of support is harmful

Offense Related Aspects

17. Taking personal responsibility is important
18. Accepting the consequences of the offending behaviour is important
19. Coming to terms with how others view the offense is important
20. Learning to forgive oneself for the offense is important
21. Taking medication in the long term to reduce levels of risk is important
22. Developing an awareness of situations that are likely to lead to offending behaviour is important
23. Finding a way to help others/give back to the community is important

Relationships with Friends and Family

24. Keeping contact with friends and family is important
25. Support to improve family relationships is important
26. Involving family in risk management and care plans is important
27. Support for close friends/family members is important
28. Opportunities for sexual intimacy with consenting others is important
29. Engaging in peer support groups/programmes is important
30. Feeling less alone is important

Relationships with Staff

- 31. Developing genuine relationships with staff is important
- 32. Working with non-judgemental staff who make time to listen is important
- 33. Having ongoing discussions about recovery with hopeful and optimistic staff members is important
- 34. Working with staff who have clear and consistent boundaries is important
- 35. Choosing one's key support staff is important
- 36. Maintaining links with support staff after leaving the service is harmful
- 37. Working collaboratively with staff to arrive at a shared understanding of the problem is important

Basic Needs

- 38. Engaging in spiritual or religious practices is important
- 39. Whilst restrictive, living in a secure environment with locked doors promotes feelings of safety and is important
- 40. Freedom from constant money worries is important
- 41. Engaging in enjoyable and relaxing activities is important
- 42. Establishing healthy routines is important

Empowerment

- 43. Identifying personal values and working towards positive goals is important
- 44. Engaging in creative arts is important
- 45. Opportunities to take risks are harmful
- 46. Being offered choice about whether or not to take medication is harmful
- 47. Having a say about one's risk management and care plan is important
- 48. Opportunities to get involved in the delivery and development of the service are important
- 49. Feeling able to ask for help when needed is important

Aspects of Service Provision

- 50. Working alongside a team of professionals is important
- 51. Being guided by doctor-led decisions is important
- 52. Receiving evidence-based treatments is important
- 53. Taking part in talking therapy is important
- 54. Care plans that focus less on difficulties and more on personal strengths are important

Socio-Cultural and Economic Factors

- 55. Recognising the social injustice in one's life is important
- 56. Engaging in meaningful employment (paid/voluntary) is important
- 57. Engaging in education that is personally meaningful is important
- 58. Developing life skills is important
- 59. Using community services and engaging in community-based activities is important
- 60. Discrimination/stigma within the community is harmful

Appendix 13: Summary Tables for Each Factor Array of Statements

Factor 1					
No.	Most Strongly Agree	Q-sort Value	No.	Most Strongly Disagree	Q-sort Value
7	Developing a positive sense of self and self-worth is important	6	46	Being offered choice about whether or not to take medication is harmful	-6
12	Finding a helpful way of relating to psychotic experiences is important	6	11	Being forced to take medication when displaying high levels of distress is important	-6
24	Keeping contact with friends and family is important	5	51	Being guided by doctor-led decisions is important	-5
2	Finding personal meanings in the content of psychotic experiences is important	5	4	Understanding psychotic experiences as a biological illness is important	-5
43	Identifying personal values and working towards positive goals is important	5	16	Having only non-medical forms of support in the first instance is harmful	-5
8	Developing skills and confidence to manage strong emotions is important	4	45	Opportunities to take risks are harmful	-4
3	Understanding how negative life events have contributed to one's difficulties is important	4	5	Finding a religious/spiritual understanding of psychotic experiences is important	-4
15	Being able to recognise early signs of becoming unwell and having an action plan is important	4	1	Thinking and talking about difficult past experiences is harmful	-4
32	Working with non-judgemental staff who make time to listen is important	4	36	Maintaining links with support staff after leaving the service is harmful	-4

Factor 2					
No.	Most Strongly Agree	Q-sort Value	No.	Most Strongly Disagree	Q-sort Value
15	Being able to recognise early signs of becoming unwell and having an action plan is important	6	1	Thinking and talking about difficult past experiences is harmful	-6
21	Taking medication in the long term to reduce levels of risk is important	6	36	Maintaining links with support staff after leaving the service is harmful	-6
17	Taking personal responsibility is important	5	14	The side effects of medication make it harmful	-5
50	Working alongside a team of professionals is important	5	46	Being offered choice about whether or not to take medication is harmful	-5
53	Taking part in talking therapy is important	5	45	Opportunities to take risks are harmful	-5
9	Overcoming self-harm, including substance abuse, is important	4	2	Finding personal meanings in the content of psychotic experiences is important	-4
13	Taking antipsychotic medication is important	4	28	Opportunities for sexual intimacy with consenting others is important	-4
34	Working with staff who have clear and consistent boundaries is important	4	23	Finding a way to help others/give back to the community is important	-4
22	Developing an awareness of situations that are likely to lead to offending behaviour is important	4	38	Engaging in spiritual or religious practices is important	-4

Factor 3					
No.	Most Strongly Agree	Q-sort Value	No.	Most Strongly Disagree	Q-sort Value
58	Developing life skills is important	6	36	Maintaining links with support staff after leaving the service is harmful	-6
39	Whilst restrictive, living in a secure environment promotes feelings of safety and is important	6	22	Developing an awareness of situations that are likely to lead to offending behaviour is important	-6
4	Understanding psychotic experiences as a biological illness is important	5	17	Taking personal responsibility is important	-5
23	Finding a way to help others/give back to the community is important	5	38	Engaging in spiritual or religious practices is important	-5
24	Keeping contact with friends and family is important	5	14	The side effects of medication make it harmful	-5
8	Developing skills and confidence to manage strong emotions is important	4	5	Finding a religious/spiritual understanding of psychotic experiences is important	-4
19	Coming to terms with how others view the offence is important	4	27	Support for close friends/family members is important	-4
28	Opportunities for sexual intimacy with consenting others is important	4	31	Developing genuine relationships with staff is important	-4
44	Engaging in creative arts is important	4	13	Taking antipsychotic medication is important	-4

Factor 4					
No.	Most Strongly Agree	Q-sort Value	No.	Most Strongly Disagree	Q-sort Value
15	Being able to recognise early signs of becoming unwell and having an action plan is important	6	36	Maintaining links with support staff after leaving the service is harmful	-6
23	Finding a way to help others/give back to the community is important	6	1	Thinking and talking about difficult past experiences is harmful	-6
27	Support for close friends/family members is important	5	38	Engaging in spiritual or religious practices is important	-5
13	Taking antipsychotic medication is important	5	57	Engaging in education that is personally meaningful is important	-5
49	Feeling able to ask for help when needed is important	5	10	Resolving difficult feelings and memories is important	-5
18	Accepting the consequences of the offending behaviour is important	4	45	Opportunities to take risks are harmful	-4
51	Being guided by doctor-led decisions is important	4	44	Engaging in creative arts is important	-4
9	Overcoming self-harm, including substance abuse, is important	4	14	The side effects of medication make it harmful	-4
30	Feeling less alone is important	4	5	Finding a religious/spiritual understanding of psychotic experiences is important	-4